

Employee Enrollment Application
For 51+ employee groups
Ohio



You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete electronically or in blue or black ink only.

Employer name N o r t h F o r k L o c a l S c h o o l s	Group no. L 0 8 3 4 4	Subsection
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Section 1: Employee information

Last name		First name		M.I.	Social Security no.* (required)	
Birthdate (MMDDYYYY)		Home address				
City			County		State	ZIP code
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner			Primary phone no.	
Employee email address						
Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Disabled <input type="checkbox"/> Retired				Hire date (MMDDYYYY)		No. of hours worked per week
Primary Care Physician (PCP) name				PCP ID no.		Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 2: Reason for application – Select one

New enrollment
 Annual open enrollment (not applicable to life and disability)
 New hire
 Rehire – Rehire date: _____ (MMDDYYYY)
 Marriage – Date of marriage: _____ (MMDDYYYY)
 Birth of child
 Add dependent (Fill in section 4)
 Loss of eligibility for other coverage – Date previous coverage ended: _____ (MMDDYYYY) (not applicable to life and disability)
 COBRA – Select qualifying event (not applicable to life and disability)
 Left employment Reduction in hours Death Medicare
 Loss of dependent child status Divorce or legal separation Covered employee's Medicare entitlement
 Qualifying event date: _____ (MMDDYYYY)
 Waiver (To decline ALL coverage skip to section 8.)

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Social Security no. * (required)

Section 3: Type of coverage

Medical coverage		
Large Group 51-99 options		
<input type="checkbox"/> Blue Access PPO	<input type="checkbox"/> Blue Access Options PPO 3-Tier	<input type="checkbox"/> Blue Connection Link HMO
<input type="checkbox"/> Blue Access PPO HSA	<input type="checkbox"/> Blue Access Options PPO 3-Tier HSA	<input type="checkbox"/> Blue Connection Link HMO HSA
<input type="checkbox"/> Blue Access PPO HSA with Copay	<input type="checkbox"/> Blue Access Options ERHealth PPO 3-Tier	
	<input type="checkbox"/> Blue Access ERHealth Select PPO	
<input type="checkbox"/> Add HRA Wrap (Administered by Anthem)		
Large Group 100+ options		
<input type="checkbox"/> Blue Access PPO	<input type="checkbox"/> Blue Access PPO Deductible First HRA	<input type="checkbox"/> Blue Connection Link HMO
<input type="checkbox"/> Blue Access PPO HSA	<input type="checkbox"/> Blue Access Options PPO 3-Tier	<input type="checkbox"/> Blue Connection Link HMO HSA
<input checked="" type="checkbox"/> Blue Access PPO HSA with Copay	<input type="checkbox"/> Blue Access Options PPO 3-Tier HSA	
<input type="checkbox"/> Blue Access PPO HRA	<input type="checkbox"/> Blue Access Options ERHealth PPO 3-Tier	
<input type="checkbox"/> Blue Access PPO HRA with Copay	<input type="checkbox"/> Blue Access ERHealth Select PPO	
<input type="checkbox"/> Add HRA Wrap (Administered by Anthem)		
Member medical coverage – select one:		
<input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No coverage		
Flexible Spending Account (FSA) coverage – More than one plan may be selected, depending on employer offerings.		
<input type="checkbox"/> Healthcare FSA (excluded if you have an HSA plan)	<input type="checkbox"/> Commuter Parking	
<input type="checkbox"/> Limited-Purpose FSA (for dental and vision services)	<input type="checkbox"/> Commuter Transit	
<input type="checkbox"/> Dependent Care FSA	<input type="checkbox"/> No FSA coverage at this time	
Dental coverage		
<input type="checkbox"/> Prime Essential Choice	<input type="checkbox"/> Prime Consumer Choice	<input type="checkbox"/> Complete Essential Choice
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Complete Consumer Choice	
Member dental coverage – select one:		
<input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No coverage		
Vision coverage		
<input type="checkbox"/> Vision		
Member vision coverage – select one:		
<input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No coverage		
Life and disability coverage		
If you select life and/or disability coverage over the guaranteed issue amount or are a late entrant an Evidence of Insurability form may be sent to you to complete. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder. Your employer will advise you of your plan options. These coverages may be subject to medical evidence underwriting and would only become effective upon approval.		
<input type="checkbox"/> Basic Life <input type="checkbox"/> Basic Life and Accidental Death and Dismemberment <input type="checkbox"/> Basic Dependent Life <input type="checkbox"/> Supplemental/Voluntary Life and Accidental Death and Dismemberment \$ _____ (employee amount) <input type="checkbox"/> Supplemental/Voluntary Dependent Life Spouse \$ _____ (spouse amount) <input type="checkbox"/> Supplemental/Voluntary Dependent Life Child \$ _____ (child amount) <input type="checkbox"/> Voluntary Accidental Death and Dismemberment \$ _____ (employee amount) <input type="checkbox"/> Voluntary Accidental Death and Dismemberment Family Plan (Spouse and Child coverage) <input type="checkbox"/> Voluntary Accidental Death and Dismemberment Spouse Only (no Child coverage) <input type="checkbox"/> Voluntary Accidental Death and Dismemberment Child Only (no Spouse coverage) <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Voluntary Short Term Disability <input type="checkbox"/> Voluntary Long Term Disability		
Current annual income – For employer/Anthem use \$ _____	Occupation	Life and disability class no. – For employer/Anthem use

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Social Security no.* (required)

Life and disability coverage – Continued

Beneficiary designation – Attach a separate sheet if necessary.

Beneficiary type <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
	Street address	City	State	ZIP code	Phone no.
Beneficiary type <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
	Street address	City	State	ZIP code	Phone no.
Beneficiary type <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
	Street address	City	State	ZIP code	Phone no.
Beneficiary type <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
	Street address	City	State	ZIP code	Phone no.

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

If you live in AZ, CA, ID, LA, NM, NV, TX, WA, WI and your spouse is not 50% or more beneficiary, your spouse needs to sign below. In CA, NV, and WA, Spouse also includes your registered Domestic Partner.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse consent for designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA, and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following.

Spouse authorization, if applicable
I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy.
I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws.
I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse sign here to waive community property rights	Spouse/Domestic Partner signature	Spouse/Domestic Partner name	Date (MMDDYYYY)
	X		

Group Accident, Critical Illness, and Hospital Indemnity Insurance

Group Accident Insurance – Coverage option: Employee only Employee + Spouse Employee + Children Family
If more than one Accident plan offered please select: Low Plan High Plan

Group Critical Illness Insurance – Coverage option: Employee only Employee + Spouse Employee + Children Family
If more than one Critical Illness plan offered please select: Low Plan High Plan
Have you smoked or used tobacco products in the last 12 months? No Yes, explain product used: _____

Group Hospital Indemnity Insurance – Coverage option: Employee only Employee + Spouse Employee + Children Family
If more than one Hospital Indemnity plan offered please select: Low Plan High Plan

If any person to be covered by a Critical Illness or Hospital Indemnity plan is a resident of CA, GA, NY, or CO, please answer the following question:
Will all applicants who reside in CA, GA, NY, or CO, when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy, an employer sponsored health plan, or an HMO that provides essential health benefits? Yes No (Please note that if the response is No, such applicants are not eligible for coverage)

Social Security no.* (required)

Group Accident, Critical Illness, and Hospital Indemnity Insurance beneficiary designation

Beneficiary designation — Attach a separate sheet if necessary.

Beneficiary type <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
	Street address	City	State	ZIP code	Phone no.
Beneficiary type <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
	Street address	City	State	ZIP code	Phone no.
Beneficiary type <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
	Street address	City	State	ZIP code	Phone no.
Beneficiary type <input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Name of beneficiary	Percentage %	Social Security no.*	Relationship to applicant	Date of birth
	Street address	City	State	ZIP code	Phone no.

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

Section 4: Coverage information — All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Spouse/Domestic Partner last name		First name		M.I.	Social Security no.* (required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MMDDYYYY)	Email address (if applicable)		
Relationship to applicant: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner					
PCP name			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Dependent last name		First name		M.I.	Social Security no.* (required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MMDDYYYY)	Email address (if applicable)		
Relationship to applicant: <input type="checkbox"/> Biological child of applicant/spouse/domestic partner <input type="checkbox"/> Other If other, what is relationship? _____					
PCP name			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please enter: _____					

Dependent last name		First name		M.I.	Social Security no.* (required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MMDDYYYY)	Email address (if applicable)		
Relationship to applicant: <input type="checkbox"/> Biological child of applicant/spouse/domestic partner <input type="checkbox"/> Other If other, what is relationship? _____					
PCP name			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please enter: _____					

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no. * (required)

Section 4: Coverage information – Continued.

Dependent last name		First name		M.I.	Social Security no. * (required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MMDDYYYY)	Email address (if applicable)		
Relationship to applicant: <input type="checkbox"/> Biological child of applicant/spouse/domestic partner <input type="checkbox"/> Other If other, what is relationship? _____					
PCP name			PCP ID no.	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____					

Section 5: Prior and other group coverage

Are you or anyone applying for coverage currently eligible for Medicare? Yes No
If yes, give name: _____

Medicare ID no.	Part A effective date (MMDDYYYY)	Part B effective date (MMDDYYYY)	Medicare eligibility reason (check all that apply) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD: Onset date: _____ (MMDDYY)		
Medicare Part D ID no.	Medicare Part D carrier			Part D effective date (MMDDYYYY)	

Are you or a family member previously or currently covered by a Medicare, medical ~~and/or dental~~ plan? Yes No
If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policyholder name	Dates (if applicable) (MMDDYY)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental <input checked="" type="checkbox"/> Orthodontia					Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental <input checked="" type="checkbox"/> Orthodontia					Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental <input checked="" type="checkbox"/> Orthodontia					Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental <input checked="" type="checkbox"/> Orthodontia					Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental <input checked="" type="checkbox"/> Orthodontia					Start: _____ End: _____

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Section 6: 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 (Anthem) 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 at any time.

1. I understand that I may not assign any payment under my Community Insurance Company (Anthem) program, unless allowable by law.
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 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.
5. If applying for HIC/HMO coverage, I understand that I may cancel my membership by providing written notice to Anthem within 72 hours of signing this application.
6. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.
7. I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 CFR. Parts 160 & 164) and the Ohio Revised Code § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

Life and/or Disability Authorization Section – Read carefully before signing.

1. I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, including any health or other insurance company affiliated with Anthem Life Insurance Company, consumer reporting agency or employer having information available as to claims, diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (but specifically excluding from this authorization any non-medical information that could be used to ascertain my sexual orientation or that I have a pending HIV test or that I have had negative HIV test results), to give any and all such information to authorized representatives of Anthem Life Insurance Company (Anthem Life), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life, and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Anthem representatives to evaluate and adjudicate my current application for life or disability coverage or any claims under such coverage, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Anthem solely to assist with the evaluation and adjudication of my current life or disability application or claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information as applicable. I understand that Anthem Life may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.
2. Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.

This authorization, for purposes of processing this application form, is valid from the date signed for a period of 30 months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. For the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization shall remain valid for the term of coverage of the policy for an accident and sickness insurance benefit and for the duration of the claim if the claim is not for an accident and sickness insurance benefit. A photocopy and/or electronic copy is as valid as the original. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.

I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan, including my Spouse/Domestic Partner/Civil Union Partner. I am acting as their agent and representative.

Social Security no.* (required)

Section 6: Terms, Conditions, and Authorizations (TERMS) continued

I certify each Social Security number listed on this application is correct.
I have read and accept the 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 representation 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.
Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either. I understand if I change my mind after 30 months, I will need to let Anthem know. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.
Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.
Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 7: Signature – Required if you are applying for coverage. Please review your application for errors or omissions.

Read section 6 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 X	Date (MMDDYYYY)
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Important Accident Insurance eligibility information:

The following notice applies to all Accident and Voluntary Accident coverage presented on this form:
ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Critical Illness Insurance eligibility information:

The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:
CRITICAL ILLNESS INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Hospital Indemnity Insurance eligibility information:

The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:
HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISEIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

*Anthem is required by the Internal Revenue Service to collect this information.

Section 8: Waiver/Declining coverage

Medical coverage			
Medical coverage declined for – check all that apply: Reason for declining coverage – check all that apply:	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Covered by spouse's/domestic partner's group coverage <input type="checkbox"/> Enrolled in other insurance – Please provide company name and plan: _____ <input type="checkbox"/> Enrolled in individual coverage <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Medicare/Medicaid/VA <input type="checkbox"/> Other – please explain: _____ <input type="checkbox"/> No coverage		
Dental coverage			
Dental coverage declined for – check all that apply: Reason for declining coverage – check all that apply:	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Covered by spouse's/domestic partner's group coverage <input type="checkbox"/> Enrolled in other insurance – Please provide company name and plan: _____ <input type="checkbox"/> Enrolled in individual coverage <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Medicare/Medicaid/VA <input type="checkbox"/> Other – please explain: _____ <input type="checkbox"/> No coverage		
Vision coverage			
Vision coverage declined for – check all that apply: Reason for declining coverage – check all that apply:	<input type="checkbox"/> Myself <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Dependent(s) <input type="checkbox"/> Covered by spouse's/domestic partner's group coverage <input type="checkbox"/> Enrolled in other insurance – Please provide company name and plan: _____ <input type="checkbox"/> Enrolled in individual coverage <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Medicare/Medicaid/VA <input type="checkbox"/> Other – please explain: _____ <input type="checkbox"/> No coverage		
Life and disability coverage			
 *Life/AD&D coverage declined for: Spouse, Domestic Partner and dependent coverage not available if life coverage is waived/declined. Dependent Life coverage declined for: Supplemental/Voluntary coverage declined for: Supplemental/Voluntary Dependent Life coverage declined for: Voluntary Short Term Disability coverage declined for: Voluntary Long Term Disability coverage declined for: Reason for declining coverage – check all that apply: 	 <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/domestic partner and dependents <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/domestic partner and dependents <input type="checkbox"/> Myself <input type="checkbox"/> Myself <input type="checkbox"/> Life/AD&D declined for religious reasons <input type="checkbox"/> Do not elect to enroll in Dependent Life <input type="checkbox"/> Do not elect to enroll in Supplemental/Voluntary coverage <input type="checkbox"/> Do not elect to enroll in Supplemental/Voluntary Dependent Life coverage <input type="checkbox"/> Do not elect to enroll in Voluntary Short Term Disability <input type="checkbox"/> Do not elect to enroll in Voluntary Long Term Disability 		
 *I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, 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 such coverage in the future, I may be required to provide evidence of insurability at my expense. 			
Sign here only if you are declining coverage.			
Signature of applicant X	Printed name	Social Security no.	Date (MMDDYYYY)

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