Anthem Use Only

Member ID Number_____ Firm # _____ Effective Date _____

Anthem®

Managed Care Member Enrollment/Member Change Form

PLEASE PRINT IN BLUE OR BLACK INK. SEE REVERSE SIDE FOR INSTRUCTIONS. NEW MEMBERS OF SMALL GROUPS MUST ALSO COMPLETE A STANDARDIZED HEALTH FORM.

1. Tell Us About Yourself

Current Anthem Identification Number, if any

Subscriber's Social Security Number

Last Name | First Name | M.I.

Home Address Number and Street or P.O. Box | Apt. #

City | State | Zip Code

2. New Membership

☐ Rehire ___/___/___ ☐ COBRA start date ___/___/___ ☐ Open Enrollment

☐ New Hire ___/___/___ ☐ COBRA qualifying event ___/___/___ ☐ Waive Coverage (Go to Box 6)

☐ New Group (initial enrollment) ☐ Other (reason) _____

☐ Retiree – date of retirement ___/___/___

3. Change to Existing Membership

Date of Change or Event _____

Type of Change: ☐ Name Change ☐ Address Change ☐ Add Dependent ☐ Remove Dependent ☐ PCP Change

Reason for Change. Please check all that apply:

☐ Marriage ☐ Birth ☐ Adoption ☐ Death

☐ Open Enrollment ☐ Military Entrance/Discharge ☐ Covered by Medicaid ☐ Loss of Coverage

☐ Court Order ☐ Voluntary Cancellation ☐ Divorce

☐ Other_____

4. Your Membership Choices

☐ HMO ☐ HMO New England ☐ BlueChoice ☐ BlueChoice New England

Type of Membership: ☐ Single ☐ Couple ☐ Parent/Child(ren) ☐ Family

5. Employer Information

Company Name _____ Firm No./Health Benefit Plan (ex:654321 000 000) _____

☐ Date of Hire ___/___/___ ☐ Date of Rehire ___/___/___ ☐ Date Eligible ___/___/___

6. Election Not To Enroll

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

☐ 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.

☐ I have other coverage. Name of policyholder _____ Insurance Company _____

_____ ___/___/___

Signature | Date

7. 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 enrollment form. See reverse side for further instructions.

Add	Remove	Names of Person(s) to be covered Last Name / First Name / M.I.	Sex	Birthdate	Primary Care Provider Each member must fill in PCP information. For current listing of valid PCPs go to **anthem.com** Name / PCP Number	Current Patient
		Self	☐ M ☐ F		Name / PCP Number	☐ Y ☐ N
		Legal Spouse ☐ or Domestic Partner (DP) ☐	☐ M ☐ F		Name / PCP Number	☐ Y ☐ N
		Dependent	☐ M ☐ F		Name / PCP Number	☐ Y ☐ N
		Dependent	☐ M ☐ F		Name / PCP Number	☐ Y ☐ N
		Dependent	☐ M ☐ F		Name / PCP Number	☐ Y ☐ 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.

8. Prior Coverage Information - This section must be completed.

Have you or any other family member had health insurance coverage in the 63 days prior to your date of hire or the effective date of your new policy? ☐ Yes ☐ No ***If yes, please complete the following:***

	Self	Spouse/Domestic Partner	Dependents		
			1	2	3
Name of Insurance Company					
Certificate (Policy) Number					
Insurer's Telephone Number					
Date Coverage Began					
Date Coverage Ended or Is Coverage Still In Effect?					

9. Medicare 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)	Health Insurance Claim Number	Medicare Part A Effective Date	Medicare Part B Effective Date	Medicare Part D Effective Date	Check all reasons you are Medicare qualified: Age 65	Disability	ESRD
		/ /	/ /	/ /			
		/ /	/ /	/ /			

10. 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

Anthem Use Only **Notes:**

Initials _____ Date Processed ___/___/___

Welcome to Anthem Blue Cross and Blue Shield

Please follow the instructions below to complete your Enrollment Application. You must complete and submit a Standardized Health Form if your Group Health Benefit Plan is offered through a small employer group (1-50 lives). Please check with your employer's Benefit Administrator for further information.

Box 1: Tell Us About Yourself
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, COBRA participant or a Retiree.

Box 3: Change to Existing Membership
This is required information if you are an existing member changing your membership status. 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: Employer Information
The Company Name, Firm Division Number and Health Benefit Plan Number are mandatory when completing this application. The Date of Hire/Rehire is mandatory for New Members Only.

Box 6: Election Not To Enroll
Complete this box only if you are waiving coverage.

Box 7: List Members to Be Added/Cancelled
This is required information for New Members, Dependent Removal/Additions, Primary Care Provider (PCP) Changes, Date of Birth Changes/Updates and Dependent Name Changes. It is not required for Address Changes or Terminating the Entire Policy.

Box 8: Prior Coverage 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.

Box 9: Medicare Information
This information is required for any member on this policy who is over 65 years of age or eligible for Medicare.

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

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) 665-5420