Enrollment Application

Chamber Benefit Arrangement of Indiana

Administered by:

Please complete electronically or in black or blue ink for employee and all dependents enrolling with us and return to your employer. Use extra sheets of paper if necessary. Please provide complete details to avoid delay. Please note that no one will be denied health coverage on an individual basis due to the answers provided below. All information given should apply to this employer.

Section 1: Type of coverage requested

☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ Life only ☐ No coverage

Section 2: Enrollment information

☐ Single ☐ Married ☐ Divorced

Relationship	Last name, first name, M.I.	Social Security no.[1] (required)	Sex	Date of birth (MMDDYY)	Height	Weight	Disabled
Employee			☐ M ☐ F				☐ Yes ☐ No
Spouse			☐ M ☐ F				☐ Yes ☐ No
☐ Child ☐ Other: ____			☐ M ☐ F				☐ Yes ☐ No
☐ Child ☐ Other: ____			☐ M ☐ F				☐ Yes ☐ No
☐ Child ☐ Other: ____			☐ M ☐ F				☐ Yes ☐ No
☐ Child ☐ Other: ____			☐ M ☐ F				☐ Yes ☐ No

Employee home street address	City	State	ZIP code	County

Employee home phone	Employee work phone	Employee email address

Dependent home street address – if different from employee	City	State	ZIP code	Dependent names

Section 3: Medical information

Please read the Genetic Information Non-discrimination Act (GINA) information in section 11, prior to answering the below questions.

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? ☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No

   If yes, name: ______________________ Due date: ______ (MMDDYY)
4. In the past five years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ Yes ☐ No
5. In the last five years have you or any of your dependents been diagnosed or treated for any of the following? ☐ Yes ☐ No

   Check all that apply.

   ☐ Arthritis
   ☐ Back/disk disorder
   ☐ Cancer/tumor
   ☐ COPD
   ☐ Crohn's disease
   ☐ Depression, alcohol or drug abuse/dependency
   ☐ Diabetes (list age of onset below)
   ☐ Disorder of the blood or immune system
   ☐ Emphysema
   ☐ Heart/circulatory condition
   ☐ Kidney, liver or pancreas disorder
   ☐ Lung disorder
   ☐ Lupus
   ☐ Mental/nervous disorder
   ☐ Multiple sclerosis
   ☐ Muscular dystrophy
   ☐ Stroke, aneurysm
   ☐ Ulcerative colitis
   ☐ Other condition: ______________________

Explain "Yes" answers to any question. Give complete details to avoid delay. Attach a separate sheet of paper if necessary.

Quest. no.	Name of individual	Diagnosis	Treatment	Medication	Onset date (MMDDYY)	Date(s) of treatment	Hospitalized	Surgery	Recovered
							☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
							☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
							☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N
							☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N

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

Life and Disability products underwritten by Anthem Life Insurance Company. Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensees of the Blue Cross and Blue Shield Association.
Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Name	Social Security no.

Section 4: Reason for application

☐ New enrollment/hire – Date of hire: (MMDDYY) ☐ Rehire – Date of rehire: (MMDDYY) ☐ Open enrollment (N/A for Life coverage) ☐ Add dependent ☐ COBRA – Event: ______ Date: ☐ State Continuation ☐ Waiver	Qualifying event – please complete date and reason. Event date: (MMDDYY) ☐ Marriage ☐ Divorce ☐ Birth of child ☐ Adoption ☐ Terminated employment ☐ Other: ______

Section 5: Group information

Group name			Group no.		Subgroup no.
Group street address		City	State	ZIP code	Full-time hire/rehire date
Employee status ☐ Active ☐ Disabled ☐ Retired ☐ Other: ______	Hours working per week	Occupation		Income reported by ☐ W-2 ☐ 1099 ☐ Other: ______	
Annual salary	If not actively at work, reason				Projected return date

Section 6: Coverage selection – Availability dependent upon your employer's offering

Medical coverage – Select one: ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ No coverage CHA medical plan: ______ Contract code: ______
Dental coverage – Select one: ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ No coverage
Vision coverage – Select one: ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ No coverage

Section 7: Life and disability insurance

☐ Basic Life ☐ Dependent Life	☐ Basic AD&D	☐ Short Term Disability ☐ Long Term Disability		Life class	
Current income: $______ ☐ Hour ☐ Week ☐ Month ☐ Year					
	Name of beneficiary	Percentage	Social Security no.	Relationship to applicant	Age
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

A separate health statement is required for life or disability coverage in excess of Guaranteed Benefit or late enrollment.

Name	Social Security no.

Section 8: Waiver of coverage – Must be completed if employee and/or dependents waive medical, vision, dental or life coverage.
NOTE: If waiving coverage, please complete this section. Section 12 must also be signed and dated.

Medical coverage declined for – Check all that apply: ☐ Myself ☐ Spouse ☐ Dependent(s)
Dental coverage declined for – Check all that apply: ☐ Myself ☐ Spouse ☐ Dependent(s)
Vision coverage declined for – Check all that apply: ☐ Myself ☐ Spouse ☐ Dependent(s)
Life coverage declined for: ☐ Myself

Reason for declining coverage – Check all that apply:
☐ Covered by spouse's group coverage – Carrier name: ______________________ ID no.: __________
☐ Enrolled in other insurance provided by my employer – Carrier name: ______________________ ID no.: __________
☐ Enrolled in individual coverage – Carrier name: ______________________ ID no.: __________
☐ Spouse covered by employer's group medical coverage
☐ Medicare
☐ Other: ______________________
☐ No coverage

Section 9: Prior health insurance information – Prior health care coverage during the past two years (including Anthem)

Insurance company name(s)	Policy no.	Effective date (MMDDYYYY)	Cancellation date (MMDDYYYY)

Type of prior coverage: ☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family ☐ Other: __________

Section 10: Other health insurance information

On the day your coverage begins, will you or a family member be covered by other health insurance coverage and/or Medicare? ☐ Yes ☐ No

Family members covered by other health coverage			
Insurance company name		Policy no.	Effective date (MMDDYYYY)
Insurance company street address	City	State / ZIP code	Insurance company phone no.
Policy/certificate holder's name	Social Security no.	Date of birth (MMDDYYYY)	Relationship to applicant

Family members covered by Medicare			Medicare ID no.
Part A effective date	Part B effective date	Medicare eligibility reason – Check all that apply ☐ Age ☐ Disability ☐ ESRD – Onset date: ________ (MMDDYYYY)	
Medicare Part D carrier	Medicare Part D ID no.	Part D effective date	Part D termination date

Name	Social Security no.

Section 11: Significant Terms, Conditions and Authorizations (TERMS) please read this section carefully before signing the application in section 12.

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: 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 Blue and Cross Blue Shield (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.

1. I may not assign any payment under my Anthem and/or Chamber Benefit Arrangement of Indiana program unless required by law.
2. I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied (Anthem Life Insurance Company may accept only certain persons or conditions for coverage).
3. If I am declining enrollment for myself or my dependent(s) (including my spouse) because of other health insurance or group health plan coverage, I understand that I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards my coverage or my dependent's other coverage). However, I must request enrollment within 31 days after my coverage or my dependent's other coverage ends (or after the employer stops contribution toward the other coverage).

In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent(s) provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependent or I become eligible for a subsidy (state premium assistance program).

  In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

I certify each Social Security number listed on this application is correct.

I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem and/or Chamber Benefit Arrangement of Indiana in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to coverage or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being rescinded or canceled.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

Section 12: Signature required

By signing below, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms. I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem and/or Chamber Benefit Arrangement of Indiana.

Applicant signature	Printed name	Date (MMDDYYYY)
X		

Thank you for choosing Anthem Blue Cross and Blue Shield.

Anthem use only – Coordination of benefits? ☐ Yes ☐ No