State of Indiana School Corporation
Health Care Plan Enrollment Change Form

Administered by Anthem Insurance Companies, Inc.

Anthem Insurance Companies
P.O. Box 390
Indianapolis, IN 46206-0390

School corporation name

Section 1: About the employee

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

Sex	Marital status	Phone no.	Email address
☐ Male ☐ Female	☐ Single ☐ Married ☐ Other		

Street address	City	State	ZIP code

Section 2: Your coverage option

☐ Traditional ☐ CDHP I ☐ CDHP II	Medical: ☐ Single ☐ Family

Section 3: About coverage — Please answer the following questions

Are you, or any listed dependent, presently enrolled in Medicare? ☐ Yes I have enrolled ☐ No enrollment in Medicare
If yes, enrollee name(s): ____________________

Medicare ID no.	Part A (hospital) effective date	Part B (medical) effective date	Part D (prescription) effective date

Are you, or any listed dependent, presently enrolled in any other Group Hospital and/or Medical Insurance? ☐ Yes ☐ No If yes, complete the following questions.

Insured's last name	First name	M.I.	Date of birth (MMDDYYYY)	Social Security no.

Name of employer	Employer street address	City	State	ZIP code

Name of insurance company	Insurance company address	Policy/certificate no.	Effective date (MMDDYYYY)

Section 4: About your dependents

☐ Continue current coverage Make changes: ☐ Change plan selection ☐ Add dependents ☐ Remove dependents ☐ Waive all coverage

	Last name	First name	M.I.	Date of birth (MMDDYYYY)	Social Security no.	Relationship	Disabled
☐ Add ☐ Remove						☐ Wife ☐ Husband	☐ Yes ☐ No
☐ Add ☐ Remove						☐ Son ☐ Daughter	☐ Yes ☐ No
☐ Add ☐ Remove						☐ Son ☐ Daughter	☐ Yes ☐ No
☐ Add ☐ Remove						☐ Son ☐ Daughter	☐ Yes ☐ No

Section 5: Election of coverage — Please sign the application.

I wish to apply for Enrollment in the State of Indiana Medical Plan Administered by Anthem Insurance Companies, Inc. I understand that I may not assign any payment under my Plan Enrollment. I agree that in the normal course of business, Anthem Insurance Companies, Inc. and its designated contractors may obtain any and all reports and records or copies thereof concerning any injury, illness or condition for which service was provided to me or my Eligible Dependents after this date, together with like reports and records or copies thereof of earlier services, for purposes of processing this application for purposes of determining the eligibility of any claim for payment or the propriety of any payment made. I authorize Hospitals, Physicians, or other Providers of services having such information to furnish such information to Anthem Insurance Companies, Inc. and its designated contractors. I also agree that in the normal course of its business Anthem Insurance Companies, Inc. may furnish it to its designated contractors, the Group, and the designated contractors of the Group information relating to medical services and treatment rendered to me and my Eligible Dependents. I understand that my coverage will not begin until the date shown on my Identification card. I also understand that a claim of mine may be denied or my coverage canceled and nullified if it is determined I gave false information on this application or with a claim for payment.

I wish to enroll in the State of Indiana plan selected above.

Signature	Date (MMDDYYYY)
X	

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