Firm # \_\_\_\_\_ Effective Date \_\_\_\_\_



# **PPO/Indemnity 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. 1	Fell	Us About Yourself			2. New Membership								
Current Anthem Identification Number, if any					□ Rehire//	rt date/			Open Enrollment				
					New Hire/      COBRA qualifying event/     New Group (initial enrollment)      Retiree – date of retirement					Waive Coverage ( Life Event	Go to Box 6)		
Sub	scrib	er's Social Security Number		Other (reason)									
1	Nan	ne First Name		M.I.	3. Change to Existing Membership Date of Change or Event								
Last	Nan	ie First Name		Type of Change: 🗆 Name Change 🔅 Address Change 🔅 Add Dependent 📄 Remove Dependent									
Hom	ne Ac	Idress Number and Street or P.O. Box	Apt. #	Reason for Change. Please check all that apply:       Marriage       Birth       Adoption   Death									
				Open Enrollment Military Entrance/Discharge Covered by Medicaid Loss of Coverage									
City		State	Zip Code	Court Order Other	□ Voluntary Cancellation	LI Div	orce						
4. Your Membership Choices 5. Employer Information													
Preferred Blue®     Indemnity     Other:     Lumenos® H.S.A.*     Lumenos H.R.A.     Lumenos H.I.A. Plus				pany Name Firm No./Health Benefit Plan (ex:654321 000 000)									
Lumenos H.I.A.			A	Date of Hire/ Date of Rehire/ Date Elig						ole/ /			
		them will facilitate the opening of a Health Saving me, if directed by your Employer.	is Account in your										
	Гуре	of Membership:	d(ren) 🗆 Family										
	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.													
		Signatu	ate										
7.1	7. List Members To Be Added/Cancelled 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 o	covered								
4	Ber	Last Name		First Name		M.I.		Sex		Birthdate			
		Self						□ M □ F					
		Legal Spouse 🔲 or Domestic Partner (DP) 📋						□ M □ F					
	Dependent												
	Dependent							□ F □ M					
Dependent							□ F □ M						
								ΠF					
	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.												
		or Coverage Information - This section n	•										
Hav	Have you or any other family member had health insurance coverage in the 63 days			days prior to your da Self	bur date of hire or the effective date of your new policy?  Yes No Spouse/Domestic Partner			If yes, please complete the following: Dependents					
				3611				1 2 3			3		
	Name of Insurance Company												
		ate (Policy) Number s Telephone Number											
		werage Began											
		verage Ended or Is Coverage Still In Effect?											
		dicare Information one listed on this application currently eligibl	e for Medicare?	🗆 Yes 🗖 No 🛛	lf yes, please complete	the following for each	person to be cove	ered who	has Medi	icare.			
Name(s)			Health Insurance		Medicare Part A	Medicare Part B Medicare		Part D Check all r		easons you qualified for Medicare			
			Claim	Number	Effective Date	Effective Date	Effective Date	•	Age 65	Disability	ESRD		
					/ /	/ /	1 1						
					/ /	/ /	/ /						
		ployee Signature questing coverage for myself and all dependents li	sted and authorize n	nv employer to deduc	t any required contributio	ns for this insurance from	my earnings. All st	tatements	and answe	ers I have given a	re 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.													
Per	iditi	es may include imprisonment, tines or denial of ins	surance denefits. I ur	iderstand all denetits	are subject to conditions	stated in the group agreen	ient and Certificate	UI GOVERA	ye.				
		Employee Signature		/ / Date									
						540							
Anthem Use Only Notes:													
Init	ial	s Date Processed _	/ /										
				Shield is the trade name of Anti	hem Health Plans of New Hamoshiro In	c., an independent licensee of the Rive (	Cross and Blue Shield Δeencia	ation.					
0			® R	egistered marks of the Blue Cross	hem Health Plans of New Hampshire, In s and Blue Shield Association. ® LUME	NOS is a registered trademark.		-					

# 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 is 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.

Anthem Comsumer-driven Plan Descriptions:

Anthem Lumenos H.S.A. = Lumenos Health Savings Account Anthem Lumenos H.I.A. = Lumenos Health Incentive Account Anthem Lumenos H.I.A. Plus = Lumenos Health Incentive Account Plus Anthem Lumenos H.R.A. = Lumenos Health Reimbursement Account

### **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 Physician (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 03111-0001Fax:(603) 665-5420