Employee Enrollment Application

Anthem

Your Anthem enrollment application is inside. It is essential that you read it carefully and complete all necessary sections.

If you are a new enrollee

- **Applying for health, vision and/or [redacted] benefits, please complete Sections 1, 3, 4, 5, 6, 7, and 8. Your signature is required in Section 8.**
- **Waiving any or all benefits, please complete Sections 1, 4, and 9. Your signature is required in Section 9.**

If you are adding a dependent(s)

Complete Section 2 in addition to the above.

It is important that you read and understand the Significant Terms, Conditions and Authorizations in Section 8.

Thank you for choosing Anthem Blue Cross and Blue Shield.

www.anthem.com

Note: You may be required to supply additional information.

Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.

Enrollment Application

Anthem

Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.
Please complete this form in ink and return to your employer. Use extra sheets of paper if necessary.
All information given should apply to this employer. Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through www.anthem.com.

EMPLOYER USE ONLY			
Group no. 004002025	Section no.	Package no.	Request effective date (MM/DD/YYYY)
Employer name: Mahoning County School Employees Insurance Consortium		Address (please include suite no., city, state, ZIP code)	
Health effective date (MM/DD/YYYY)	Dental effective date (MM/DD/YYYY)	Vision effective date (MM/DD/YYYY)	

Section 1. REASON FOR APPLICATION

☐ New enrollment ☐ Waiver ☐ Add dependent (see Section 2) ☐ Rehire (event date) _____
☐ New hire ☐ Annual open enrollment ☐ COBRA Qualifying event _____

Section 2. STATUS CHANGE/EVENT

☐ Event date (MM/DD/YYYY)	☐ Marriage ☐ Birth	☐ Adoption* ☐ Legal guardianship* *Include legal documentation	☐ Other _____

Section 3. TYPE OF COVERAGE/PLAN

Health coverage	Dental coverage	Vision coverage
☐ Medical	☐ Dental	☐ Vision
☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family coverage ☐ No coverage	☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family coverage ☐ No coverage	☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family coverage ☐ No coverage

Section 4. EMPLOYEE INFORMATION (*Only complete Primary Care Physician (PCP) information when enrolling in HMO or POS products.)

Social security no. (required)	Last name	First name	M.I.	Age	Date of birth (MM/DD/YYYY)

Home address (street, city, state, ZIP code)	County	☐ Single ☐ Divorced ☐ Married	Sex ☐ M ☐ F

Home phone	Work phone	E-mail address	Are you retired? ☐ Yes ☐ No	Are you disabled? ☐ Yes ☐ No	Are you hospitalized? ☐ Yes ☐ No

Occupation	Full-time hire date (MM/DD/YYYY)	Income reported by ☐ W2 ☐ 1099 ☐ Other	Hours working per week

Policyholder name	Policyholder social security no.

Section 5. FAMILY INFORMATION – Spouse and dependents to be enrolled. Attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information under Significant Terms, Conditions and Authorizations section, prior to answering questions below.

1 — Relationship to employee: ☐ Spouse

Dependent name (last name, first name, M.I.)	Social security no. (required for spouse)	Sex ☐ M ☐ F	Date of birth
Is dependent's address different than applicant's address? ☐ Yes ☐ No If yes, please provide full address _____	**Court ordered health care benefits? ☐ Yes ☐ No** (If Yes, include legal documentation)	**Currently hospitalized or disabled? ☐ Yes ☐ No** (If Yes, give reason)	

2 — Relationship to employee: ☐ Son ☐ Daughter ☐ Other _____

Dependent name (last name, first name, M.I.)	Social security no.	Sex ☐ M ☐ F	Date of birth
Is dependent's address different than applicant's address? ☐ Yes ☐ No If yes, please provide full address _____	**Court ordered health care benefits? ☐ Yes ☐ No** (If Yes, include legal documentation)	**Currently hospitalized or disabled? ☐ Yes ☐ No** (If Yes, give reason)	
Is dependent handicapped? ☐ Yes ☐ No			

3 — Relationship to employee: ☐ Son ☐ Daughter ☐ Other _____

Dependent name (last name, first name, M.I.)	Social security no.	Sex ☐ M ☐ F	Date of birth
Is dependent's address different than applicant's address? ☐ Yes ☐ No If yes, please provide full address _____	**Court ordered health care benefits? ☐ Yes ☐ No** (If Yes, include legal documentation)	**Currently hospitalized or disabled? ☐ Yes ☐ No** (If Yes, give reason)	
Is dependent handicapped? ☐ Yes ☐ No			

Section 6. OTHER HEALTH COVERAGE Please check one: ☐ Yes (complete below) ☐ No

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Name of person(s) covered	Relationship to employee ☐ Self ☐ Spouse ☐ Child(ren)	Name of the HMO or insurance company	Policy/certificate no.
Address of the HMO or insurance company		Phone no. of HMO or insurance company	Effective date (MM/DD/YYYY)
Policyholder name		Policyholder social security no.	Policyholder date of birth

Section 7. MEDICARE COVERAGE If you or your dependents are enrolled in Medicare or Medicaid, complete the following.

1 — Name of enrollee (last name, first name, M.I.)		Medicare Part A effective date	Medicare Part B effective date
Medicare/Medicaid ID no.	ESRD onset date	Medicare Part D ID no.	Medicare Part D carrier
Reason for Medicare entitlement ☐ Age ☐ Disability ☐ End stage renal disease (ESRD) ☐ ESRD and disability		Medicare Part D effective date	Medicare Part D term date
2 — Name of enrollee (last name, first name, M.I.)		Medicare Part A effective date	Medicare Part B effective date
Medicare/Medicaid ID no.	ESRD onset date	Medicare Part D ID no.	Medicare Part D carrier
Reason for Medicare entitlement ☐ Age ☐ Disability ☐ End stage renal disease (ESRD) ☐ ESRD and disability		Medicare Part D effective date	Medicare Part D term date

Policyholder name	Policyholder social security no.

Section 8. SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATION (TERMS)

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application, the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: Except as otherwise provided in any agreement between me and *the financial custodian*, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before *the financial custodian* may provide Anthem Blue Cross and Blue Shield with information regarding my HSA. I hereby authorize *the financial custodian* to provide Anthem Blue Cross and Blue Shield with information about my HSA, including account number, account balance and information, regarding account activity. I also understand that I may provide Anthem Blue Cross and Blue Shield with a written request to revoke my authorization at any time.

Please read this section carefully before signing the application.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield administered benefit plan.
2. I authorize deduction from my wages/pension, if necessary for the required payment for the benefit for which I, or any dependents have applied.
3. I am applying for the benefit selected on this application. If I select a coverage, or combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.
6. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of enrollment. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to benefits or rates. Any material misrepresentation or significant omission found in this application may result to denial of benefits or rescission or cancellation of my benefits.

Ohio: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

Kentucky: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health benefit plan will be administered by one of the following companies based upon the state in which your employer is located:

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.

In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.

In Missouri: Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc.

In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

In Wisconsin: Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin ("BCBSWi"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Read the TERMS section above carefully before signing. Please review your application for errors or omissions.

By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Applicant signature X	Date

Policyholder name	Policyholder social security no.

Section 9. WAIVER OF COVERAGE – For employee and/or any eligible dependent not enrolling.

Check all that apply:

Waiving: □Health □Dental □Vision □All

Name of person waiving	Already protected by coverage of: □ Spouse □Parent □None

Employer name	Carrier:□Anthem (give certificate/policy no.)	□Other carrier (give name, ID no.)

Check all that apply:

Waiving: □ Health □Dental □Vision □All

Name of person waiving	Already protected by coverage of: □ Spouse □Parent □None

Employer name	Carrier:□Anthem (give certificate/policy no.)	□Other carrier (give name, ID no.)

Check all that apply:

Waiving:□Health□ Dental □Vision □ All

Name of person waiving	Already protected by coverage of: □ Spouse □Parent □None

Employer name	Carrier:□Anthem (give certificate/policy no.)	□ Other carrier (give name, ID no.)

Check all that apply:

Waiving: □ Health □ Dental □ Vision □All

Name of person waiving	Already protected by coverage of: □ Spouse □ Parent□None

Employer name	Carrier:□Anthem (give certificate/policy no.)	□ Other carrier (give name, ID no.)

Check all that apply:

Waiving: □ Health □ Dental□ Vision□ All

Name of person waiving	Already protected by coverage of: □Spouse □Parent □None

Employer name	Carrier:□Anthem (give certificate/policy no.)	□ Other carrier (give name, ID no.)

I certify that I have been given an opportunity to apply for the employer's health benefits plan, and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such benefits hereafter, I may do so, subject to established procedures.

If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- **Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or**
- **My dependent or I become eligible for a subsidy (state premium assistance program).**

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Applicant signature X	Date