Employee Enrollment Application
For 2–50 Employee Small Groups
Missouri

Anthem BlueCross BlueShield

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete in blue or black ink only.

Section A: Employee Information

Last name	First name	M.I.	Social Security no.

Home address – Street and PO Box if applicable	City	State	ZIP code

County	Marital status ☐ Single ☐ Married ☐ Domestic Partner	Primary phone no.	Secondary phone no.

Employee email address

Employer name	Group no. (if known)

Employer street address	City	State	ZIP code

Employment status ☐ Full time ☐ Part time ☐ Disabled ☐ Retired	Hire date (MM/DD/YYYY)	First date of full-time employment (MM/DD/YYYY)	No. of hours worked per week

Section B: Application Type

Select one

☐ New enrollment

☐ COBRA –
Select qualifying event
☐ Left employment
☐ Loss of dependent child status
☐ Medicare
☐ Reduction in hours
☐ Divorce or legal separation
☐ Covered employee's Medicare entitlement
☐ Death

Qualifying event date

Reset Form Save and Print

Employee name	Social Security no.

Section C: Type of Coverage

1. Medical Coverage

Enter network selected: _____

Enter product selected: _____

Enter contract code selected: _____

Member medical coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

Please Note:
You must enroll in the pediatric dental coverage option/rider/endorsement unless you will be enrolled in a standalone dental plan that has been certified by a state Exchange. To determine if your standalone dental plan has been certified by a state Exchange, please refer to your health plan enrollment information or the website for your state Exchange. If you will be enrolled in a standalone dental plan meeting this requirement, please check here. ☐

2. Dental Coverage

☐ I am enrolling in my Employer's dental plan.

Member dental coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

3. Vision Coverage

☐ I am enrolling in my Employer's vision plan, if any.

Member vision coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

Employee name	Social Security no.

4. Life and Disability Coverage

If you select Life and/or Disability coverage over the guarantee issue amount or are a late entrant an Evidence of Insurability form will be sent to you to complete.

☐ Basic Life & AD&D ☐ Short-Term Disability ☐ Basic Dependent Life ☐ Long-Term Disability	Life Class
Current income: $ _____ ☐ Hour ☐ Week ☐ Month ☐ Year	Occupation

Primary Beneficiary – Attach a separate sheet if necessary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Contingent Beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address					Percentage to be paid to beneficiary

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above.

NOTICE OF EXCHANGE OF INFORMATION: To proposed Insured and other persons proposed to be Insured, if any – information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse consent for designation.)
If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature	Spouse name	Date
X		

Employee name	Social Security no.

Section D: Coverage Information — All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Employee last name	First name	M.I.	Sex	Disabled	Birthdate (MM/DD/YYYY)
			☐ Male ☐ Female	☐ Yes ☐ No	
Relationship to applicant Self	PCP name				PCP ID no.

Have you used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Are you currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.	Sex	Disabled	Birthdate (MM/DD/YYYY)
				☐ Male ☐ Female	☐ Yes ☐ No	
Relationship to applicant ☐ Spouse ☐ Domestic Parther	PCP name					PCP ID no.

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

Dependent last name	First name	M.I.	Social Security no.	Sex	Disabled	Birthdate (MM/DD/YYYY)
				☐ Male ☐ Female	☐ Yes ☐ No	
Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ________	PCP name					PCP ID no.

Does this dependent have a different address?
☐ Yes ☐ No If yes, please enter: ________

Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

Dependent last name	First name	M.I.	Social Security no.	Sex	Disabled	Birthdate (MM/DD/YYYY)
				☐ Male ☐ Female	☐ Yes ☐ No	
Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ________	PCP name					PCP ID no.

Does this dependent have a different address?
☐ Yes ☐ No If yes, please enter: ________

Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

Dependent last name	First name	M.I.	Social Security no.	Sex	Disabled	Birthdate (MM/DD/YYYY)
				☐ Male ☐ Female	☐ Yes ☐ No	
Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ________	PCP name					PCP ID no.

Does this dependent have a different address?
☐ Yes ☐ No If yes, please enter: ________

Has this dependent used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this dependent currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

Employee name	Social Security no.

Section E: Other Group Coverage

Are you or anyone applying for coverage currently eligible for Medicare?
☐ Yes ☐ No

If yes, give name: _____

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date _____

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date

On the day your coverage begins, will you or a family member be covered by Medicare?
☐ Yes ☐ No

On the day your coverage begins, will you or a family member be covered by other health coverage?
☐ Yes ☐ No

If yes to either of these questions, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:

Employee name	Social Security no.

Section F: Waiver/Declining Coverage

Medical Coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Reason for declining medical coverage – check all that apply:

- ☐ Covered by spouse's group coverage
- ☐ Spouse covered by employer's group coverage
- ☐ Enrolled in other Insurance – List plan: _____
- ☐ Enrolled in Individual coverage
- ☐ Spouse covered by employer's group medical Coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other: _____
- ☐ No coverage

Dental Coverage

Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Reason for declining dental coverage – check all that apply:

- ☐ Covered by spouse's group coverage
- ☐ Spouse covered by employer's group coverage
- ☐ Enrolled in other Insurance – List plan: _____
- ☐ Enrolled in Individual coverage
- ☐ Spouse covered by employer's group medical Coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other: _____
- ☐ No coverage

Vision Coverage

Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Reason for declining vision coverage – check all that apply:

- ☐ Covered by spouse's group coverage
- ☐ Spouse covered by employer's group coverage
- ☐ Enrolled in other Insurance – List plan: _____
- ☐ Enrolled in Individual coverage
- ☐ Spouse covered by employer's group medical Coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other: _____
- ☐ No coverage

Life/Disability Coverage

***Life/Disability** coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Reason for declining life/disability coverage – check all that apply:

- ☐ Covered by spouse's group coverage
- ☐ Spouse covered by employer's group coverage
- ☐ Enrolled in other Insurance – List plan: _____
- ☐ Enrolled in Individual coverage
- ☐ Spouse covered by employer's group medical Coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other: _____
- ☐ No coverage

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Social Security no.	Date (MM/DD/YYYY)
X			

Employee name	Social Security no.

Section G: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 30 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible dependent:

- Employee's spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental handicap, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that:

I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

For Health Savings Account enrollees: 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 with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

Sign here	Applicant signature X	Date (MM/DD/YYYY)

Special Enrollment Rights

If you declined enrollment for yourself or your dependent(s) (including a spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:

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

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

Employee name	Social Security no.