Enrollment Application
Group size 51+ eligible employees

Anthem. BlueCross BlueShield Anthem Life

INSTRUCTIONS:

Please read carefully, complete electronically, or in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer. Anthem's Primary Care Physician (PCP) listings for HMO/POS plans can be obtained through www.anthem.com

TOTAL RETAIL SERVICES

COMPLETE AREAS HIGHLIGHTED

SECTION 1: EMPLOYER/GROUP USE - Required

Employer name	Employer address			
TRENDS INTERNATIONAL	5188 W. 74TH ST, INDIANAPOLIS, IN 46268			
Group no.	Sub-group no./ Life division no.	Requested effective date	Life classification	Employee no./Dept. name
00084333	0002 - TRS	0 1 0 1 2 0 1 5		

SECTION 2: REASON FOR APPLICATION - Required

☐ New enrollment ☑ Annual open enrollment (N/A to Life)	☐ COBRA Qualifying event_____ event date_____ ☐ Waiver (To decline ALL coverage skip to Section 12)	☐ New hire ☐ Rehire date_____	☐ Add dependent (Fill in Section 3)

SECTION 3: STATUS CHANGE/EVENT - Required, if you checked "Add dependent" option in Section 2.

Event date			
0 1 0 1 2 0 1 5	☐ Marriage ☐ Birth	☐ Adoption (Attach legal documentation) ☐ Legal guardianship (Attach legal documentation)	☐ Loss of coverage (reason) _____ ☐ Other_____ ☐ Termed employment

SECTION 4: PLAN/TYPE OF COVERAGE - Required. To decline a plan type, check "No coverage". If you are waiving all coverage, go to Section 12.

Medical

If multiple Medical Plans are available, please indicate the plan type below and write plan number in the space provided.

Deductibles: ☐ HSA Plan #1 2,000/4,000 ☐ HSA Plan #2 3,000/6,000

If multiple Medical Plans are available, write plan number:

*Anthem will facilitate the opening of a Health Savings Account (HSA) in your name, if directed by your Employer.

Type of coverage
☐ Employee only
☐ Employee+spouse (DP)
☐ Employee+child(ren)
☐ Family coverage
☐ No coverage

Dental

To apply for BUY-UP coverage, check PPO and write in the plan number on the line provided.

☐ PPO_____
☐ DentaCare (HMO)
☐ Dental Blue® 100/200/300
☑ Dental Blue® 100

Type of coverage
☐ Employee only ☐ Employee+spouse
☐ Employee+child(ren) ☐ Family coverage
☐ No coverage

Vision

Type of coverage
☐ Employee only ☐ Employee+spouse (DP)
☐ Employee+child(ren) ☐ Family coverage
☐ No coverage

Life

☑ Life (Fill in Section 7)

SECTION 5: EMPLOYEE INFORMATION - Required

Last name	First name	M.I.	Date of birth	Age	Social security no. (required)

Sex		Height	Weight	Home phone	Business phone	Email address
☐ M ☐ F	☐ Single ☐ Married ☐ Divorced					

Address	City	State	ZIP code	County

Retired	Disabled	Hospitalized	Occupation	Full-time hire date	Hours working per week	Income reported by
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			40	☑ W2 ☐ 1099 ☐ Other_____

Complete Primary Care Physician (PCP) information for HMO or POS plans only.

Anthem PCP name and address	Anthem PCP ID no.	New patient
		☐ Yes ☐ No

***ATTACH ADDITIONAL PAGES AS NEEDED TO LIST DEPENDENTS FOR SECTION 6.

Employee name _____ Social security no. _____

SECTION 6: FAMILY INFORMATION – Required. List only dependents you wish to enroll, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under Section 10, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 6.

Spouse/Domestic Partner

Last name	First name	M.I.	Social security no. (required)

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled
			☐ M ☐ F	☐ Spouse ☐ Domestic Partner	☐ Yes ☐ No (If yes, give reason)

If spouse/DP address is different than employee, please provide full address

Anthem PCP name and address (for HMO or POS plans only)	Anthem PCP ID no.	New patient
		☐ Yes ☐ No

Dependent

Last name	First name	M.I.	Social security no.	Full-time student
				☐ Yes ☐ No

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled
			☐ M ☐ F	☐ Child ☐ Other_____	☐ Yes ☐ No (If yes, give reason)

Court ordered health care coverage	If dependent address is different than employee, please provide full address
☐ Yes ☐ No (If yes, attach legal documentation)	

Anthem PCP name and address (for HMO or POS plans only)	Anthem PCP ID no.	New patient
		☐ Yes ☐ No

Dependent

Last name	First name	M.I.	Social security no.	Full-time student
				☐ Yes ☐ No

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled
			☐ M ☐ F	☐ Child ☐ Other_____	☐ Yes ☐ No (If yes, give reason)

Court ordered health care coverage	If dependent address is different than employee, please provide full address
☐ Yes ☐ No (If yes, attach legal documentation)	

Anthem PCP name and address (for HMO or POS plans only)	Anthem PCP ID no.	New patient
		☐ Yes ☐ No

SECTION 7: LIFE AND DISABILITY INSURANCE - Required, if this type of coverage was selected in Section 4.

Current income $_____ ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Life Class

☐ Basic Life ☐ Optional Life _____ x Annual Earnings ☐ Basic AD&D ☐ Short-Term Disability_____

☐ Dependent Life OR $_____ ☐ Optional AD&D ☐ Long-Term Disability _____

Anthem ByDesign Buy-Up. Check appropriate box and write in the percentage next to the benefit selected. Complete separate election form.

☐ Short-Term Disability_____% ☐ Long-Term Disability_____% ☐ Basic Life

Primary beneficiary

Last name	First name	M.I.	Social security no.	Relationship to employee	Age

Contingent beneficiary

Last name	First name	M.I.	Social security no.	Relationship to employee	Age

SECTION 8: OTHER HEALTH COVERAGE - Required

Do you and/or your dependents have other health coverage? ☐ Yes ☐ No If yes, complete below.

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage

Provide name, phone number and address of the HMO or insurance company	Policy/certificate no.	Effective date

Policy/certificate holder name	Social security no.	Date of birth	Relationship to employee

Are you and/or your dependents enrolled in Medicare or Medicaid? ☐ Yes ☐ No If yes, complete below.

Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date

Medicare Part D ID no.	Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date

Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

Employee name _____ Social security no. _____

SECTION 9: PRIOR HEALTH COVERAGE - Required

Have you and/or your dependents had prior health coverage? ☐ Yes ☐ No If yes, complete below.

Have you been covered by Anthem within the past two (2) years ☐ Yes ☐ No	Policy/certificate no.	
Group name/ID no.	Date policy in effect	Date policy termed

Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years ☐ Yes ☐ No

List prior carrier(s)	Date policy in effect	Date policy termed

Please check the type of prior coverage

☐ Employee ☐ Employee+Spouse/DP ☐ Employee+Child(ren) ☐ Employee+Spouse/DP+Child(ren)

Termination reason:

☐ Divorce/legal separation ☐ Employment terminated ☐ Employer/group contribution ceased ☐ Other
☐ Death of spouse/DP ☐ COBRA coverage exhausted ☐ Group plan terminated

SECTION 10: SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) – Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem Blue Cross and Blue Shield at any time.

1. I understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline to this application for coverage (and that Anthem Life Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage. I also understand that I may not be covered for pre-existing conditions.
5. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
6. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

Thank you for choosing Anthem Blue Cross and Blue Shield.

SECTION 11: SIGNATURE – Required, if you are applying for coverage. Please review your application for errors or omissions.

Read Section 10 carefully before signing.
I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature	Date
X	

COMPLETE THIS PAGE ONLY IF WAIVING COVERAGE

Employee name _____ Social security no. _____

SECTION 12: WAIVER OF COVERAGE – Complete for yourself and/or any eligible dependents. Check all that apply.

Type of coverage	Waived for	Name	Reason for waiving (already protected by coverage)	
☐ Medical	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ Dental	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ Vision	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ Life	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ All	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	

Check all that apply:

☐ I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. If I want to apply for such coverage at a later date, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse or domestic partner) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. The pre-existing exclusion may not apply to a dependent who is enrolled in the plan prior to his or her 19th birthday. In addition, if I have a dependent as a result of marriage, 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, birth, adoption or placement of adoption.

I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependents or I become eligible for a subsidy (state premium assistance program).

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

☐ I have been given an opportunity to apply for the available group life benefits offered by my employer/group. The benefits have been explained to me, and I and/or my dependent(s) decline to participate. My dependent(s) or I were not induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for coverage in the future, I may be required to provide evidence of insurability at my expense.

Please check if any of the following apply:

☐ I am covered or will be covered under another plan that is not sponsored by my employer. I am not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).

☐ My dependents are covered or will be covered under another plan that is not sponsored by my employer. My dependents are not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).

☐ Other: _____

SIGNATURE – Required, if you want to waive coverage for yourself and your dependents.

Employee signature	Date
X	

**IF WAIVING COVERAGE, PLEASE LIST ALL FAMILY MEMBERS THAT YOU ARE WAIVING. IF FAMILY MEMBERS ARE NOT LISTED ABOVE, AND YOU HAVE A QUALIFYING EVENT OUTSIDE OF OPEN ENROLLMENT, THEY WILL NOT BE ELIGIBLE FOR INSURANCE.