State of Indiana School Corporation Enrollment Form

Anthem

Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.
Please complete this form electronically or in black ink and return to your employer. Use extra sheets of paper if necessary.
All information given should apply to this employer.

Employer use only

Group no.	Sub-group no.	Applicant no./dept. name	Requested effective date (MMDDYYYY)
Employer name		Address (please include suite no., city, state, ZIP code)	

Anthem use only

Plan	COB ☐ Yes ☐ No	Health effective date (MMDDYYYY)

Section 1: Reason for application

☐ New enrollment ☐ Annual open enrollment ☐ New hire ☐ Rehire (event date)
☐ Add dependent (see section 2)
☐ COBRA – Qualifying event: _____
☐ Conversion (event date)
☐ Waiver of coverage

Section 2: Status change/event

Event date (MMDDYYYY)	☐ Marriage ☐ Birth ☐ Adoption* ☐ Legal guardianship* ☐ Other: _____

*Include legal documentation

Section 3: Plan/Type of coverage

Plan: ☐ CDHP 1 ☐ CDHP 2 ☐ Traditional
Coverage for: ☐ Employee only ☐ Employee and spouse ☐ Employee and child(ren) ☐ Family coverage ☐ No coverage

Section 4: Employee information

Last name	First name	M.I.	Date of birth (MMDDYYYY)	Social Security no. (required)
Sex ☐ M ☐ F	Marital status ☐ Single ☐ Married ☐ Divorced	Home phone	Work phone	Email address
Are you retired? ☐ Yes ☐ No	Are you disabled? ☐ Yes ☐ No	Are you hospitalized? ☐ Yes ☐ No		
Home street address	City	County	State	ZIP code
Occupation	Full-time hire date (MMDDYYYY)	Income reported by ☐ W-2 ☐ 1099 ☐ Other: _____	Hours working per week: _____	

Policyholder name	Policyholder Social Security no.

Section 5: Family information — Spouse and dependents to be enrolled. Attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information under Significant Terms, Conditions and Authorizations section, prior to answering questions below.

1 — Relationship to employee: Spouse Sex: ☐ M ☐ F

Spouse last name	First name	M.I.	Date of birth (MMDDYYYY)	Social Security no. (required)

Is spouse's address different from applicant's address? ☐ Yes ☐ No
If yes, provide full address: _____

Court ordered health care benefits? ☐ Yes ☐ No If yes, include legal documentation.	Currently hospitalized or disabled? ☐ Yes ☐ No If yes, give reason: _____

2 — Relationship to employee: ☐ Son ☐ Daughter Sex: ☐ M ☐ F

Dependent last name	First name	M.I.	Date of birth (MMDDYYYY)	Social Security no. (required)

Is dependent's address different from applicant's address? ☐ Yes ☐ No
If yes, provide full address: _____

Court ordered health care benefits? ☐ Yes ☐ No If yes, include legal documentation.	Currently hospitalized or disabled? ☐ Yes ☐ No If yes, give reason: _____

3 — Relationship to employee: ☐ Son ☐ Daughter Sex: ☐ M ☐ F

Dependent last name	First name	M.I.	Date of birth (MMDDYYYY)	Social Security no. (required)

Is dependent's address different from applicant's address? ☐ Yes ☐ No
If yes, provide full address: _____

Court ordered health care benefits? ☐ Yes ☐ No If yes, include legal documentation.	Currently hospitalized or disabled? ☐ Yes ☐ No If yes, give reason: _____

Section 6: Other health coverage

Do you or a family 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.

Name of person covered	Relationship to employee	Name of person covered	Relationship to employee
1.	☐ Self ☐ Spouse ☐ Child(ren)	2.	☐ Self ☐ Spouse ☐ Child(ren)
3.	☐ Self ☐ Spouse ☐ Child(ren)	4.	☐ Self ☐ Spouse ☐ Child(ren)
5.	☐ Self ☐ Spouse ☐ Child(ren)	6.	☐ Self ☐ Spouse ☐ Child(ren)

Name of HMO or insurance company	Policy/certificate no.	Effective date (MMDDYYYY)

Street address of the HMO or insurance company	City	State	ZIP code	Phone no. of HMO or insurance company

Policyholder name	Policyholder Social Security no.	Policyholder date of birth

Policyholder name	Policyholder Social Security no.

Section 7: Medicare coverage – If you or your dependents are enrolled in Medicare or Medicaid, complete the following.

1 – Enrollee last name	First name	M.I.	Medicare Part A effective date	Medicare Part B effective date

Medicare/Medicaid ID no.	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 ☐ End stage renal disease (ESRD) ☐ ESRD and disability ESRD onset date:

2 – Enrollee last name	First name	M.I.	Medicare Part A effective date	Medicare Part B effective date

Medicare/Medicaid ID no.	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 ☐ End stage renal disease (ESRD) ☐ ESRD and disability ESRD onset date:

Section 8: Significant Terms, Conditions and Authorization (TERMS)

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application, the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem Blue Cross and Blue Shield with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem Blue Cross and Blue Shield with information about my HSA, including account number, account balance and information, regarding account activity. I also understand that I may provide Anthem Blue Cross and Blue Shield with a written request to revoke my authorization at any time.

Please read this section carefully before signing the application.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield administered benefit plan.
2. I authorize deduction from my wages/pension, if necessary for the required payment for the benefit for which I, or any dependents have applied.
3. I am applying for the benefit selected on this application. If I select a coverage, or 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.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude for pre-existing conditions.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.
6. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.

   I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of enrollment. 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 Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to benefits or rates. Any material misrepresentation or significant omission found in this application may result to denial of benefits or rescission or cancellation of my benefits.

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health benefit plan will be administered by Anthem Blue Cross and Blue Shield.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Read the TERMS section above carefully before signing. Please review your application for errors or omissions.

By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Applicant signature **X**	Date (MMDDYYYY)

Policyholder name	Policyholder Social Security no.

Section 9: Waiver of coverage — Complete for employee and/or any eligible dependent not enrolling.

Last name of person waiving	First name	M.I.	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy no.)	☐ Other carrier (give name and ID no.)	

Last name of person waiving	First name	M.I.	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy no.)	☐ Other carrier (give name and ID no.)	

Last name of person waiving	First name	M.I.	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy no.)	☐ Other carrier (give name and ID no.)	

Last name of person waiving	First name	M.I.	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy no.)	☐ Other carrier (give name and ID no.)	

Last name of person waiving	First name	M.I.	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy no.)	☐ Other carrier (give name and ID no.)	

I certify that I have been given an opportunity to apply for the employer's health benefits plan, and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such benefits hereafter, I may do so, subject to established procedures.

If I am declining enrollment for myself or my dependents (including my spouse) 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 benefit booklet, 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/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 dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependent 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.

Applicant signature if you are waiving coverage	Date (MMDDYYYY)
X	