

Social Security or Member No.									

3. Declination — Complete this section only if you want to decline coverage(s) for yourself and/or any eligible dependent(s).

Type of Coverage:	Declined for:	Please write in "A", "B", "C", etc. per the list below to identify reason for declining (proof of other coverage may be required).
Dental plan	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DB* <input type="checkbox"/> Child(ren)	A Covered by another group plan; carrier and ID are: _____ B Covered by individual policy; carrier and ID are: _____ C Covered by military service insurance D Have no other insurance coverage and am not interested E I and/or my dependent(s) have coverage under a state child health insurance program or state Medicaid plan F Other _____
Vision plan	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DB* <input type="checkbox"/> Child(ren)	
Life	<input type="checkbox"/> Self <input type="checkbox"/> Dependents	
Disability	<input type="checkbox"/> Self <input type="checkbox"/> Dependents	

I UNDERSTAND THAT:

- If I decline coverage under a PPO policy and have no other group or individual health coverage at this time, I and my dependent(s) will not be able to enroll until the next enrollment period subject to an exclusion of coverage for pre-existing conditions for a period of up to 6 months.
- If I decline coverage for myself and/or my dependent(s) (including my spouse or designated beneficiary) because of other group or individual insurance coverage except coverage under a state child health insurance program or a state Medicaid plan, I may in the future be able to enroll myself and/or my dependent(s) in this plan if I and/or my dependent(s) lose eligibility for that other coverage, provided that I request enrollment within 31 days after that other coverage ends. In addition, if I have a new dependent as a result of marriage or Recorded Designated Beneficiary Agreement, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 31 days after the marriage or Recorded Designated Beneficiary Agreement, birth, adoption or placement for adoption.
You have the right to obtain a Certificate of Creditable Coverage from your prior plan. Please contact customer service at the number listed on your health benefit ID card for assistance in obtaining such certificate or if you have questions regarding pre-existing conditions.
- If I decline coverage for myself and/or my dependent(s) because of coverage under a state child health insurance program and I and/or my dependent(s) lose eligibility for that coverage, I must request enrollment for this group coverage within 90 days after the date the coverage under the state child health insurance program ends.
- If I decline coverage for myself and/or my dependent(s) because of coverage under a state Medicaid plan and I and/or my dependent(s) lose eligibility for that coverage, I must request enrollment for this group coverage within 60 days after the date the coverage under the state Medicaid plan ends.
- If I become eligible for state premium assistance for group coverage, I must request enrollment for this group coverage within 60 days after the date I become eligible for state premium assistance.
- I may be required to submit additional information upon request.
- If I decline life and/or disability coverage for any reason, my dependents and I may enroll in the future as late entrants only if we provide satisfactory proof of insurability.

I hereby certify that I have been given the opportunity to participate in my employer's group insurance plan(s) underwritten by the company(ies) indicated on this enrollment application. The plan has been explained to me, and I decline to participate.

X _____
 Employee Signature if declining coverage for self/dependent(s) _____
Date

4. Authorization — The following Authorization is to be signed by ALL EMPLOYEES applying for coverage.

I AM APPLYING FOR LIFE AND/OR DISABILITY COVERAGE: I understand that I am submitting this application to Anthem Life Insurance Company (Anthem Life) and that if one or more of the following circumstances apply, then the health history information on my *Colorado Uniform Employee Application for Small Group Health Benefits Plans* will be used by Anthem Life to determine whether or not life and/or disability insurance will be offered to me. 1) the date of this application is more than 31 days after my eligibility date for coverage; 2) the amount of term life coverage I am applying for is more than the guaranteed issue limit; 3) I am applying for long term disability coverage and my employer has less than six enrolled employees. I understand that if I am not actively at work on the date my insurance would otherwise become effective, the insurance will not become effective until I return to active work.

Signature of Employee (if applying for life and/or disability coverage): X _____

I understand that the coverage I am applying for is subject to eligibility requirements. I acknowledge that I have read all sections of this application, including the information on the back pages, and certify that I agree to all matters covered herein. I also acknowledge that all information provided on this application is complete and accurate to the best of my knowledge. I understand and agree that this application shall become part of the contract between Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado and me.

Employee Signature	Date	Spouse/DB* Signature (if applying for coverage)	Date
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*A person named as designated beneficiary (DB) under a Recorded Designated Beneficiary Agreement. Ask your employer if dependent coverage for designated beneficiary is offered under your selected plan.