

# Managed Care Member Enrollment/Member Change Form



PLEASE PRINT IN BLUE OR BLACK INK. SEE REVERSE SIDE FOR INSTRUCTIONS.

|   |   |   |   |                               |                              |                         |
|---|---|---|---|-------------------------------|------------------------------|-------------------------|
| <b>1. Tell Us About Yourself</b><br>Current Anthem Identification Number, if any _____<br>Subscriber's Social Security Number _____<br>Last Name _____ First Name _____ M.I. _____<br>Home Address Number and Street or P.O. Box _____ Apt. # _____<br>City _____ State _____ Zip Code _____<br>Home Telephone ( ) _____<br>Please check one:<br>The applicant is <input type="checkbox"/> Active Employee <input type="checkbox"/> Retired Employee <input type="checkbox"/> COBRA <input type="checkbox"/> Other: _____   | <b>2. New Membership</b><br><input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment<br><input type="checkbox"/> New Group (initial enrollment) <input type="checkbox"/> Waive Coverage (Go to Box 10)<br><input type="checkbox"/> Rehire<br><input type="checkbox"/> Retiree - date of retirement _____<br><input type="checkbox"/> COBRA - start date _____<br>COBRA qualifying event: _____<br><input type="checkbox"/> Other (reason) _____ | <b>Anthem Use Only</b><br><table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%;">Issued Effective Date<br/>____/____/____</td> <td style="width:50%;">Firm Division Number<br/>_____</td> </tr> <tr> <td>Health Benefit Plan<br/>_____</td> <td>Waiting Period<br/>_____</td> </tr> </table> | Issued Effective Date<br>____/____/____ | Firm Division Number<br>_____ | Health Benefit Plan<br>_____ | Waiting Period<br>_____ |
| Issued Effective Date<br>____/____/____   | Firm Division Number<br>_____   |   |   |                               |                              |                         |
| Health Benefit Plan<br>_____  | Waiting Period<br>_____   |   |   |                               |                              |                         |
| <b>3. Change Membership</b> Date of Change or Event _____<br><b>Type of Change:</b> <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Add Dependent <input type="checkbox"/> Remove Dependent <input type="checkbox"/> PCP Change<br><b>Reason for Change. Please check all that apply:</b><br><input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Death<br><input type="checkbox"/> Involuntary Loss of Coverage <input type="checkbox"/> Involuntary Loss of Medicaid <input type="checkbox"/> Covered by Medicaid <input type="checkbox"/> Covered by Other Insurance<br><input type="checkbox"/> Open Enrollment <input type="checkbox"/> Entrance to the Military <input type="checkbox"/> Discharge from the Military <input type="checkbox"/> Divorce<br><input type="checkbox"/> Court Order <input type="checkbox"/> Voluntary Cancellation <input type="checkbox"/> Other _____ |   |   |   |                               |                              |                         |

|   |   |   |
|---|---|---|
| <b>4. Your Membership Choices</b><br><input type="checkbox"/> HMO <input type="checkbox"/> HMO New England <input type="checkbox"/> BlueChoice <input type="checkbox"/> BlueChoice New England<br><b>Type of Membership:</b> <input type="checkbox"/> Single <input type="checkbox"/> Couple <input type="checkbox"/> Parent/Child(ren) <input type="checkbox"/> Family | <b>5. Where You Work</b><br>Company Name _____<br>Date of Hire <input type="checkbox"/> Rehire <input type="checkbox"/> ____/____/____ Date Eligible ____/____/____ | <b>Firm Number/Health Benefit Plan</b><br>(ex: 123456000 001) |
|---|---|---|

**6. List Members To Be Added/Cancelled**

\*In order to be eligible for the highest level of benefits available through your coverage, you and your dependents must choose a primary care provider from the Network Directory and write the provider's code number in the Primary Care Provider/PCP code box(es). Before selecting a provider designated as "Current Patients Only" in the directory, be sure to contact the provider's office to verify your status as a current patient.  
 If your Group Health Benefit Plan includes covering Domestic Partners, a completed affidavit of Domestic Partnership must be attached to this application. See reverse side for further instructions.

| Sex  | Names of Person(s) to be covered  |            |      | Add | Remove | Birthdate | Primary Care Physician<br>Each member must fill in PCP information.<br>For current listing of valid PCP's go to <a href="http://www.anthem.com">www.anthem.com</a> | PCP Number | Current Patient  |
|--|---|------------|------|-----|--------|-----------|--|------------|--|
|  | Last Name   | First Name | M.I. |     |        |           |  |            |  |
| <input type="checkbox"/> M<br><input type="checkbox"/> F | Self  |            |      |     |        |           | Name   | PCP Number | <input type="checkbox"/> Y<br><input type="checkbox"/> N |
| <input type="checkbox"/> M<br><input type="checkbox"/> F | Legal Spouse <input type="checkbox"/> or Domestic Partner (DP) <input type="checkbox"/> |            |      |     |        |           | Name   | PCP Number | <input type="checkbox"/> Y<br><input type="checkbox"/> N |
| <input type="checkbox"/> M<br><input type="checkbox"/> F | Dependent   |            |      |     |        |           | Name   | PCP Number | <input type="checkbox"/> Y<br><input type="checkbox"/> N |
| <input type="checkbox"/> M<br><input type="checkbox"/> F | Dependent   |            |      |     |        |           | Name   | PCP Number | <input type="checkbox"/> Y<br><input type="checkbox"/> N |
| <input type="checkbox"/> M<br><input type="checkbox"/> F | Dependent   |            |      |     |        |           | Name   | PCP Number | <input type="checkbox"/> Y<br><input type="checkbox"/> N |

**Note: If Electing Dependent Coverage, please list all eligible children, and complete a Dependent Student Certification Form if dependent has reached the age of 19 and is attending an accredited school full time. If your child is disabled, incapable of self-support and over the age of 19 complete a Certification for a Mentally or Physically Incapacitated Dependent Child Form. This form must also be completed by your physician.**

**7. Tell Us About Your Other Insurance** **Note: All questions must be answered before Enrollment/Member Change form can be processed.**

**A.** Will you or any other family member covered under this policy also have medical coverage from another health plan? (Including another Anthem or Blue Cross Blue Plan)  
 Yes  No If yes, name and address of insurer \_\_\_\_\_  
 Name of insured \_\_\_\_\_ Date of birth \_\_\_\_\_ Policy # \_\_\_\_\_ Effective Date \_\_\_\_\_  Single  Two Person  Family

**B.** Will medical coverage you are now electing replace another health insurance?  Yes  No If yes, name and address of insurer \_\_\_\_\_  
 Group # \_\_\_\_\_ Policy # \_\_\_\_\_ Effective Date of Policy \_\_\_\_\_ End Date of Policy \_\_\_\_\_

**C.** Are all of your eligible dependents/spouse applying for coverage?  Yes  No If not, why \_\_\_\_\_

**D.** If you have listed a dependent that is not a stepchild and does not have your last name, please indicate why. \_\_\_\_\_

**8. Other Information**

Is anyone listed on this application currently eligible for Medicare?  Yes  No *If yes, please complete the following for each person to be covered who has Medicare.*

| Name(s) of Medicare Beneficiaries |      |           | Health Insurance Claim Number | Medicare Part A Effective Date | Medicare Part B Effective Date | Check all reasons you qualified for Medicare |            |      |
|-----------------------------------|------|-----------|-------------------------------|--------------------------------|--------------------------------|--|------------|------|
| First Name                        | M.I. | Last Name |                               | / /                            | / /                            | Age 65                                       | Disability | ESRD |
|                                   |      |           |                               | / /                            | / /                            |  |            |      |
|                                   |      |           |                               | / /                            | / /                            |  |            |      |

**9. Employee Signature**

I am requesting coverage for myself and all 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 to the best of my knowledge and belief. 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 denial of insurance benefits. I understand all benefits are subject to conditions stated in the group agreement and Certificate of Coverage.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

**10. Election Not To Enroll**

I do not wish to enroll in a plan. Please check one:

I have other coverage. Employer offering coverage \_\_\_\_\_ Insurance Co \_\_\_\_\_

I do not have any other coverage. I understand that the opportunity to enroll at any future date will be subject to any group requirements, Anthem policies and NH RSA 420-G:8.

\_\_\_\_\_  
Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date

# Welcome to Anthem Blue Cross and Blue Shield

Please follow the instructions below to complete your Enrollment Application.

## **Box 1: Tell Us About Yourself**

This is required information. The Current Anthem Identification Number should only be completed if you are changing, updating or terminating an existing policy. You will not have an Anthem ID Number if this is a new enrollment.

## **Box 2: New Membership**

This is required information if you are a New Hire, Rehire, New Enrollee or COBRA participant.

## **Box 3: Change Membership**

This is required information if you are an existing member changing your membership. New subscribers are not required to complete this information.

## **Box 4: Your Membership Choices**

This information is mandatory for New Enrollment. It is optional for all other changes.

## **Box 5: Where You Work**

The Company Name, the Firm Division Number and the Health Benefit Plan Number are mandatory when completing this application. The Date of Hire/Rehire is mandatory for New Members only.

## **Box 6: List Members To Be Added/Cancelled**

This is required information for New Members, Dependent Removals/Additions, Primary Care Physician (PCP) Changes, Date of Birth Changes/Updates, and Dependent Name Changes. It is not required for: Address Changes or Terminating the Entire Policy.

**Note:** The Domestic Partner rider may be available to be purchased by your group if certain criteria have been met. Please check with your Benefit Administrator to find out if your group offers this benefit and to complete the required affidavit.

## **Box 7 and 8: Tell Us About Your Other Insurance and Other Information**

This information is **required** when enrolling as a new member or when a member is added to your existing policy. Your application will be returned, if this information is not completed.

**Note:** Each year, Anthem Blue Cross and Blue Shield saves millions of dollars for our members and groups through Coordination of Benefits. Other insurance and/or Medicare information helps to ensure that you receive all the benefits to which you are entitled. By dividing health care expenses appropriately between your plans, we can better control health care costs.

## **Box 9: Employee Signature**

You must sign your application for it to be valid. If you are a Benefit Administrator terminating a Subscriber, please sign your name in the space provided.

## **Box 10: Election Not To Enroll**

Complete this box only if you are waiving coverage.

**Completed applications may be returned to Anthem Blue Cross and Blue Shield by one of two methods:**

**Mail:** Anthem Blue Cross and Blue Shield, 3000 Goffs Falls Road, Manchester, NH 03111-0001

**Fax:** (603) 645-5830