

Enrollment Application

Welcome to Anthem Blue Cross and Blue Shield. This is your Enrollment Application and Change Form. Because we are dedicated to making the enrollment process easy for you, this form may be used to enroll in medical coverage as well as dental, vision, and life and disability insurance coverage where available. This form may also be used to waive coverage, change information, cancel coverage or re-enroll. When completing this form, please follow the guidelines listed below. We appreciate the opportunity to serve you.

- **Complete all required information, and print legibly in all capital letters.** Inaccurate or illegible information will be returned, causing a delay in the application process.
- If you are applying for HMO or HMO point-of-service coverage, you must indicate the primary care physician (PCP) choice **for each enrollee** on the first page of this application. If you do not indicate a PCP, we may need to select one for you. You can find a PCP online at anthem.com by clicking **Find a Doctor**.
- If you or another member of your family applying for coverage under this policy had health insurance within the last six months before enrolling with Anthem, **you must complete section 4**, in order to receive credit for this coverage against pre-existing condition time periods. 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.
- Be sure to read the entire application, including the information on the back pages.
- If you have a dependent with a mental or physical disability, as certified by your dependent's physician, that physician must complete a Mentally/Physically Disabled Dependent Enrollment Request Form.
- Complete and attach the Common-law Marriage Affidavit/Recorded Designated Beneficiary Agreement/Certificate of Domestic Partnership if applicable.
- You may easily locate these forms mentioned above at anthem.com by clicking the **Members** tab, selecting your state, clicking **Answers@Anthem**, and then clicking **Download Forms**.
- Please contact your group benefits administrator if you need help completing this application.

To Enroll/Open Enrollment

- When enrolling for coverage for the first time, please complete sections 1, 2, 3 and 4 completely and sections 5 and 7, if applicable.
- After reading all areas of the application, read section 8, and sign and date the enrollment application where requested.

To Waive Coverage

- To waive coverage for yourself, complete sections 2, 3 and 6.
- Read section 8, and sign and date the enrollment application where requested.

To Change Information

- If you need to make a change for yourself or one of your eligible dependents, please complete section 1. Be sure to include the date the change becomes effective.
- In section 3, please list all family members affected by the change. If you are changing your address, you may fill in your new address in this section. If you are adding a dependent, he/she must be added within any of the following days of becoming eligible:
 - 31 days, if eligibility is due to marriage/Registered Designated Beneficiary Agreement/Certificate of Domestic Partnership, birth, adoption, placement for adoption; or involuntary loss of coverage except coverage under a state child health insurance program or a state Medicaid plan
 - 90 days, if eligibility is due to involuntary loss of coverage under a state child health insurance program; or
 - 60 days, if eligibility is due to involuntary loss of coverage under a state Medicaid plan; or
 - 60 days, from the date you become eligible for state premium assistance for group coverage.
- Indicate any other changes in the applicable areas of sections 2, 4, 5 or 7.
- Read section 8, and sign and date the enrollment application where requested.

After Completing This Form

- **Read through the instructions above and make any required corrections. This will help ensure that your application is processed as quickly and accurately as possible.**
- **Promptly deliver your completed enrollment application to your group benefits administrator.**

Enrollment Application and Change Form: Medical - Dental - Vision

Check all coverage that applies: Medical Dental Vision Life

Social Security/Member # **Must be Completed by Employee**

<input type="text"/>	<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>	—	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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1. Reason for Completing Application

- New Enrollment PCP Change
 Reinstatement of Coverage Beneficiary Change
 Canceling Coverage Personal Information Change
 Coverage Change Other _____

Employer Case Number **Must Be Completed by Employer**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Life Group Number **Must Be Completed by Employer**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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Qualifying Event _____ Effective Date of Change _____

Ask your employer for coverage available. For life and disability insurance, see page four. Ask your employer if dependent coverage for designated beneficiary (DB)³ or domestic partner (DP)⁴ is offered under your selected plan. Include information on designated beneficiary or domestic partner only if coverage for designated beneficiary or domestic partner is offered by your employer.

2. Benefits and Coverage Desired

MEDICAL BENEFIT PLAN

- HMO¹
 POS¹ (Point of Service)
 PPO
 Lumenos[®] HSA² _____
 Lumenos[®] HRA _____
 Lumenos[®] HIA Plus _____
 Other _____

MEDICAL COVERAGE

- Employee
 Employee and Spouse/DB/DP
 Employee and Child(ren)
 Family
 Decline and Complete Waiver (Section 6)

DENTAL COVERAGE PLAN

- Anthem Dental
 Option _____
 Anthem Voluntary Dental
 Option _____
 Other _____

DENTAL NETWORK

- Prime
 Complete
 Other _____

DENTAL COVERAGE

- Employee
 Employee and Spouse/DB/DP
 Employee and Child(ren)
 Family
 Decline and Complete Waiver (Section 6)

VISION COVERAGE PLAN

- Blue View Vision
 Other _____

VOLUNTARY VISION

Plan Name _____

VISION COVERAGE

- Employee
 Employee and Spouse/DB/DP
 Employee and Child(ren)
 Family
 Decline and Complete Waiver (Section 6)

3. Employee and Family Information

List yourself and all eligible family members who are applying for or waiving coverage. Use a separate sheet if needed.

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	Employee's Last Name	First Name	M I	Gender M F	Birthdate (MM-DD-YYYY)	Relationship Self
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Mailing Address for Member Correspondence

City	State	ZIP Code	Home Telephone	Date of Hire (MM-DD-YYYY)	Date of Full-time Employment (MM/DD/YYYY)
Full Company Name			Position Title	<input type="checkbox"/> Hourly <input type="checkbox"/> Salaried	Hrs. Worked/Week Earnings \$ _____ per _____
Primary Care Physician (PCP) - HMO or POS Only			¹ PCP ID Number	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	Last name of Spouse/Designated Beneficiary/ Domestic Partner	First Name of Spouse/Designated Beneficiary/ Domestic Partner	M I	Gender M F	Birthdate (MM-DD-YYYY)	Relationship (Select One) <input type="checkbox"/> Spouse <input type="checkbox"/> Designated Beneficiary (DB) <input type="checkbox"/> Domestic Partner (DP)
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¹ Primary Care Physician (PCP)	¹ PCP ID Number	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	If you and your spouse have different last names, check the applicable box: <input type="checkbox"/> Spouse Retaining Name <input type="checkbox"/> Common-law Marriage (Attach Common-law Marriage Affidavit) <input type="checkbox"/> Designated Beneficiary (Attach Recorded Designated Beneficiary Agreement) <input type="checkbox"/> Domestic Partnership (Attach Certificate of Domestic Partnership)	Social Security Number □□□-□□-□□□□
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<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	Dependent's Last Name	First Name	M I	Gender M F	Birthdate (MM-DD-YYYY)	Relationship
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¹ Primary Care Physician (PCP)	¹ PCP ID Number	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Over-age Mentally/Physically Disabled Dependent (Initial Over-age Dependent Affidavit in section 7, and attach Mentally/Physically Disabled Dependent Form.) <input type="checkbox"/> Court-ordered Health Care Coverage (Attach copy of court order.)	Social Security Number □□□-□□-□□□□
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<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	Dependent's Last Name	First Name	M I	Gender M F	Birthdate (MM-DD-YYYY)	Relationship
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<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel	Dependent's Last Name	First Name	M I	Gender M F	Birthdate (MM-DD-YYYY)	Relationship
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¹ Primary Care Physician (PCP)	¹ PCP ID Number	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Over-age Mentally/Physically Disabled Dependent (Initial Over-age Dependent Affidavit in section 7, and attach Mentally/Physically Disabled Dependent Form.) <input type="checkbox"/> Court-ordered Health Care Coverage (Attach copy of court order.)	Social Security Number □□□-□□-□□□□
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¹For HMO and POS Members: If you do not select a PCP, one may be assigned for you.

²Confirm with your employer which HSA custodian was selected.

³A person named as Designated Beneficiary (DB) under a Recorded Designated Beneficiary Agreement.

⁴A person named as Domestic Partner (DP) under a Certificate of Domestic Partnership

Required: Employee Social Security/Member Number

□	□	□	—	□	□	—	□	□	□	□
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4. Other Insurance

Have you or any of your dependents had any other health coverage in the last six months, or currently have coverage other than the applied-for coverage? Yes No

If yes, please complete the section below for all covered members.

Member Name	Type	Carrier	Start (MM-DD-YYYY)	End (MM-DD-YYYY)
	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription			
	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription			
	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription			
	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription			

5. Medicare Coverage

Complete if you, your spouse or dependent child(ren) have Medicare coverage. Use a separate sheet if needed.

Member's Name (First, Middle Initial, Last)	Part A Effective Date	Part B Effective Date	Reason for Disability if Under Age 65	Medicare Claim Number

6. Waiver of Insurance

Complete only if you intend to waive insurance.

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.

I do not want to participate in the group insurance plan at this time for the following reason(s):

- | | |
|--|--|
| <input type="checkbox"/> I have other group health insurance. | <input type="checkbox"/> I have other individual health insurance. |
| <input type="checkbox"/> I have other group dental insurance. | <input type="checkbox"/> I have other group vision insurance. |
| <input type="checkbox"/> I am a dependent of an active or retired military service member. | <input type="checkbox"/> I have no other insurance coverage, and I am not interested at this time. |
| <input type="checkbox"/> I am retired from military service. | <input type="checkbox"/> I have religious objections (non-contributory life insurance). |
| <input type="checkbox"/> I do not wish to participate (contributory life insurance). | <input type="checkbox"/> I and/or my dependent(s) have coverage under a state child health insurance program or a state Medicaid plan. |

7. Over-age Dependent Affidavit

By initialing below, I verify and attest that my dependent(s), age 26 and over, is/are unmarried and financially or otherwise dependent on me due to mental and/or physical disability; and therefore eligible for coverage under the policy for which I am applying. I understand that I am responsible for notifying Anthem within 31 days of any changes to the status of my dependent(s). I understand that coverage is dictated by the actual situation at the time services are rendered, and if my dependent does not qualify as a dependent when services are provided, the charges for those services are not reimbursable by Anthem and may become my sole responsibility. I also understand that over-age dependent eligibility must be renewed each year as specified by the certificate. I understand that Anthem reserves the right to request, at any time, proof of over-age dependency.

Initials _____

8. Signature

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 page, 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 and me.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Description of Special Enrollments

If you decline enrollment for yourself or your dependents (including your spouse/designated beneficiary/domestic partner) because of other health insurance or group health plan coverage except coverage under a state child health insurance program or a state Medicaid plan, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you decline enrollment for yourself or your dependents (including your spouse/designated beneficiary/domestic partner) because of coverage under a state child health insurance program, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility under the state child health insurance program. However, you must request enrollment within 90 days after the date the coverage under a state child health insurance program ends.

If you decline health coverage for yourself or your dependent(s) (including your spouse/designated beneficiary/domestic partner) because of coverage under a state Medicaid plan, you may be able to enroll yourself and your dependents in this plan if you or your dependent(s) lose eligibility under a state Medicaid plan. However, you must request enrollment within 60 days after the date the coverage under a state Medicaid plan ends.

If you become eligible for state premium assistance for group coverage, you may be able to enroll yourself and your dependent(s) (including your spouse/designated beneficiary/domestic partner) in this plan. However, you must request enrollment within 60 days after the date you become eligible for state premium assistance for group coverage.

In addition, if you have a new dependent as a result of marriage/Recorded Designated Beneficiary Agreement/Certificate of Domestic Partnership, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage /Recorded Designated Beneficiary Agreement/Certificate of Domestic Partnership, birth, adoption or placement for adoption.

To request special enrollment submit a completed application to the address below. To obtain more information, contact Anthem Customer Service at 1-877-811-3106 or Anthem Blue Cross and Blue Shield, P.O. Box 5858, Denver, CO 80217-5858.

Employee Signature _____

Date _____



□ □ □ — □ □ — □ □ □ □

Enrollment Application: Life and Disability

1. Coverage Type

Coverage is limited to benefits offered by your employer.

Check all applicable boxes.

Life and AD&D Short Term Disability Supplemental Life Amount \$ _____ Supplemental AD&D Amount \$ _____ STD Buy-up Amount \$ _____

Dependent Life Long Term Disability Other _____ Current Income \$ _____ Hour Week Month Year

Are you actively at work? Yes No. If no, when are you expected to return? _____ Retired? Yes No

Disabled? Yes No Hospitalized? Yes No Income reported by W2 1099 Other _____

Class Assignment _____ Division Assignment _____

If married, please list spouse's occupation _____

2. Primary Beneficiaries

1.	First Name	MI	Last Name	
	Social Security Number		Relationship to Applicant	Age

2.	First Name	MI	Last Name	
	Social Security Number		Relationship to Applicant	Age

3. Contingent Beneficiaries

1.	First Name	MI	Last Name	
	Social Security Number		Relationship to Applicant	Age

2.	First Name	MI	Last Name	
	Social Security Number		Relationship to Applicant	Age

4. Additional Questions

1. Has any person applying for coverage ever been rated or declined for, or refused reinstatement or renewal of, life or health insurance? Yes No.
If yes, please provide the name of person, the date and the reason.

2. In the past three years, has any person applying for coverage been engaged in or does anyone contemplate being engaged in sports or hobbies such as aviation, scuba diving, sky diving, racing or similar activities? Yes No If yes, please list their names and activities.

5. Signature

Employee Signature

Date

EMPLOYEE AUTHORIZATION FOR LIFE AND/OR DISABILITY COVERAGE (Please read if applying for Anthem Life coverage(s). Your signature in the Enrollment Application: Life and Disability and Health Statement acknowledges your agreement with the Authorization below.)

I understand that Anthem Life Insurance Company (Anthem Life) may collect personal information about me from outside sources and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by applicable state law. I also understand that under applicable state law, I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem Life.

For the purpose of evaluating my Health Statement for Anthem Life Insurance Company coverage, I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility; insurance company; the Medical Information Bureau, Inc.; or other organization, institution or person that has any records or knowledge of me or my health, or that of my family for whom this Health Statement is made or their health to give Anthem Life or its reinsurers any such information. I also authorize Anthem Life or its reinsurers to release any information regarding me or my health, or that of my family for whom insurance application is made to the Medical Information Bureau Inc.; or other life insurance companies in which I have policies or to which I may apply; and other insurers to which a claim for benefits may be submitted. I understand that this information will be used by Anthem Life to determine eligibility for insurance. This information includes information about drugs, alcoholism or mental illness. This authorization, for purposes of processing this application form, will be valid from the date signed for a period of 30 months, a photocopy of this authorization will be as valid as the original. I understand that I may request a photocopy. For the purposes of processing a claim under this coverage, this authorization is valid for the duration of the claim.

EMPLOYEE REPRESENTATIONS CERTIFICATION FOR LIFE AND/OR DISABILITY COVERAGE (Please read if applying for Anthem Life coverage(s). Your signature on the Enrollment Application: Life and Disability acknowledges your agreement with the representation.)

1. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured. Payment of proceeds shall be made in accordance with the terms of the group contract subject to change by my written notice to my employer.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder. I understand that by applying for the type of coverage checked, I authorize deduction from my wages, if necessary, for the required premium for the coverage for which I have applied.
3. I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
4. I am applying for the coverage selected on this application. If I select a coverage, or a combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
5. I understand that Anthem Life reserves the right to accept or decline this application and that no right whatsoever is created by this application.

I acknowledge that I have read the foregoing provisions and I expressly accept such provision as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s). A photocopy is as valid as the original.

I give this representation for and on behalf of myself and my eligible dependents, including my children and my spouse if covered by the plan. I am acting as their agent and representative.

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

Information regarding your insurability will be treated as confidential. Anthem Life, or its reinsurers may, however, make a brief report thereon to Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is PO Box 105, Essex Station, Boston, MA 02112.

Anthem Life, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. You may want to keep a copy of this statement for your records.

Important Legal Information

The following statement applies to fully insured groups in Colorado, with 50 employees or less: **COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.**

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Important Information

- I hereby authorize my employer, until this authorization is revoked by notice in writing, to deduct in advance each month from the earned or accrued wages due me, such amounts as may be necessary to pay the rates which are currently in effect or shall be in effect in the future for coverage for which I am applying.
- If applying for health insurance coverage, I certify that I work at least 24 hours per week for the employer named in the application.
- For individuals applying for HMO or point-of-service (POS) coverage: To make the most of my health care benefits, I have indicated the primary care physician of my choice on this application. If I do not select a primary care physician for me and/or my dependent(s), I understand that HMO Colorado may need to assign a primary care physician(s) to me and/or my dependent(s).
- If I decline health coverage for a PPO policy, I understand that I will not be able to enroll until the next open enrollment period or within 31 days of a qualifying event. I may be subject to the pre-existing condition exclusion below.
- If I decline health coverage for an HMO policy, I understand that I will not be able to enroll until the next open enrollment period, or within 31 days after a qualifying event, as defined by my plan.
- If I decline health coverage for myself and/or my dependent(s) (including my spouse/designated beneficiary/domestic partner) because of other group or individual health insurance coverage except coverage under a state child health insurance program or state Medicaid plan, I may in the future be able to enroll myself and/or my dependent(s) in this plan if I or my dependent(s) lose eligibility under that other coverage, provided that I request enrollment within 31 days after the other coverage ends. In addition, if I have a new dependent as a result of marriage/Recorded Designated Beneficiary Agreement/Certificate of Domestic Partnership, 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/Recorded Designated Beneficiary Agreement/Certificate of Domestic Partnership, birth, adoption or placement for adoption.
- If I decline health coverage for myself or my dependents (including my spouse/designated beneficiary/domestic partner) because of coverage under a state child health insurance program, I may in the future be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility under the state child health program, provided that I request enrollment within 90 days after the date the coverage under a state child health insurance program ends.
- If I decline health coverage for myself or my dependent(s) (including my spouse/designated beneficiary/domestic partner) because of coverage under a state Medicaid plan, I may in the future be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility under a state Medicaid plan, provided that I request enrollment within 60 days after the date the coverage under a state Medicaid plan ends.
- If I become eligible for state premium assistance for group coverage, I may in the future be able to enroll myself and my dependent(s) (including my spouse/designated beneficiary/ domestic partner) in this plan provided that I request enrollment within 60 days after the date I become eligible for state premium assistance for group coverage.
- I understand that I may be required to submit additional information upon request.

GENERAL NOTICE OF PRE-EXISTING CONDITION EXCLUSION

The pre-existing condition exclusion does not apply to pregnancy; dependent children who are enrolled in the plan within 31 days after birth, adoption, or placement for adoption; or persons under 19 years old. If your plan is a PPO plan, it imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins.

This exclusion may last up to 6 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can receive credit toward this exclusion period if you have had prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to waive the pre-existing condition exclusion if you have not experienced a break in coverage of at least 90 days in Colorado. To have the six-month exclusion period waived based on your prior creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Anthem at 1-877-811-3106, or mailed to Anthem Blue Cross and Blue Shield, PO Box 5858, Denver CO, 80217-5858.



Visit our website at [anthem.com](https://www.anthem.com)