



Anthem Life

HMO Colorado



THIS SECTION MUST BE COMPLETED

Social Security #, Health Group #, Dental / Vision Group #, Life Group #

Health • Dental • Life • Vision Enrollment Application / Change Form

REASON FOR COMPLETION OF APPLICATION (Qualifying Event)

Reasons for completion: New Application, Salary Change, Name Change, PCP Change, Dentist Change, Remove Family Members, Add Family Members, Address/Telephone Change, Qualifying Event, Beneficiary Change, Effective Date or Date of Qualifying Event

HEALTH COVERAGE DESIRED (See your employer for coverages available)

BlueAdvantage HMO, BlueAdvantage Point-of-Service (POS), BluePreferred Plan Name, Other (Name of Coverage), Employee, Employee + Spouse, Employee + Child(ren), Family, Decline & complete waiver form

DENTAL COVERAGE DESIRED (See your employer for coverages available)

Anthem Dental, Anthem Dental / no non-network provider penalty, Employee, Employee + Spouse, Employee + Child(ren), Family, Decline & complete waiver form, Dentist Name / Location

VISION COVERAGE DESIRED

YES NO, Employee, Employee + Spouse, Employee + Child(ren), Family, Decline & complete waiver form

EMPLOYEE NAME (First, Middle Initial, Last)

Employee name input fields

HOME ADDRESS (Street address where you will receive member correspondence)

Home address input fields

CITY, STATE, ZIP CODE, +4 input fields

HOME TELEPHONE, OFFICE TELEPHONE, HEALTH GROUP NUMBER, DIVISION NUMBER input fields

FULL COMPANY NAME, POSITION TITLE input fields

DATE OF HIRE (MM/DD/YY), FULL TIME EMPLOYMENT DATE (MM/DD/YY) (If Different from Date of Hire), GENDER (M/F), BIRTHDATE (MM/DD/YY) input fields

IF YOU AND YOUR SPOUSE ARE USING DIFFERENT LAST NAMES CHECK APPLICABLE BOX: Common Law Marriage, Spouse Retaining Name, HOURS WORKED PER WEEK, EARNINGS \$

I certify that the below-named children are dependent on me or dependent because of a court order. (Attach a copy of court order or coverage dependent form or disabled dependent affidavit.)

LIST SELF AND ALL ELIGIBLE DEPENDENTS INCLUDING SPOUSE YOU WISH TO COVER (If additional space is required, attach separate sheet.)

Table with columns: NAME (First, Middle Initial, Last), RELATION, M/F, BIRTHDATE, PRIMARY CARE PROVIDER NAME, PROVIDER NUMBER, CURRENT PATIENT, Do you or any dependents have other insurance?, Carrier

Complete this section if you are enrolling in a health plan that is NOT an HMO or Point of Service Plan.

An individual may qualify for a waiver of the pre-existing waiting period as stated on the back, if the individual has had other health coverage within the last 90 days. Have you had a health plan in the last 90 days? YES NO. If yes, attach a copy of your Certificate of Coverage, if available, or other evidence of coverage. If no, the individual may be subject to a pre-existing condition waiting period of 6 or 18 months, unless the individual is applying for coverage within 30 days of eligibility.

MEDICARE COVERAGE INFORMATION — ARE YOU, YOUR SPOUSE, OR ANY DEPENDENT CHILDREN COVERED UNDER MEDICARE? IF "YES," COMPLETE.

Table with columns: NAME (First, Middle Initial, Last), PART A EFF. DATE, PART B EFF. DATE, IF YOU ARE UNDER AGE 65, GIVE REASON FOR DISABILITY, MEDICARE CLAIM NUMBER

COMPLETE FOR ANTHEM LIFE INSURANCE COMPANY COVERAGE ONLY (See your employer for coverage available)

COVERAGES YOU ARE APPLYING FOR (If Applicable): Group Term Life, Dependent Life, Short Term Disability, Long Term Disability, Supplemental Life Amount, PRIMARY BENEFICIARY NAME (First, Middle Initial, Last), RELATIONSHIP, SECONDARY BENEFICIARY NAME (First, Middle Initial, Last), RELATIONSHIP

EMPLOYEE SIGNATURE, DATE, SPOUSE SIGNATURE, DATE

See reverse side of this form for additional provisions. I acknowledge that I have read the front as well as the reverse side of this application and certify that I agree to all matters covered therein.

The following statement applies to fully insured groups, with 50 employees or less: "COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN"