

# Application for Group Insurance



By supplying the information requested in this Application, the Applicant applies for one or more of the group health benefit plans offered or administered by Anthem Blue Cross and Blue Shield and/or Anthem Life, (the "Companies"). The Companies shall not be bound by any term or provision herein. The Companies shall not be obligated to issue any insurance coverages or begin providing any benefits administration or services to Applicant or any eligible person(s) until all required information is submitted. Such information must be approved by the Companies in writing by an authorized employee at its home office in North Haven, Connecticut.

If the Applicant qualifies as a Small Employer as defined by State of Connecticut Insurance law, medical underwriting evaluation is required by the Company.

Firm no.	Coverage applied for <input type="checkbox"/> Employee Assistance Program (EAP) <input type="checkbox"/> Medical/Rx <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life <input type="checkbox"/> Other _____	Requested effective date 
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(Subject to approval by the Company)

## PART I: FIRM INFORMATION

Employer exact legal name		DBA	
Legal/corporate address		City	State      ZIP code
Mailing address (if different from above)		City	State      ZIP code
Benefit administrator	Phone no.	Fax no.	E-mail address
Mailing address (if different from above)		City	State      ZIP code
Additional firm contact	Phone no.	Fax no.	E-mail address
Mailing address (if different from above)		City	State      ZIP code
TIN/EIN	Standard industry code (SIC)	Business effective date	Current owner date
Name of association		Organization type <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Trustee <input type="checkbox"/> Union <input type="checkbox"/> Other _____	

Will you expect coverage to reflect the outcome of collective bargaining?    Yes    No

Will bargaining agreement participants be considered eligible employees?    Yes    No

Subsidiaries/division to be included: List name, location, and number of employees at each location.

Are separate billings required for subsidiaries?    Yes    No

For classes?    Yes    No (If yes, attach detailed information)

### SECTION A: FIRM RELATIONSHIPS (PLEASE INDICATE ANY RELATIONSHIPS WITH OTHER FIRMS)

Firm name	Relationship type	Relationship effective date	Currently covered by Anthem BCBS
1.			<input type="checkbox"/>
2.			<input type="checkbox"/>
3.			<input type="checkbox"/>

### SECTION B: BILLING INFORMATION

Billing contact	Phone no.	Fax no.	E-mail address
Billing address		City	State      ZIP code

**SECTION C: ELIGIBILITY***Please indicate the total number of employees**Of the Employees enrolled in Anthem BCBS, please state*

Total no. of employees	Covered by Taft-Hartley	Working at locations outside of CT	Anthem BCBS	
Total no. of eligible employees	Not actively at work	Working at locations outside of ME	BlueCare	
Covered by spouse's insurance (waivers)	Covered by management-labor contract	Working at locations outside of NH	Dental	Blue View vision
Total eligible for Anthem BCBS coverage	Covered by COBRA or C.G.S. 38a-538	PT (20-29 hrs/wk) (for groups of 1-50 FTEs, by request)	Medicare supplemental	Life

**SECTION D: ADDITIONAL INFORMATION**

<i>List each prior medical carrier and last date of coverage for the last three years</i>	<i>List each prior vision and/or dental carrier for the last 12 months</i>
1.	1.
2.	2.
3.	3.
Name of prior carrier(s) (please attach final bill from prior carrier)	Coverage termination date 
Nature of business (Supply details of service or product, manufacturing materials used. Describe any hazards)	Open enrollment period(s)
Is your Health Benefit Plan subject to ERISA? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employee Contributions: Employee \$ _____ or % _____ Frequency: _____	
Dependent \$ _____ or % _____ Frequency: _____	
Please indicate if your firm's waiting period is other than the standard waiting period of first of the month following one month. (Please be specific.) <input type="checkbox"/> 60 days <input type="checkbox"/> 90 days <input type="checkbox"/> Other _____	Domestic partner rider <input type="checkbox"/> Same sex <input type="checkbox"/> Opposite sex <input type="checkbox"/> Both <input type="checkbox"/> None

**SECTION E: UNION INFORMATION**

Union no.	Union name	Next negotiation date	Contract effective date	Contact person and title
1.				
2.				

**PART II: BENEFIT PLAN SELECTION(S)**Type of funding (check all that apply):  Fully  ASO  MPP  Contingent  Split funding  Other**SECTION A: HEALTH AND PHARMACY PLANS**

<input type="checkbox"/> PPO / Century Preferred (Plan: _____)	<input type="checkbox"/> BlueCare HMO (Plan: _____)
<input type="checkbox"/> Century Preferred Comp	<input type="checkbox"/> BlueCare POS (Plan: _____)
<input type="checkbox"/> Comprehensive	<input type="checkbox"/> BlueCare Access 10
<input type="checkbox"/> Rx Option _____	<input type="checkbox"/> Other _____

Lumenos Health Savings Account (HSA) (Plan: \_\_\_\_\_) Rx included?  Yes  No Plan year? \_\_\_\_\_ Calendar year? \_\_\_\_\_

Group will establish the HSA, but **does not** want Anthem Blue Cross and Blue Shield (Anthem) to facilitate.

Group will establish HSA and **does want** Anthem to facilitate via Bank of New York Mellon (requires completion of an HSA agreement for all group sizes and an HSA addendum for groups of 51+)

Include CASH incentives (available for self-funded groups only and requires the employer to provide HSA through a cafeteria plan)

Include Gift Card incentives (available for fully-insured groups)

Provide e-mail address of Mellon Bank contact:

Lumenos Health Reimbursement Account (HRA)\* (Plan: \_\_\_\_\_) Rx included?  Yes  No

\*For Fully Insured Health Plans, requires completion of HRA Agreement and Banking Authorization

Lumenos Health Incentive Account (HIA) Plus (Plan: \_\_\_\_\_) Rx included?  Yes  No

Lumenos Health Incentive Account (HIA) (Plan: \_\_\_\_\_) Rx included?  Yes  No

**SECTION B: VISION COVERAGE APPLIED FOR (INDICATE PLAN DESIGN AND COPAYMENT) – Attach signed copy of Blue View Vision rate plan**

<input type="checkbox"/> <b>Full service plan</b> (exams and materials)		<b>Coverage Level</b>	
<input type="checkbox"/> Employer paid <input type="checkbox"/> Voluntary <input type="checkbox"/> ASO		<input type="checkbox"/> Two tier (sub only, sub plus family) <input type="checkbox"/> Three tier (sub only, sub plus one dependent, sub plus family) <input type="checkbox"/> Four tier (sub only, sub plus spouse, sub plus child(ren), sub plus family) <input type="checkbox"/> ASO PEPM (per employee per month)	
<b>Frequency (exam/eyeglass lenses/frames)</b>		<b>Copayment (exam/eyeglass lenses)</b>	
<input type="checkbox"/> 12/12/12 <input type="checkbox"/> 12/12/24 <input type="checkbox"/> 12/24/24 <input type="checkbox"/> 24/24/24		<input type="checkbox"/> \$5.00/\$0.00 <input type="checkbox"/> \$15.00/\$15.00 <input type="checkbox"/> \$10.00/\$0.00 <input type="checkbox"/> \$20.00/\$20.00 <input type="checkbox"/> \$10.00/\$10.00 <input type="checkbox"/> Other <input type="checkbox"/> \$10.00/\$25.00	
<input type="checkbox"/> <b>Exam only plan</b> (employer paid only)		<b>Coverage Level</b>	
		<input type="checkbox"/> Two tier (sub only, sub plus family) <input type="checkbox"/> Three tier (sub only, sub plus one dependent, sub plus family) <input type="checkbox"/> Four tier (sub only, sub plus spouse, sub plus child(ren), sub plus family) <input type="checkbox"/> ASO PEPM (per employee per month)	
<b>Frequency</b>		<b>Copayment</b>	
<input type="checkbox"/> 12 months <input type="checkbox"/> Other		<input type="checkbox"/> \$10.00 <input type="checkbox"/> \$15.00 <input type="checkbox"/> \$20.00 <input type="checkbox"/> \$25.00 <input type="checkbox"/> Other	
<input type="checkbox"/> <b>Materials only plan</b>		<b>Coverage Level</b>	
<input type="checkbox"/> Employer paid <input type="checkbox"/> Voluntary		<input type="checkbox"/> Two tier (sub only, sub plus one family) <input type="checkbox"/> Three tier (sub only, sub plus one dependent, sub plus family) <input type="checkbox"/> Four tier (sub only, sub plus spouse, sub plus child(ren), sub plus family) <input type="checkbox"/> ASO PEPM (per employee per month)	
<b>Frequency (lenses/frames)</b>		<b>Copayment (eyeglass lenses)</b>	
<input type="checkbox"/> 12/12 <input type="checkbox"/> 12/24 <input type="checkbox"/> 24/24		<input type="checkbox"/> \$10.00 <input type="checkbox"/> \$25.00 <input type="checkbox"/> Other	
		<input type="checkbox"/> \$130/\$130 <input type="checkbox"/> Other	

**SECTION C: DENTAL COVERAGE APPLIED FOR**

Attach signed copy of Anthem Dental proposal.		<b>Benefit Percentage</b>	<b>Deductible Employee/Family</b>	<b>Annual Max.</b>
<input type="checkbox"/> Employer Paid with Medical	# Eligible _____ # Enrolled _____	Type I _____	<input type="checkbox"/> \$0/\$0	<input type="checkbox"/> \$750
<input type="checkbox"/> Employer Paid Stand Alone	# Eligible _____ # Enrolled _____	Type II _____	<input type="checkbox"/> \$25.00/\$75.00	<input type="checkbox"/> \$1,000
<input type="checkbox"/> Voluntary	# Eligible _____ # Enrolled _____	Type III _____	<input type="checkbox"/> \$50.00/\$150.00	<input type="checkbox"/> \$1,500
<input type="checkbox"/> Ortho	Lifetime maximum _____	Type IV _____	<input type="checkbox"/> Other \$ _____ / _____	<input type="checkbox"/> \$2,000
				<input type="checkbox"/> \$ _____

**SECTION D: DENTAL AND VISION CONTRIBUTION AND ENROLLMENT REQUIREMENTS**

Employer Paid Vision has a minimum employer contribution of 25% of the employee single premium and a minimum participation of 75% of eligible employees. Voluntary Vision has no minimum employer contribution. The minimum participation for Voluntary Vision is 20% of eligible employment. Enrollment guidelines vary by state so please refer to the specific guidelines from your Anthem Blue Cross and Blue Shield Representative or your Producer/Broker. Employer Paid Dental has a minimum participation requirement of 100% of eligible employees for groups of 5-9 lives and a minimum participation requirement of 75% of eligible employees for groups of 10+ lives. Enrollment guidelines vary by state. Voluntary Dental has no minimum employer contribution. Minimum participation for Voluntary Dental varies for group size. Please refer to the specific guidelines from your Anthem Blue Cross and Blue Shield Representative or your Producer/Broker.

**SECTION E: DENTAL AND VISION DEPENDENTS**

Coverage is extended to children and stepchildren who meet your employer's guidelines for eligibility.

**SECTION F: EMPLOYEE ASSISTANCE PROGRAM (EAP)**

Coverage applied for		No. of employees enrolled in EAP	
<input type="checkbox"/> Basic EAP <input type="checkbox"/> Enhanced EAP/4 sessions <input type="checkbox"/> Enhanced EAP/6 sessions			
EAP will be billed separately from health. Please select from the following billing cycles: <input type="checkbox"/> Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly			
EAP contact	Phone no.	Fax no.	E-mail address

**SECTION G: HMO NEW ENGLAND**

HMO Blue New England       Blue Choice New England       Access Blue New England

**SECTION H: OVER AGE 65 HEALTH INSURANCE**

Group retiree plan: \_\_\_\_\_  \_\_\_\_\_ *Individual rates* \$ \_\_\_\_\_  
with optional drug benefit  \_\_\_\_\_  Copay \_\_\_\_\_ \$ \_\_\_\_\_

**SECTION I:**

No agent may set an effective date; make, modify or waive any term or provision of any contract or policy of insurance for the Company; or extend the time for premium payment without the written agreement of the Company. Such agreement must be signed by an officer or authorized employee of the Company at its home office (in North Haven, Connecticut; Portland, Maine; or Manchester, New Hampshire).

Attached is a check or money order in the amount of \$ \_\_\_\_\_. This is advance payment of premium toward the coverage for which this Application is made. If this Application is accepted by the Company at its home office, and if the advance payment is more than the first premium due, the excess will be applied to the next premium due under the insurance policy. However, the Applicant may opt to have the excess premium returned. If this Application is not accepted by the Company, or if insurance coverage does not become effective, advance payment will be returned to the Applicant. Cashing of advance payment by the Company shall not constitute acceptance of this Application. A completed copy of this Application, signed by the agent, shall serve as evidence to the Company of advance payment.

The Company reserves the right to set all premium rates for insurance coverage in accordance with its underwriting rules and other applicable requirements. The Applicant understands that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims. The undersigned Employer hereby certifies, to the best of its knowledge, and belief, the information herein is true and complete.

**PART III: ANTHEM LIFE INSURANCE – to be completed if purchasing life and/or disability coverage**

**SECTION A: APPLICANT INFORMATION**

Reason for application Requested effective date  
 New application     Change of address     Change of benefits     Reinstatement

If applying for life and/or disability coverage, has your group been turned down for coverage in the last 12 months?  Yes  No

If yes, by whom Why When

The benefits you have selected are outlined on the attached proposal, herein incorporated by reference.

Basic Life       Dependent Life       Supplemental AD&D       Long Term Disability       Other: \_\_\_\_\_  
 Basic AD&D       Voluntary Group Term Life       Supplemental Life       Short Term Disability       Other: \_\_\_\_\_

**SECTION B: ELIGIBILITY AND WAITING PERIOD**

Eligible full-time employees must work at least 30 hours per week (20 hours per week for VSTD & VGTL coverages) must be actively-at-work, and must satisfy any applicable eligibility waiting period:

The waiting period for individuals employed on or before the effective date will be:  
 none       \_\_\_ days continuous employment       first premium due date following \_\_\_ days of continuous employment

The waiting period for individuals employed after the effective date will be:  
 none       \_\_\_ days continuous employment       first premium due date following \_\_\_ days of continuous employment

Does any class have a different waiting period?  Yes  No

If yes, please describe.

**SECTION C: CONTRIBUTIONS**

Group contribution percentage for life insurance products:

Basic Life \_\_\_\_\_%      Dependent Life \_\_\_\_\_%      Supplemental AD&D \_\_\_\_\_%      Long Term Disability \_\_\_\_\_%  
Basic AD&D \_\_\_\_\_%      Supplemental Life \_\_\_\_\_%      Short Term Disability \_\_\_\_\_%      Voluntary Group Term Life \_\_\_\_\_%  
Other \_\_\_\_\_%      Other \_\_\_\_\_%

Does any class(es) have a different group contribution?  Yes  No

If yes, please describe.

**SECTION D: ACTIVELY-AT-WORK REQUIREMENTS**

The employees listed below are not presently actively-at-work and/or are not expected to be actively-at-work on the requested group effective date. Anthem Life may make an exception and assume liability, subject to Underwriting approval, for certain employees. Unless this exception is applied for and granted as indicated below, they will not be covered until they return to active work. To qualify for this exception, the following conditions must all be satisfied.

1. The employee's absence must be due to illness or injury.
2. The employee must be covered by the prior carrier on the date immediately prior to Anthem Life's effective date of coverage for your group.
3. The employee must not be eligible to have coverage continued or extended by the prior carrier after that policy/contract terminates. In no event will the actively-at-work requirement be waived for coverage which provides benefits due to total disability, such as short term disability, waiver of premium or extension of benefits. In no event will any increase in coverage or any additional coverage become effective until the employee returns to work. Coverage approved below will end when your group's coverage under Anthem Life's policy ends or at the end of any time period shown below, whichever occurs first. (Attach additional sheet if necessary.)

Name of employee	Amount of insurance	Date of birth	Date last worked	Reason not working	Date expected to return	Insured by prior carrier	Request actively at-work waiver	Waiver request approved	Underwriter approval
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION E: VOLUNTARY GROUP INSURANCE**

Mode of Payment:  Payroll Deduction  Quarterly  Semi-Annual  Annual For VGTL: Is Accidental Death included?  Yes  No  
 If payroll deduction, bill:  1/12 Annual  Special Frequency

**SECTION F: AUTHORIZATION (READ CAREFULLY BEFORE SIGNING)**

The undersigned employer and/or authorized representative on page 6 hereby requests that it be approved for insurance coverage through Anthem Life Insurance Company (Anthem Life). Employer understands and represents to the best of his knowledge and belief the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Anthem Life trust policy(ies), if applicable;
2. To make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed;
3. To maintain records and furnish to Anthem Life or their designated agent(s), any information required in connection with administration of the insurance coverage;
4. To provide notice of applicable conversion rights to eligible employees and eligible dependents;
5. That approval for this insurance may cancel any prior contracts/or coverage with Anthem Life effective immediately preceding the effective date of the employer's coverage;
6. To pay Anthem Life by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership;
7. That claims filed by or on behalf of members may, at Anthem Life's option, be suspended if premiums are not received timely;
8. Employer will receive, on behalf of members, all notices delivered by Anthem Life, and immediately forward such notices to persons involved, at their last known address, including certificates of coverage;
9. The advance premium check does not create temporary or interim insurance coverage and that receipt and deposit of that payment does not guarantee issuance of insurance coverage. Rather, issuance of insurance coverage is expressly conditioned on Anthem Life's

- determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem Life except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees;
10. That in order for Anthem Life to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem Life, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem Life may be different than the coverage applied for herein. In that event, Anthem Life shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued;
  11. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem Life by the employer. Anthem Life reserves the right to review such rates upon receipt of all individual applications for employers' employees and modify the rates, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the group's coverage or premium rate as of the effective date of coverage;
  12. The entire application for Group Insurance has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief;
  13. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work full-time (unless otherwise approved by Anthem Life in writing) and meet any other eligibility requirements for coverage;
  14. The requested coverage is not in effect unless and until this application is approved by Anthem Life, that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem Life.

ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM.

**PART IV: GENERAL AGREEMENT**

The undersigned Employer and/or authorized representative hereby request(s) that it be approved for insurance coverage through Anthem Blue Cross and Blue Shield. The undersigned Employer by signing this Application agrees to be bound by the terms of the contract. Employer agrees:

**The requested coverage is not in effect until this application is approved by Anthem Blue Cross and Blue Shield, that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the Employer. An employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem Blue Cross and Blue Shield;**

**That the advance premium check does not create temporary or interim insurance coverage and that receipt and deposit of that payment does not guarantee issuance of insurance coverage. Rather, issuance of insurance coverage is expressly conditioned on Anthem Blue Cross and Blue Shield's determination that the Employer is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem Blue Cross and Blue Shield except to refund the payment. The Employer will be responsible for returning to individual employees any part of the payment contributed by those employees;**

That in order for Anthem Blue Cross and Blue Shield to accept this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem Blue Cross and Blue Shield or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The Employer understands that the coverage issued by Anthem Blue Cross and Blue Shield may be different from the coverage applied for herein. In that event, Anthem Blue Cross and Blue Shield shall notify the Employer of such differences, and by payment of the appropriate premiums, the Employer will accept the coverage as issued.

AUTHORIZED GROUP REPRESENTATIVE			
Signature of authorized group representative <b>X</b>		Date 	
Print name	Title	City/state where signed	
PRODUCER/AGENT			
Signature of producer/agent <b>X</b>		Print name	Date 
Producer/agent address		City	State   ZIP code
Producer/agent no.	Tax ID no. to be paid	Phone no.	Fax no.
AGENCY			
Agency name (if applicable)		General agent (if applicable)	Anthem sales representative

## DEFINITIONS

The definitions listed below apply only to Health Coverage, and are for informational purposes only. For additional information, please refer to your Group Health Care Benefits Contract, Subscriber Agreement or the Evidence of Coverage.

**ELIGIBLE EMPLOYER:** An Eligible Employer is either a Corporation, Partnership, or Proprietorship that is actively engaged in business, in the State of Connecticut. The majority of employees must have worked at least 50% of the work days during the preceding year, and must be employed within the State of Connecticut.

**EMPLOYEE:** Any person who works for the employer, whether or not they are eligible for health insurance coverage. This includes full-time and part-time employees; this does NOT include retirees or former employees on a continuation plan (e.g. COBRA).

**ELIGIBLE EMPLOYEE:** An Eligible Employee is defined as a full-time employee of the employer. In order to qualify as a full-time employee, the employee must be actively at work and working at least 30 hours per week on a regularly scheduled basis unless a higher number of hours per week is required by the employer. Groups with 1 to 50 full-time employees can also offer medical coverage to part-time employees who work at least 20 hours per week (if requested by employer). Temporary employees and seasonal employees are not eligible for coverage.

### **ELIGIBLE DEPENDENTS:**

- a. An Eligible Employee's spouse under a legally valid existing marriage;
- b. For insured accounts: A child of an Eligible Employee up to age 26 if the child meets Anthem's guidelines for dependent eligibility under federal and state law. Please check with Anthem regarding those guidelines.
- c. For self-insured accounts: A child up to age 26 who meets your employer's guidelines for eligibility. Please check with your employer regarding those guidelines.

**EXCEPTION FOR NEWBORN OR ADOPTED CHILD:** Newborn and adopted children are automatically entitled to coverage for the first 31 days following birth or adoption. If no additional premium is due Anthem BCBS, a completed Enrollment and Membership Change Form must be submitted to Anthem BCBS within a reasonable amount of time following birth or adoption in order to continue coverage without interruption.

If additional premium is required, a completed Enrollment and Membership Change Form must be submitted to Anthem BCBS within 31 days following birth or adoption in order for coverage to be continued without interruption.

**ACTIVELY AT WORK:** The term Actively At Work means the employee must: work at the employer group's place of business or at such place(s) as normal business requires; and perform all the duties of the job as required of a full-time employee working 30 or more hours per week on a regularly scheduled basis. If a group with 1 to 50 full-time employees also offers medical coverage to part-time employees, the part-time employees must work at least 20 hours per week on a regularly scheduled basis.

**DATE OF HIRE/REHIRE:** The first day the individual performs services for wages or any other form of compensation is the Date of Hire/Rehire.

**WAITING PERIOD:** Means a period of time that must pass before an employee or dependent is eligible to enroll in the plan. The Anthem BCBS standard waiting period allows for new hires to be eligible to enroll for coverage following 30 days of continuous "actively at work employment." Generally new hires and their dependents who apply for coverage more than 31 days from the date first eligible will be considered a Late Enrollee.

**EFFECTIVE DATES:** New hires and their dependents will be effective the first of the month following completion of the waiting period. Effective dates for new hires may be deferred if all required data is not received, or is incomplete.

**\*PRE-EXISTING CONDITION:** (Required for Small Employer Groups 1-50) A condition for which medical advice, care or treatment was recommended or received within the Pre-Existing Condition Period, as specified in the Schedule of Benefits.

**\*PRE-EXISTING CONDITION PERIOD:** A period of time immediately prior to the effective date of coverage.

**BENEFITS EXCLUSION PERIOD:** A period of time during which no benefits will be provided for a pre-existing condition. Prior creditable coverage can reduce the length of a benefit exclusion period. We will request a certificate of prior creditable coverage from you regarding your previous health care plan if necessary.

**OPEN ENROLLMENT PERIOD:** The term open enrollment period means the period of time during which an employer group allows employees to select group health coverage. Open Enrollment does not apply to life coverage.

\*These provisions are not applicable to HMO products.