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