

Enrollment Application and Change Form.



New Coverage Request for Change

EMPLOYEE INFORMATION

1		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"/> Married <input type="checkbox"/> Domestic Partner	
		Home Address	City of St. Louis, Group 00221231			City	State	Zip Code	Home Phone Number
		Employer Name	Department					Work Phone Number	

2 TYPE OF MEDICAL COVERAGE

Plan Selection: AccessChoice - High Option or AccessChoice - Low Option
 Reason for Application: New Enrollment New Hire COBRA
 Decline Coverage: I decline coverage for myself. I decline coverage for my dependents
 Reason for Decline: Covered under another plan; 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)

3 WHO SHOULD BE COVERED

- Employee Only
 Employee Plus Spouse
 Employee Plus Child(ren)
 Employee Plus Family

4 TYPE OF CHANGE

- Add Spouse/Child (complete Sec. 5) Surviving Spouse - Former Employee SSN:
 Terminate Spouse/Child (complete Sec. 5) COBRA Continue - Former employee SSN:
 Address (enter above)
 Name Change (complete Sec. 5)
 Reinstatement - Reason: _____
 Other: _____
 HIPAA Qualifying Event: Date of qualifying event: ____/____/____
 Marriage, Birth, Adoption, Legal Guardianship, Other _____

COVERAGE INFORMATION

5	(A) Add (D) 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:					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:					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:					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

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? Y N
 Is another person legally responsible for coverage for your children? Y N
 If you answered Yes to either of the questions above, complete the following:
 Person's Name with Other Health Plan: _____ Social Security Number: _____

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: _____

TO BE COMPLETED BY EMPLOYER

8	Date of Hire:	Date Submitted:	Health/Change Eff. Date:	Policy Number:	Health Plan:	Subgroup:	Employer Signature:
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