

EMPLOYEE HEALTH ENROLLMENT APPLICATION

Group Size 2-14

Please PRINT in ink and return to your employer. Use extra sheets of paper if necessary. Primary Care Physician (PCP) listings can be obtained through www.anthem.com.

APP

EMPLOYER/GROUP USE ONLY

Group Name		Group Number		Effective Date M D Y	
Date of hire	Full time hire date	# Hours working per week	Date of eligibility for coverage		
Position/Title			Employee's Social Security #:		

1. CHECK COMPANY(S) AND WRITE IN PRODUCT THAT APPLIES. APPLICATION COMPLETED FOR:

Anthem Blue Cross and Blue Shield

HealthKeepers, Inc. _____ (HMO)

Note for Lumenos Health Savings Account (HSA) enrollees:

If you enroll in an Anthem Lumenos HSA plan, Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

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 or by Anthem Blue Cross and Blue Shield.

Limited Mandate PPO Plan Disclosures

In addition to offering health benefit plans that include all mandated benefits, Anthem Blue Cross and Blue Shield offers Limited Mandate PPO plans.

The Limited Mandate PPO plans, which are now authorized by Virginia law, are not required to provide all state-mandated health benefits. These plans specifically exclude the following state mandated benefits: coverage for supplies and services related to cancer clinical trials for treatment studies on cancer, prescription contraceptives, hospitalization and anesthesia for dental procedures, diabetes education and training, early intervention, hemophilia, lymphedema except in the connection of breast reconstruction, mental health and substance abuse and TMJ. Obstetrical supplies and services are also excluded in Limited Mandate PPO plans offered in the 2-14 market only. **It is the group's responsibility to ensure it meets the federal requirement to have maternity coverage if it employs 15 or more employees.** Further, all Limited Mandate PPO plans include a limitation on one state-mandated benefit. There is a limit of one glucometer per member per calendar year or plan year, as applicable.

2. REASON FOR APPLICATION (Check as many as apply)

<input type="checkbox"/> Initial enrollment	<input type="checkbox"/> Marriage
<input type="checkbox"/> Annual open enrollment	Date of marriage: _____
<input type="checkbox"/> New hire	<input type="checkbox"/> Loss of eligibility for other coverage
<input type="checkbox"/> Rehire – Date of rehire: _____	Date previous coverage ended: _____
<input type="checkbox"/> COBRA – Qualifying Event: _____	<input type="checkbox"/> Birth of child
Event Date: _____	<input type="checkbox"/> Add Dependent*
	Date of adoption/placement for adoption, court order or legal appointment: _____

*If adding a dependent due to adoption, placement for adoption, medical child support order, legal appointment (such as guardianship), legal documentation must be attached to the enrollment application.

3. TYPE OF COVERAGE/PLAN

Health Coverage

- | | | |
|--|---|--|
| <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee and One Child | <input type="checkbox"/> Employee and Family |
| <input type="checkbox"/> Employee and Spouse | <input type="checkbox"/> Employee and Children | |

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia. Anthem Blue Cross and Blue Shield and its affiliated HMO, HealthKeepers, Inc., are independent licensees of the Blue Cross and Blue Shield Association. ©ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

4. EMPLOYEE INFORMATION* (Please refer to Definitions of Eligibility, Section 9)

**If applying for coverage that requires a Primary Care Physician (PCP), list the PCP name, PCP number and address.*

Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Last name	First name	M.I.
Street address (Please include Apt. #)		
City	State	Zip
Daytime phone (with area code) () -	Evening phone (with area code) () -	
Anthem PCP name* (please provide first and last name)	Anthem PCP ID number*	
PCP Address	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

IF NO DEPENDENTS, PLEASE SKIP TO QUESTION 6 ON PAGE 3

5. FAMILY INFORMATION* (If electing Employee Only coverage, skip to Section 6)

**If applying for HMO coverage, list the PCP name and PCP number. Each family member may select a different PCP.*

List all family members applying for coverage. List additional dependents on a separate sheet and attach it to the application. Please indicate the relationship between you and each dependent and provide the social security number and date of birth for each covered dependent. In the event of adding a newborn for which their social security number is not available, please complete this application at this time and forward to Anthem their social security number when obtained.

Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Last name	First name	M.I.	
Check all that apply: a. Child to be covered by non-custodial parent due to medical child support order? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach documentation) b. Disabled prior to age 26/handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach physician certification)			
Anthem PCP Name*	Anthem PCP ID #*		
Anthem PCP Address	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Relationship to applicant <input type="checkbox"/> Child	Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Last name	First name	M.I.	
Check all that apply: a. Child to be covered by non-custodial parent due to medical child support order? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach documentation) b. Disabled prior to age 26/handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach physician certification)			
Anthem PCP Name*	Anthem PCP ID #*		
Anthem PCP Address	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Relationship to applicant <input type="checkbox"/> Child	Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Last name	First name	M.I.	
Check all that apply: a. Child to be covered by non-custodial parent due to medical child support order? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach documentation) b. Disabled prior to age 26/handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach physician certification)			
Anthem PCP Name*	Anthem PCP ID #*		
Anthem PCP Address	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

6. TELL US ABOUT YOUR OTHER INSURANCE

Please list any health care plan/HMO that you or your family members have been covered by within the past 24 months including Anthem. List additional information on a separate sheet and attach it to the application.

Other carrier/plan name _____ Policy/ID number _____

Effective date (MM/DD/YY) _____ Please indicate whom this coverage applies to (check all that apply):
Self Spouse All Children Child: _____
Last Name First Name

Do you intend to continue this coverage? Yes No
If no, please provide cancellation date of coverage: _____
If yes, please provide the following information:

Address of other coverage _____

City _____ State _____ Zip _____

Phone number of other carrier/plan _____ Policyholder name (Last, First, M.I.) _____

Policyholder's date of birth _____ Type of coverage:
Health Dental Group Insurance Non Group Insurance

7. MEDICARE COVERAGE

If you or your dependents are enrolled in Medicare Part A, B & D complete the following. List additional dependents on a separate sheet and attach it to the application.

Last name of covered person _____ First name _____ M.I. _____

HIC # _____	Medicare Part A Effective date _____	Medicare Part B Effective date _____	Medicare Part D Effective date _____	65 or over: <input type="checkbox"/> Working <input type="checkbox"/> Retired
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Reason for Medicare Entitlement:
Age Disability End Stage Renal Disease (ESRD) ESRD & Disability

8. EMPLOYEE STATEMENT (Please date and sign this statement and the employee certification on page 6 of this application.)

I certify that the information I have provided on this application is complete and true to the best of my knowledge and that Anthem Blue Cross and Blue Shield or HMO will rely upon it in processing my application. I understand that Anthem Blue Cross and Blue Shield may deny claims and void my coverage or HMO may cancel my coverage with 31 days advance written notice of termination if Anthem Blue Cross and Blue Shield or HMO finds, within two years of the effective date of my coverage, that I misrepresented any of this information. I acknowledge that this certification pertains to all responses provided by me on this application and not just those that precede the certification.

For Lumenos 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.

I certify that I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage under the policy.

The employee, and any person authorized to act on behalf of the employee, is entitled to receive a copy of this form and will be provided with a copy upon their request.

Employee Signature _____ Date _____

9. DEFINITIONS

Eligible employee:

- An active employee of the Group Policyholder who works at least 25 hours per week and 50 weeks per year 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 Group Policyholder, provided that written approval of their eligibility is obtained from the HMO or Anthem Blue Cross and Blue Shield; or
- Employees eligible for continuous coverage under state or federal laws, e.g. COBRA.
- To become an eligible employee, a director or officer of a corporate Group must meet the same requirements as other employees of the Group Policyholder.
- Independent contractors (those whose wages are reported on IRS Form 1099) are considered to be self-employed and are not eligible for group coverage.

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 new dependent age limit of 26 applies at the group's first renewal after September 23, 2010.)*
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity 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, e.g. COBRA.

10. MEDICAL INFORMATION

Please note that no person will be denied health coverage on an individual basis due to the answers provided below.

Employee

Social security #	Date of birth (MM/DD/YY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height (ft./in.)	Weight (lbs.)
____-____-____	____/____/____		____/____	____
Last name		First name		M.I.
_____		_____		_____

Spouse

Social security #	Date of birth (MM/DD/YY)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Height (ft./in.)	Weight (lbs.)
____-____-____	____/____/____		____/____	____
Last name		First name		M.I.
_____		_____		_____

Please indicate the type of health coverage you are applying for:

- Employee Only Employee & Spouse Employee & One Child Employee & Children Employee & Family

In answering this question, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you may be at risk.

1. Has any person to be covered by this plan had indications of, been diagnosed with, treated for or had treatment recommended for any of the following conditions? Yes No **If yes, place a check beside the condition.**

- | | | |
|--|--|--|
| <input type="checkbox"/> Benign Tumor, Location _____ | <input type="checkbox"/> Heart Disease, Angina | <input type="checkbox"/> Liver Condition |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cancer, Type/ Location : _____ | <input type="checkbox"/> Connective Tissue Disease |
| <input type="checkbox"/> Blood or circulatory problems (excluding high blood pressure) | | <input type="checkbox"/> Stroke |

2. Has any person to be covered by this plan had indications of, been diagnosed with, treated for or had treatment recommended for any of the following conditions within the past 5 years? Yes No **If yes, place a check beside the condition.**

Alcohol or Drug Abuse/Addiction:

Inpatient – Dates Treated _____ Outpatient – Dates Treated _____

Arthritis or Rheumatism: Type _____ Degree of Severity _____

List medication used within the last 12 months _____

Asthma or Other Respiratory conditions:

Frequency of attacks _____ Date of last attack _____

Dates of any hospitalizations _____ Dates of any ER visits _____

List medication used within the last 12 months and indicate how often taken _____

Colitis or intestinal condition

Diabetes: Diet Oral Medication or Insulin controlled

Diseases of eyes, ears, nose or throat

Disorder of spine and joints

Elevated Cholesterol — List medication used within the last 12 months _____

Emotional or mental conditions: Diagnosis:

Inpatient — Dates Treated _____ Outpatient — Dates Treated _____

List medication used within the last 12 months _____

Medication was prescribed by: Psychiatrist Family Physician

Date medication last used _____

Epilepsy or Seizures: Type and date of last seizure _____

List medication used within the last 12 months _____

Gall bladder disease or gall stones

High blood pressure: Last reading and date _____

List medication used within the last 12 months _____

Intervertebral Disc Disorders: Date of last symptom or treatment _____

Kidney disease or kidney stones

Lung condition or tuberculosis

Lupus: Systemic Discoid

Muscle/nervous system disorder

Paralysis

Sleep Apnea

Thyroid or goiter

Ulcers or or other stomach condition

3. Has surgery been performed for any of the conditons listed in question 2? Yes No

Type of surgery _____ Date of surgery _____

4. Has any person to be covered by this plan been diagnosed with AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)? Yes No

5. Has any person to be covered by this plan been advised to have future medical treatment or surgery? Yes No

6. Has any person to be covered by this plan been examined or treated by a physician, psychotherapist, counselor, or other medical professional or taken any prescription drugs within the past 5 years for any illness or condition not already noted (excludes colds, flu and routine exams not related to a medical condition)? Yes No

7. If you answered yes to any of the questions above, please provide details in Section 11.

