Enrollment Agreement

NOTE: Shaded areas to be completed by **EMPLOYER**
Boxed areas for internal use only
All other areas to be completed by **SALES** prior to submission

☐ Matthew Thornton Blue℠† ☐ BlueChoice®† 2 Tier ☐ BlueChoice®† 3 Tier ☐ HMO Blue®† NE
☐ BlueChoice®† NE ☐ PPO ☐ Indemnity
☐ Lumenos Health Savings Account*
 ☐ Group will establish the H.S.A., but does not want Anthem to faciliate.
 ☐ If Lumenos H.S.A. with Incentives is selected, Employer will provide the H.S.A. plan through a cafeteria plan.
☐ Lumenos Health Reimbursement Account
 ☐ Contribution to H.R.A. $____________ individual $ ____________ family
☐ Lumenos Health Incentive Account ☐ Lumenos Health Incentive Account Plus ☐ Other ____________________

Effective Date ____________________ ☐ New ☐ Benefit Change ☐ Rate Change Only ☐ Other ____________________

* requires completion of H.S.A. addendum for groups of 51+.

Firm Number ____________________ Firm/Division Number ____________________ HBP Number ____________________

Employer Name ____________________
Contact Name ____________________
Anthem Account Manager ____________________
Mailing Address ____________________
Physical Address ____________________
Phone Number (______) ____________________ Fax Number (______) ____________________
E-Mail Address ____________________

Anniversary ____________________ Renewal month (only if different than anniversary) ____________________
65 Type ________________ Medicomp Group Number ____________________ SIC ____________________

New Hire Policy (Probationary Period) First of the month following ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ Other (explain) ____________________
____
Rehire Policy ____________________
Termination Policy ____________________

Standard Indicator ____________________ Benefit Description ____________________
Bill Format: ☐ 1 Invoice per Firm ☐ 1 Invoice per Division ☐ 1 Invoice per HBP
Dependent Student Age Policy _______to________ Rate Method ☐ Fully insured ☐ Self insured ☐ Contingent ☐ Other ____________
Proration Policy ____________________ Tier (TR) ____________________
Binder Check Received ☐ Yes (complete below) ☐ No
Name as it appears on check ____________________
Check Number ________________ Check Amount ________________
COBRA Compliant? (please circle) Yes No OBRA Compliant? Yes No
Takeover Group: Yes No Name of carrier replaced ____________________
Prior BCBS Firm/Division Number ____________________

Employer Contribution toward Health Premium: Employee ________________ Dependent ____________________
Coverage Eligibility: HRS ____________________

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In New Hampshire, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of New Hampshire, Inc., an independent licensee of the Blue Cross and Blue Shield Association.
® Registered marks of the Blue Cross and Blue Shield Association.

† Administered by Anthem Blue Cross and Blue Shield and underwritten by Matthew Thornton Health Plan.

Enrollment Agreement (Page 2)

Firm/Division Name ______________________ Firm/Division Number ______________________

Enrollment:

Total Employees on Payroll	Total Employees Eligible	New Applications	Transfer Applications	Covered Through Spouse	Covered Through HMO	Total Covered	Refusals	% Participation

Date Business established: ____/____/____ Nature of Business ______________________

Monthly premium rates for the period of ______________ to ______________ are as follows:

Individual	Couple	Parent/Child	Family
$	$	$	$

Premium Arrangement ______________________

Proposal Number ______________________ Workers Comp Carrier ______________________

Comments: ______________________

These rates are effective for the period outlined above. Prior to each annual date, renewal rates will be provided and community rates will be automatically renewed.

By signing this agreement the undersigned acknowledges that the remitting agent is not an agent of Anthem BCBS.

Dated at ______________ This ______ day of ______________ .

Signature of Employer

Signature of Anthem BCBS Representative

Information below to be completed only for groups sold through a broker:

Check if change in broker: ☐ Check if no broker: ☐

Broker Information:

Cross Reference # ______________

Arrangement Start Date: ______________ Arrangement End Date: ______________

Contract Start Date: ______________ Contract End Date: ______________

Agency Name: ______________ Agency #: ______________

Broker Name: ______________ Broker #: ______________

Address: ______________________

Commission Scales:

☐ Market Leader ☐ Value Partner ☐ Exceptional Achiever

Phone number ______________ Fax number ______________

Signature of Employer

Signature of Broker

This signature designates said broker as the “Broker of Record” for our health insurance program. I understand this authorizes payment of any commission he/she is entitled to as a result of this agreement.

For Office Use Only: ______________
Date Received: ______________
Completed by ______________ on ______________

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