Employee Enrollment Form
For Small Groups
New Hampshire

Anthem BlueCross BlueShield

You, the employee, must fill out this enrollment form. You must be sure that all the information is correct and that you fill out all the sections that relate to you. To make sure you are enrolled as soon as possible, please answer all questions and then sign and date the form.

Please fill out in blue or black ink only.

Section A: Employee Information

Last name	First name	M.I.	Social Security no.* (required)

Home address – Street and PO Box if applicable

City	County	State	ZIP code

Marital status	Main phone no.	Secondary phone no.
☐ Single ☐ Married ☐ Domestic Partner ☐ Civil Union		

Employee email address

Employer name	Group no. (if known)

Employer street address

City	County	State	ZIP code

Employment status	Hire date (MM/DD/YYYY)	Re-hire date (MM/DD/YYYY)	No. of hours worked per week
☐ Full time ☐ Part time ☐ Disabled ☐ Retired			

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other – please specify: _____

Do you read and write English?
☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability

Section B: Enrollment Type

Choose one

☐ New enrollment
☐ Open enrollment

☐ COBRA –
Choose qualifying event
☐ Left employment
☐ Loss of dependent child status
☐ Medicare
☐ Reduction in hours
☐ Divorce or legal separation
☐ Covered employee's Medicare entitlement
☐ Death

COBRA Qualifying event date	COBRA start date	COBRA end date

*Anthem is required by the Internal Revenue Service to collect this information.

Section C: Type of Coverage

1. Medical Coverage — choose one plan

PPO Plans	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
Preferred Blue PPO		☐ 1000/20%/3500 ☐ 1000/20%/3500 P2 ☐ 2000/0%/3500 ☐ 2000/20%/3500 P2 ☐ 2000/20%/4000 ☐ 3000/0%/3250 ☐ 3000/0%/4000 ☐ 5000/0%/5000	☐ 1500/20%/6350 w/HSA ☐ 2500/20%/4500 w/HSA ☐ 3000/0%/3000 w/HSA ☐ 4000/0%/6500 ☐ 4000/20%/6350 ☐ 5000/0%/6000 ☐ 5250/20%/6350	☐ 4000/20%/6350 Plus w/HSA ☐ 4000/20%/6350 Plus w/HSA w/Dental ☐ 5500/0%/5500 w/HSA
POS Plans	**Anthem Platinum**	**Anthem Gold**	**Anthem Silver**	**Anthem Bronze**
BlueChoice New England POS			☐ 1500/20%/6350 w/HSA ☐ 2500/20%/4500 w/HSA ☐ 3000/0%/3000 w/HSA	☐ 4000/20%/6350 Plus w/HSA ☐ 4000/20%/6350 Plus w/HSA w/Dental ☐ 5500/0%/5500 w/HSA
HMO Plans	**Anthem Platinum**	**Anthem Gold**	**Anthem Silver**	**Anthem Bronze**
Access Blue New England HMO		☐ 1000/20%/3500 ☐ 1000/20%/3500 P2 ☐ 2000/0%/3500 ☐ 2000/20%/3500 P2 ☐ 2000/20%/4000 ☐ 3000/0%/3250 ☐ 3000/0%/4000 ☐ 5000/0%/5000	☐ 4000/0%/6500 ☐ 4000/20%/6350 ☐ 5000/0%/6000 ☐ 5250/20%/6350	
HMO Blue New England		☐ 1000/20%/2500 Plus ☐ 1000/20%/2500 Plus w/Dental ☐ 1000/20%/3500 ☐ 1000/20%/3500 P2 ☐ 2000/0%/3500 ☐ 2000/20%/3500 P2 ☐ 2000/20%/4000 ☐ 3000/0%/3250 ☐ 3000/0%/4000 ☐ 5000/0%/5000	☐ 4000/0%/4250 Plus ☐ 4000/0%/4250 Plus w/Dental ☐ 4000/0%/6500 ☐ 4000/20%/6350 ☐ 5000/0%/6000 ☐ 5250/20%/6350 ☐ 5800/0%/6600	☐ 6100/0%/6600 Plus
Matthew Thornton Blue HMO		☐ 1000/20%/2500 Plus ☐ 1000/20%/2500 Plus w/Dental ☐ 1000/20%/3500 ☐ 1000/20%/3500 P2 ☐ 2000/0%/3500 ☐ 2000/20%/3500 P2 ☐ 2000/20%/4000 ☐ 3000/0%/3250 ☐ 3000/0%/4000 ☐ 5000/0%/5000	☐ 4000/0%/4250 Plus ☐ 4000/0%/4250 Plus w/Dental ☐ 4000/0%/6500 ☐ 4000/20%/6350 ☐ 5000/0%/6000 ☐ 5250/20%/6350 ☐ 5800/0%/6600	☐ 6100/0%/6600 Plus

Member medical coverage — choose one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner/Civil Union ☐ Employee + child(ren) ☐ Family

Contract Code

Please indicate the contract code for the medical plan chosen. Contract code: _____

2. Dental Coverage – choose all that apply

☐ Anthem Dental Family ☐ Anthem Dental Family Enhanced ☐ Anthem Dental Pediatric ☐ None

Member dental coverage – choose one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner/Civil Union ☐ Employee + child(ren) ☐ Family

3. Vision Coverage – choose one plan

Full Service			Materials Only Plans
☐ Anthem Blue View Vision A1	☐ Anthem Blue View Vision B1	☐ Anthem Blue View Vision C1	☐ Anthem Blue View Vision M01
☐ Anthem Blue View Vision A2	☐ Anthem Blue View Vision B2	☐ Anthem Blue View Vision C2	☐ Anthem Blue View Vision M02
☐ Anthem Blue View Vision A3	☐ Anthem Blue View Vision B3	☐ Anthem Blue View Vision C3	☐ None
☐ Anthem Blue View Vision A4	☐ Anthem Blue View Vision B4	☐ Anthem Blue View Vision C4	
☐ Anthem Blue View Vision A5		☐ Anthem Blue View Vision C7	

Member vision coverage – choose one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner/Civil Union ☐ Employee + child(ren) ☐ Family

Section D: Coverage Information — All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse, domestic partner or civil union partner, your children, your spouse's, domestic partner's or civil union partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the oldest.

Employee last name			First name		M.I.
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant Self		
PCP name			PCP ID no.	Existing patient ☐ Yes ☐ No	

Have you used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ **Yes** ☐ **No**
Are you now enrolled or willing to enroll in a tobacco cessation (stop smoking) wellness program? ☐ **Yes** ☐ **No**

Spouse/Domestic Partner/Civil Union last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Ex/Legal spouse ☐ Domestic Partner ☐ Civil Union		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ **Yes** ☐ **No**
Has this person enrolled in or is willing to enroll in a tobacco cessation (stop smoking) wellness program? ☐ **Yes** ☐ **No**

Dependent last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ____________		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No

Does this dependent have a different address?
☐ **Yes** ☐ **No If yes, please enter:** ____

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ **Yes** ☐ **No**
Has this person enrolled in or is willing to enroll in a tobacco cessation (stop smoking) wellness program? ☐ **Yes** ☐ **No**

Dependent last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ____________		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No

Does this dependent have a different address?
☐ **Yes** ☐ **No If yes, please enter:** ____

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ **Yes** ☐ **No**
Has this person enrolled in or is willing to enroll in a tobacco cessation (stop smoking) wellness program? ☐ **Yes** ☐ **No**

Dependent last name			First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ____________		
PCP name			PCP ID no.		Existing patient ☐ Yes ☐ No

Does this dependent have a different address?
☐ **Yes** ☐ **No If yes, please enter:** ____

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ **Yes** ☐ **No**
Has this person enrolled in or is willing to enroll in a tobacco cessation (stop smoking) wellness program? ☐ **Yes** ☐ **No**

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Section E: Other Group Coverage

Are you or anyone applying for coverage currently eligible for Medicare?
☐ Yes ☐ No

If yes, give name: _____

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date _____
Medicare Part D ID no.	Medicare Part D Carrier		Part D effective date

On the day your coverage starts, will you or a family member be covered by Medicare?
☐ Yes ☐ No

On the day your coverage starts, will you or a family member be covered by other health coverage?
☐ Yes ☐ No

If yes to either of these questions, please include the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental				Start: End:

Section F: Waiver/Declining Coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner/Civil Union ☐ Dependent(s)

Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner/Civil Union ☐ Dependent(s)

Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner/Civil Union ☐ Dependent(s)

Reason for declining coverage – check all that apply:

☐ Covered by spouse's group coverage
☐ Enrolled in other Insurance provided by my employer
☐ Enrolled in Individual coverage
☐ Spouse covered by employer's group medical Coverage
☐ Medicare/Medicaid/VA
☐ Other – please explain: _____
☐ No coverage

Section G: Terms, Conditions and Authorizations

Please read this section carefully before signing the enrollment form.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 31 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they don't work the required number of hours per week described above.

Eligible dependent:

- Employee's spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of a child who cannot support himself or herself because of mental or physical handicap that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

As an eligible employee, I am requesting coverage for myself and all eligible 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 a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Agreement and coverage document.

W-9 Certification Language – Please check below to indicate your understanding:

☐ As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

In signing this enrollment form I represent that:

I have read or have had read to me the completed enrollment form, and I realize any false statement or misrepresentation in the enrollment form may result in loss of coverage.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time. ☐ Yes ☐ No

Sign here	Applicant signature X	Date (MM/DD/YYYY)

Coverage Option

If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, Anthem Blue Cross and Blue Shield or by another carrier.

The following applies if you selected stand alone vision or dental in Section C:

- **Limited benefit disclosure:** The policy/certificate provides vision benefits only. Review your policy/certificate carefully.
- **Limited benefit disclosure:** The policy/certificate provides dental benefits only. Review your policy/certificate carefully.

Sign here	Applicant signature X	Date (MM/DD/YYYY)