Member Enrollment/Member Change Form

SECTION 1: MEMBER/APPLICANT INFORMATION

Current Anthem Blue Cross and Blue Shield contract no., if any	Last name	First name	M.I.

Home address or P.O. Box	City	State	ZIP code

Home phone	Work phone	Email address	Please check one: ☐ Active employee ☐ COBRA ☐ Retired employee ☐ Other: ________

SECTION 2: ENROLLMENT REASON — Please check the reason below and date, if required.

☐ Annual enrollment ☐ New group (Initial enrollment) ☐ COBRA – start date: ☐ Retiree - date of retirement:
☐ New hire ☐ Portability or Qualifying Life Event ☐ COBRA – event date: ☐ Other: ________

SECTION 3: CHANGE STATUS — Please check type and date of change below.

☐ Name change ☐ Add dependent ☐ Delete dependent ☐ Address change ☐ PCP change Date of change:

Reason for change
☐ Adoption ☐ Annual enrollment ☐ Birth ☐ Court order
☐ Court order changing custody ☐ Covered by Medicaid ☐ Covered by other insurance ☐ Death
☐ Discharge from the military ☐ Divorce ☐ Entrance to the military ☐ Involuntary loss of coverage
☐ Involuntary loss of Medicaid ☐ Marriage ☐ Other: ________

SECTION 4: MEMBERSHIP CHOICES

☐ Lumenos® HSA[1] Plan ☐ HMO Maine ☐ CompCare
☐ Lumenos® HRA Plan ☐ HMO Choice ☐ Other: ________
☐ Full Service ☐ Blue Choice ☐ Blue View Vision: ________
1 Confirm with your employer which HSA custodian was selected. Desired deductible for selected plan: ________

NOTICE: There are hospitals, health care facilities, physicians or other health care providers who are not included in this plan's network. Your financial responsibilities for payment of covered services may differ if you use a network provider or a non-network provider. Please refer to the online provider directory available at anthem.com to determine if a particular provider is in the network, or contact customer service for assistance.

SECTION 5: EMPLOYER INFORMATION

Company name	Group no. (if existing group)

Address	City	State	ZIP code

Date of hire[2] (MM/DD/YYYY)	Date of rehire (if applicable)[2] (MM/DD/YYYY)	Date eligible (MM/DD/YYYY)	No. hours worked per week

2 Date of hire/rehire: The first day the individual performs services for wages or any other form of compensation is the Date of hire/rehire.

SECTION 6: APPLICANT AND MEMBER INFORMATION — List only family members you wish to enroll, delete or change.

You may apply to cover your legal spouse, Domestic Partner (if applicable to your group – a completed Affidavit of Domestic Partnership must also be attached to this application) and children/stepchildren who meet your employer's guidelines for eligibility. Contact your employer for specific eligibility rules for these dependents.

Medical	Vision	Name(s) of person(s) (Last name, first name, M.I.)	Sex	Has other insurance?	Social Security no.[3] (required)	Date of birth (MM/DD/YYYY)	Full-time student?	Primary care physician (PCP)[4] (See below for instructions)	Current patient
☐ Yes ☐ No	☐ Yes ☐ No	Self	☐ M ☐ F	☐ Yes ☐ No				Name PCP no.	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Legal spouse ☐ Domestic partner	☐ M ☐ F	☐ Yes ☐ No				Name PCP no.	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	Dependent	☐ M ☐ F	☐ Yes ☐ No			☐ Yes ☐ No	Name PCP no.	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	Dependent	☐ M ☐ F	☐ Yes ☐ No			☐ Yes ☐ No	Name PCP no.	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	Dependent	☐ M ☐ F	☐ Yes ☐ No			☐ Yes ☐ No	Name PCP no.	☐ Yes ☐ No

3 Anthem is required by the Internal Revenue Service to collect this information.
4 For HMO Maine or HMO Choice: You must fill in PCP information for each member. For current listing of valid PCPs, go to anthem.com. For other benefit selections, do not complete this section.

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SECTION 6: APPLICANT AND MEMBER INFORMATION (CONTINUED) — List only family members you wish to enroll, delete or change.

Indicate name of college for student(s): ______

Are you or any family members currently claiming Workers' Comp Medical Benefits? ☐ Yes ☐ No
If yes, name of claimant: ______

SECTION 7: PRIOR COVERAGE INFORMATION — This section must be completed.

Have you or any other family member had health insurance coverage in the 90 days prior to your date of hire or the effective date of your new policy? ☐ Yes ☐ No
If yes, please complete the following:

	Self	Spouse/Domestic partner	Dependents		
			1	2	3
Name of insurance company					
Certificate (policy) no.					
Insurer's telephone no.					
Date coverage began					
Date coverage ended or is coverage still in effect?					

SECTION 8: MEDICARE BENEFICIARIES INFORMATION

Is anyone listed on this application currently eligible for Medicare? ☐ Yes ☐ No
If yes, please complete the following for each person to be covered who is eligible for or covered by Medicare.

Name(s) of Medicare beneficiaries	Health insurance claim no.	Medicare Part A effective date	Medicare Part B effective date	Medicare Part D effective date	Check all reasons you qualified for Medicare
					☐ Age 65 ☐ ESRD ☐ Disability[5] Disability date:
					☐ Age 65 ☐ ESRD ☐ Disability[5] Disability date:
					☐ Age 65 ☐ ESRD ☐ Disability[5] Disability date:
					☐ Age 65 ☐ ESRD ☐ Disability[5] Disability date:

5 Provide dates of disability for members under age 65 and enrolled in Medicare.

SECTION 9: APPLICANT SIGNATURE

I am requesting coverage for myself and all dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the *Group Agreement* and *Certificate of Coverage*. I understand that, under the HMO Maine plan, each family member's care must be provided or arranged by his/her Primary Care Physician (PCP) except as described in my Certificate of Coverage.

W–9 Certification Language

I certify each Social Security Number listed on this application is correct.

Applicant signature	Print name	Date (MM/DD/YYYY)
X		

SECTION 10: ELECTION NOT TO ENROLL

I do not wish to enroll in a plan. Please check one: ☐ I have other coverage (Please complete section 7) OR ☐ I do not have any other coverage
I understand that the opportunity to enroll at any future date will be subject to the regulations of Anthem Blue Cross and Blue Shield.

Applicant signature	Print name	Date (MM/DD/YYYY)
X		

For questions about HMO Maine, HMO Choice: please call 1-800-527-7706, or in the Portland area, 1-207-822-8282;
For questions about Blue Choice, CompCare or any other coverage: please call 1-800-482-0966, or in the Portland area 1-207-822-7272;
For questions about Lumenos HSA or HRA: please call 1-888-224-4896. All questions need to be completed before this application can be processed.