

Enrollment Application and Change Form.

New Coverage Request for Change



1 EMPLOYEE INFORMATION									
Last Name	First Name	MI	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Social Security Number	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Domestic <input type="checkbox"/> Married <input type="checkbox"/> Partner			
Home Address				City	State	Zip Code	Home Phone Number		
Employer Name City of St. Louis, Group 00210779.		Department			<input type="checkbox"/> Active <input type="checkbox"/> Retired (Date: _____)		Work Phone Number		

2 TYPE OF MEDICAL COVERAGE	3 WHO SHOULD BE COVERED	4 TYPE OF CHANGE
Plan Selection: <input type="checkbox"/> AccessChoice -- High Option or <input type="checkbox"/> AccessChoice -- Low Option Reason for Application: <input type="checkbox"/> New Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> COBRA Decline Coverage: <input type="checkbox"/> I decline coverage for myself; <input type="checkbox"/> I decline coverage for my dependents Reason for Decline: <input type="checkbox"/> Covered under another plan; <input type="checkbox"/> Other: _____ *Note: If you are declining coverage for yourself or your dependents, because of coverage under other health coverage, you are required to complete this section. Your failure to do so may cause you or your dependents to be considered a late enrollee if you enroll in this plan at a later date. (see Sections 6 and 7 below)	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee Plus Spouse <input type="checkbox"/> Employee Plus Child(ren) <input type="checkbox"/> Employee Plus Family	<input type="checkbox"/> Add Spouse/Child (complete Sec. 5) <input type="checkbox"/> Surviving Spouse -- Former Employee SSN: <input type="checkbox"/> Terminate Spouse/Child (complete Sec. 5) _____ <input type="checkbox"/> Address (enter above) <input type="checkbox"/> COBRA Continuee -- Former employee SSN: <input type="checkbox"/> Name Change (complete Sec. 5) _____ <input type="checkbox"/> Reinstatement -- Reason: _____ <input type="checkbox"/> Other: _____ HIPAA Qualifying Event: Date of qualifying event: ____/____/_____ <input type="checkbox"/> Marriage, <input type="checkbox"/> Birth, <input type="checkbox"/> Adoption, <input type="checkbox"/> Legal Guardianship, <input type="checkbox"/> Other _____

5 COVERAGE INFORMATION									
(A) Add (T) Term (C) Chg	Last Name	First Name	MI	Dependent SSN	Date of Birth (MM/DD/YY)	Relation to Employee	Sex	Other Insurance	Disabled
	Employee:								
	Dependent:					<input type="checkbox"/> Spouse, <input type="checkbox"/> Daughter, <input type="checkbox"/> Son <input type="checkbox"/> Other:	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	
	Dependent:					<input type="checkbox"/> Spouse, <input type="checkbox"/> Daughter, <input type="checkbox"/> Son <input type="checkbox"/> Other:	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Dependent:					<input type="checkbox"/> Spouse, <input type="checkbox"/> Daughter, <input type="checkbox"/> Son <input type="checkbox"/> Other:	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Dependent:					<input type="checkbox"/> Spouse, <input type="checkbox"/> Daughter, <input type="checkbox"/> Son <input type="checkbox"/> Other:	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

6 OTHER INSURANCE		
On the day coverage begins, will you, your spouse, or any of your dependents be covered under any other health plan or policy including another Anthem plan, Medicare or Medicaid? <input type="checkbox"/> Y <input type="checkbox"/> N		
Is another person legally responsible for coverage for your children? <input type="checkbox"/> Y <input type="checkbox"/> N		
<i>If you answered Yes to either of the questions above, complete the following:</i>		
Person's Name with Other Health Plan:		Social Security Number:
Date of Birth:	Sex:	Other Company's Name and Phone Number:
Other Company's Policy Number and Effective Date:		
Medicare Number:	Part A Eff. Date:	Part B Eff. Date:

7 AUTHORIZATION
On behalf of myself and anyone enrolled on or added to this form ("Us"), I authorize any health care professional or entity to give Anthem and its affiliates (and the employer) or any of their designees, any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes, I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statements made on this application may invalidate my and/or my dependents' coverage. I further understand that coverage will become effective only on the date specified by the Insurer or Plan Administrator after it has been approved by the insurer or Plan Administrator and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct. If my employer's Plan plan is a contributory plan, I direct my employer to deduct the amount of any required contributions from my pay. I can cancel this direction in writing at any time.
Notice of Enrollment Rights: I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health Coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.
Signature: _____ Date: _____

8 TO BE COMPLETED BY EMPLOYER						
Date of Hire:	Date Submitted:	Health/Change Eff. Date:	Policy Number:	Health Plan:	Subgroup:	Employer Signature: