

Employee Enrollment Application

For 51+ employee groups

Indiana



You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete electronically or in blue or black ink only.

Employer name C l a r k s v i l l e S c h o o l s	Group no. L 1 0 1 2 0	Subsection
--	--------------------------	------------

Section 1: Employee information

Last name		First name		M.I.	Social Security no.* (required)	
Birthdate (MMDDYYYY)		Home address				
City			County		State	ZIP code
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner			Primary phone no.		
Employee email address						
Employment status <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Disabled <input type="checkbox"/> Retired			Hire date (MMDDYYYY)		No. of hours worked per week	
Primary Care Physician (PCP) name			PCP ID no.		Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Section 2: Reason for application — Select one

<input type="checkbox"/> New enrollment <input type="checkbox"/> Annual open enrollment <input type="checkbox"/> New hire <input type="checkbox"/> Rehire — Rehire date: _____ (MMDDYYYY) <input type="checkbox"/> Marriage — Date of marriage: _____ (MMDDYYYY) <input type="checkbox"/> Birth of child <input type="checkbox"/> Add dependent (Fill in section 4) <input type="checkbox"/> Loss of eligibility for other coverage — Date previous coverage ended: _____ (MMDDYYYY) <input type="checkbox"/> COBRA — Select qualifying event <input type="checkbox"/> Left employment <input type="checkbox"/> Reduction in hours <input type="checkbox"/> Death <input type="checkbox"/> Medicare <input type="checkbox"/> Loss of dependent child status <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Covered employee's Medicare entitlement Qualifying event date: _____ (MMDDYYYY) <input type="checkbox"/> Waiver (To decline ALL coverage skip to section 8.)	
---	--

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Social Security no.* (required): _____

C. Dependents, Critical Illness, and Hospital Indemnity Insurance beneficiary designation. Attach a separate sheet if necessary.

Beneficiary type	Name of beneficiary	Percentage	Social Security no.	Relationship to applicant	Date of birth
<input type="checkbox"/> Primary	_____	____%	_____	_____	____/____/____
<input type="checkbox"/> Contingent	Street address	City	State	ZIP code	Phone no.
_____	_____	_____	_____	_____	_____
Beneficiary type	Name of beneficiary	Percentage	Social Security no.	Relationship to applicant	Date of birth
<input type="checkbox"/> Primary	_____	____%	_____	_____	____/____/____
<input type="checkbox"/> Contingent	Street address	City	State	ZIP code	Phone no.
_____	_____	_____	_____	_____	_____
Beneficiary type	Name of beneficiary	Percentage	Social Security no.*	Relationship to applicant	Date of birth
<input type="checkbox"/> Primary	_____	____%	_____	_____	____/____/____
<input type="checkbox"/> Contingent	Street address	City	State	ZIP code	Phone no.
_____	_____	_____	_____	_____	_____
Beneficiary type	Name of beneficiary	Percentage	Social Security no.*	Relationship to applicant	Date of birth
<input type="checkbox"/> Primary	_____	____%	_____	_____	____/____/____
<input type="checkbox"/> Contingent	Street address	City	State	ZIP code	Phone no.
_____	_____	_____	_____	_____	_____

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

Section 4: 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 or domestic partner, your children, or your spouse or domestic 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 eldest.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 6 of the application, under Section 6, Terms, Conditions, and Authorizations, prior to answering the questions in Section 4.

Spouse/Domestic Partner last name		First name		M.I.	Social Security no.* (required)
_____		_____		_____	_____
Sex	Disabled	Birthdate (MMDDYYYY)	Relationship to applicant		
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		
PCP name			PCP ID no.	Existing patient?	
_____			_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Dependent last name		First name		M.I.	Social Security no.* (required)
_____		_____		_____	_____
Sex	Disabled	Birthdate (MMDDYYYY)	Relationship to applicant		
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	<input type="checkbox"/> Biological child of applicant/spouse/domestic partner		
<input type="checkbox"/> Other If other, what is relationship? _____					
PCP name			PCP ID no.	Existing patient?	
_____			_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please enter: _____					

Dependent last name		First name		M.I.	Social Security no.* (required)
_____		_____		_____	_____
Sex	Disabled	Birthdate (MMDDYYYY)	Relationship to applicant		
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____	<input type="checkbox"/> Biological child of applicant/spouse/domestic partner		
<input type="checkbox"/> Other If other, what is relationship? _____					
PCP name			PCP ID no.	Existing patient?	
_____			_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please enter: _____					

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

Social Security no.* (required): _____

Section 4: Coverage information — Continued.

Dependent last name		First name		M.I.	Social Security no.* (required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MMDDYYYY)	Relationship to applicant <input type="checkbox"/> Biological child of applicant/spouse/domestic partner <input type="checkbox"/> Other If other, what is relationship? _____		
PCP name			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____					

Section 5: Prior and 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 (MMDDYYYY)	Part B effective date (MMDDYYYY)	Medicare eligibility reason (check all that apply) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD: Onset date: _____ (MMDDYY)		
Medicare Part D ID no.	Medicare Part D carrier			Part D effective date (MMDDYYYY)	

Are you or a family member previously or currently covered by a Medicare, medical and/or dental plan? Yes No
If yes, please provide 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.	Policyholder name	Dates (if applicable) (MMDDYY)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia					Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia					Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia					Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia					Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia					Start: _____ End: _____

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

Section 6: Terms, Conditions, and Authorizations (TERMS)**Please read this section carefully before signing the application.**

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield (Anthem) facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem at any time.

1. I understand that I may not assign any payment under my Anthem program.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I have read and accept the Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. For a period of two (2) years from the earlier of the policy date or the issue date, Anthem may deny benefits, rescind your policy or cancel coverage based on material misrepresentation or significant omission found in this application. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

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

FRAUD NOTICE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 7: Signature — Required if you are applying for coverage. Please review your application for errors or omissions.**Read section 6 carefully before signing.**

I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature

X

Date (MMDDYYYY)

Important Accident Insurance eligibility information:

The following notice applies to all Accident and Voluntary Accident coverage presented on this form:

ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Critical Illness Insurance eligibility information:

The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:

CRITICAL ILLNESS INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Hospital Indemnity Insurance eligibility information:

The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:

HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Section 8: Waiver/Declining coverage

Medical coverage			
<p>Medical coverage declined for — check all that apply: Reason for declining coverage — check all that apply:</p>	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Covered by spouse's/domestic partner's group coverage <input type="checkbox"/> Enrolled in other insurance — Please provide company name and plan: _____ <input type="checkbox"/> Enrolled in individual coverage <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Medicare/Medicaid/VA <input type="checkbox"/> Other — please explain: _____ <input type="checkbox"/> No coverage		
Dental coverage			
<p>Dental coverage declined for — check all that apply: Reason for declining coverage — check all that apply:</p>	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Covered by spouse's/domestic partner's group coverage <input type="checkbox"/> Enrolled in other insurance — Please provide company name and plan: _____ <input type="checkbox"/> Enrolled in individual coverage <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Medicare/Medicaid/VA <input type="checkbox"/> Other — please explain: _____ <input type="checkbox"/> No coverage		
Vision coverage			
<p>Vision coverage declined for — check all that apply: Reason for declining coverage — check all that apply:</p>	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Covered by spouse's/domestic partner's group coverage <input type="checkbox"/> Enrolled in other insurance — Please provide company name and plan: _____ <input type="checkbox"/> Enrolled in individual coverage <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Medicare/Medicaid/VA <input type="checkbox"/> Other — please explain: _____ <input type="checkbox"/> No coverage		
Sign here only if you are declining coverage.			
<p>Signature of applicant</p> <p>X</p>	<p>Printed name</p>	<p>Social Security no.</p>	<p>Date (MMDDYYYY)</p>

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish

Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese

您有權免費獲得透過您使用的語言提供的幫助。請撥打您的ID卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese

Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean

귀하는 자국어로 무료 지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog

May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian

Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian

Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi

"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French

Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic

لك الحق في الحصول على مساعدة بلغتك مجاناً. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese

お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian

Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòm tou.

Italian

Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish

Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi

ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫਤ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800-368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>