Employer Enrollment Application/Change Form

EmployeeElect for 1-50 Employee Small Groups

Anthem

Please Complete in Ink

Purpose:	Coverage Type(s):	Requested Effective Date:
☐ Submit a new application ☐ Request change(s)for Group No. _____	☐ Medical ☐ Dental ☐ Life ☐ Vision	(mm-dd-yyyy)

1. Please tell us about your company…

Company Name		Group Administrator Name
Street Address		County
City, State, ZIP Code		Phone Number ( )
Billing Address (if different from above)		FAX Number ( )
City, State, ZIP Code (if different from above)		E-mail Address
Nature of Business (please be specific)	Employer Tax ID Number	Standard Industrial Classification Code
Organization Type ☐ Proprietorship ☐ Corporation ☐ Government Unit/Agency ☐ Partnership ☐ Labor Union ☐ Organization Exempt from Income Tax ☐ Other:_____		Date Business Established (mm-dd-yyyy)

2. Medical Coverage Preferences…*what payment option and medical plan(s) would you like to select?*

2a. My employer medical contribution each month will be:

☐ Traditional option-I will contribute (50% to 100%): _____% per employee _____% per dependent.

☐ Fixed dollar option-I will contribute (at least $125 in $5 increments): $ _____ per employee $ _____ per dependent.

2b. I choose to offer:

☐ **ALL EmployeeElect PLANS**

OR

☐ **DESIGNATED PLAN(S)** (designate single plan or mix and match by checking as many plans below as desired):

☐ Premier PPO $15 Copay
☐ Premier PPO $25 Copay
☐ PPO $30 Copay
☐ PPO $40 Copay
☐ PPO $35 Copay GenRx
☐ PPO $45 Copay GenRx

☐ Lumenos HSA 2000/100*
☐ Lumenos HSA 3000/100*
☐ Lumenos HSA 5000/100*
☐ Lumenos HIA Plus 2000/100
☐ Lumenos HIA Plus 3000/100

☐ Premier HMO
☐ Classic HMO
☐ Premier HMO*Select***
☐ Classic HMO*Select***

***Will employer establish a Mellon Health Savings Account?**
☐ Yes ☐ No

**HMO*Select* plans are only available in specific employer- based geographic areas.

OR

☐ **COLORADO-MANDATED PLAN(S)**

☐ PPO Basic ☐ PPO Standard ☐ HMO Basic ☐ HMO Standard

Other Use:

COSGEECOCAFRM (Rev. 12/04/06)

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3. Dental Coverage…what payment option and dental plan(s) would you like to select?

3a. My employer dental contribution each month will be (50% to 100% for stand-alone coverage or 25% to 100% if dental coverage is purchased with medical coverage): _____% per employee _____% per dependent.

3b. I choose to offer (please check as many as apply):

- ☐ Anthem Blue Dental PPO Option 1 with ortho
- ☐ Anthem Blue Dental PPO Option 1
- ☐ Anthem Blue Dental PPO Option 2
- ☐ Anthem Blue Dental PPO Option 3 with ortho
- ☐ Anthem Blue Dental PPO Option 3
- ☐ Anthem Blue Dental PPO Option 4
- ☐ Anthem Blue Dental PPO Plus Option 1 with ortho
- ☐ Anthem Blue Dental PPO Plus Option 1
- ☐ Anthem Blue Dental PPO Plus Option 2
- ☐ Anthem Blue Dental PPO Plus Option 3 with ortho
- ☐ Anthem Blue Dental PPO Plus Option 3
- ☐ Anthem Blue Dental PPO Plus Option 4

Other Use:

4. Vision Coverage Preferences…what payment option and vision plan(s) would you like to select?

4a. My employer vision contribution each month will be (50% to 100%): _____% per employee % _____ per dependent.

4b. I choose to offer: ☐ Blue View **AND/OR** ☐ Blue View Plus

5. Life/Disability Benefit Selections…what employer contribution(s) and product(s) would you like to select?

Life Products - Employer Contributions:

Per Employee _____% (25% to 100%)

Per Dependent _____% (Optional)

Term Life

Check only one schedule: for Schedules A-C, specify amount (at least $15,000 in $1,000 increments; maximum $200,000):

☐ **Schedule A** - Benefit is the same for all job titles: $_____

☐ **Schedule B** - Benefit differs by job title:

Class I, officers, managers, supervisors: $_____

Class II, all other group members: $_____

(Class I amount cannot exceed 2.5 times Class II amount)

☐ **Schedule C** - Benefit is a percentage of salary; check one of the following for **all** employees:

☐ 1 x annual salary

☐ 2 x annual salary

(please provide list of employees and base salaries)

Supplemental Life

Only available if other Life options are also selected.

☐ Check for Supplemental Life (100% employee paid)

Dependent Life

Check only one (please note that Option 1 is only available if employee Life benefit is $20,000 or more):

☐ Option 1: $10,000 spouse; $10,000 children 6 mo to 19 yrs (thru age 24 if full-time student); $1,000 children under 6 mo

☐ Option 2: $5,000 spouse; $5,000 children 6 mo to 19 yrs (thru age 24 if full-time student); $500 children under 6 mo

Disability Products - Employer Contributions (25% to 100%):

Long Term Disability (LTD) _____%

Short Term Disability (STD) _____%

LTD and STD

Check one of 3 options for LTD and/or one of 6 options for STD:

LTD	☐ Gold	☐ Silver	☐ Bronze
STD			
Percentage[1]	☐ 1/8/13	☐ 1/8/26	☐ 5/15/26
Flat Amount[2]	☐ 1/8/13	☐ 1/8/26	☐ 5/15/26

[1]Percentage: 66.67% of Weekly Salary

[2]Flat Amount: $200 per week

Protection*Pack* - Employer Contributions (25% to 100%):

_____%

Protection*Pack* Option (check one):

- ☐ Basic
- ☐ Essential
- ☐ Enhanced
- ☐ Deluxe
- ☐ Premium

6. Premium Only Plan…*I am applying for P.O.P. administrative services.*

☐ Yes ☐ No I want to set up a Premium Only Plan (P.O.P.) to be administered by Ceridian (an independent company not affiliated with Anthem Blue Cross and Blue Shield). I have read the P.O.P. brochure and am enclosing my completed P.O.P. enrollment form and separate check for the first year's fee of $125, along with my application.

7. Eligibility…*please tell us more about your group.*

A. How many employees (including owners/officers) work at least 24 hours/week, not including those working on a temporary or substitute basis? _____

B. How many have met the required probationary/waiting period? _____

C. How many are enrolling in this employer's group coverage? _____

D. How many are enrolled in group coverage elsewhere, or have an individual policy? _____

E. How many work or live outside the state of Colorado? _____

F. Will coverage be restricted to a certain classification of employees or employees working a certain number of hours per week? ☐ Yes ☐ No
If yes, please explain what class or number of work hours required (must be at least 24 hours): _____

G. If you are a Business Group of One, was your prior health coverage Group or Individual? ☐ Grp ☐ Ind
If Individual:
Please indicate the length of time covered: _____

H. Please identify the probationary/waiting period for new employees as being the 1st of the month after:
☐ hire date ☐ 1 month ☐ 2 months ☐ 3 months
☐ 4 months ☐ 5 months ☐ 6 months

I. Is your group currently subject to COBRA? (employed 20 or more employees on at least 50% of working days in previous calendar year) ☐ Yes ☐ No

J. Is your group subject to State Continuation Coverage? ☐ Yes ☐ No

K. Under TEFRA/DEFRA, which one applies to your group?
☐ Medicare is primary (for groups with fewer than 20 employees)
☐ Anthem is primary (for groups with more than 20 employees)

L. How many months are employees eligible to continue group coverage while on an employer-approved temporary ***personal*** leave of absence (maximum 3 months)?
☐ none ☐ 1 month ☐ 2 months ☐ 3 months

M. How many months are employees eligible to continue group coverage while on an employer-approved temporary ***medical*** leave of absence (maximum 6 months)?
☐ none ☐ 1 month ☐ 2 months ☐ 3 months
☐ 4 months ☐ 5 months ☐ 6 months

N. Is any employee currently ***NOT*** actively at work? ☐ Yes ☐ No

O. To your knowledge, is any person to be covered unable to work due to injury or illness? ☐ Yes ☐ No

P. To your knowledge, is any person unable to perform the normal duties of another person in the same employment class of the same age and gender? ☐ Yes ☐ No

Q. Provide name(s), date(s) and degree of recovery for any "Yes" answers to Questions O and P:

_____
_____
_____
_____
_____

8. Please tell us if your group has had coverage within 90 days of this application's signature date…

Will this plan replace current:	If yes, the carrier is/was:	Termination date is/was:
Medical coverage? ☐ Yes ☐ No	_____	____/____/____
Dental coverage? ☐ Yes ☐ No	_____	____/____/____
Life coverage? ☐ Yes ☐ No	_____	____/____/____
LTD coverage? ☐ Yes ☐ No	_____	____/____/____
STD coverage? ☐ Yes ☐ No	_____	____/____/____

9. Reserved…*please skip this section unless special instructions are provided.*

10. Employer Information…*please read carefully*

COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.

Employers with 10 or more eligible employees are entitled to a choice of composite rates or four-tier family, age-banded rates. Employers have the right to see premium quoted either way. The total premium will initially be the same based on the enrollment assumption used to prepare the quote. However, subsequent enrollment changes may result in premium differences depending on the rate method selected. Composite rates use average rates by coverage type, while age rates use the actual rates for each individual in the group based on the age of the employee.

11. General Agreement

The undersigned employer and/or authorized representative hereby request(s) approval for insurance coverage by Anthem and HMO Colorado. Our signature below will indicate that Anthem and/or HMO Colorado are approving coverage. By signing this application, the undersigned employer agrees to be bound by the terms of the contract. The employer agrees that:

1. The requested coverage is not in effect until this application is approved by Anthem and/or HMO Colorado; that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer; and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem and/or HMO Colorado.
2. The advance premium check does not create temporary or interim insurance coverage, and receipt and deposit of that payment does not guarantee issuance of insurance coverage; rather, issuance of insurance coverage is expressly conditioned on Anthem's and/or HMO Colorado's determination that the employer satisfies Anthem and/or HMO Colorado's current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem and /or HMO Colorado, except to refund the advance premium payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.
3. For Anthem and/or HMO Colorado, to accept this application, all the information requested on this application must be completed. If the application is not complete, Anthem and/or HMO Colorado or their designated agent(s) are authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem and/or HMO Colorado may be different from the coverage applied for herein. If Anthem and/or HMO Colorado notifies the employer of such different coverage, and the employer pays the appropriate premium, the employer will be deemed to have accepted the coverage as issued.

12. Signatures

Name of Company Officer (Please print)	Title of Company Officer
Signature of Company Officer X	Date (month/day/year)
Accepted by Officer of Anthem Blue Cross and Blue Shield/HMO Colorado	Date (month/day/year)

13. Broker Certification…*please ask your broker to complete this section.*

1. I have reviewed the attached employee and employer application(s) and waiver(s) for completeness and accuracy.
2. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado reviews and approves the application and the employer receives a written notice from Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado.
5. I am the appointed broker and am receiving commissions for the submission of this client. No portion of my commission payments from Anthem shall be paid to a broker/producer not appointed/approved by Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado.

WRITING AGENT	**%**
Name	
Agent ID No.	
Sub-Agent ID No. (if different)	
Address	
City, State, ZIP Code	
Phone	
Fax	
E-Mail Address	
Signature	
Date	

SECOND WRITING AGENT	**%**
Name	
Agent ID No.	
Address	
City, State, ZIP Code	
Phone	
Fax	
E-Mail Address	
Signature	
Date	

FOR GENERAL AGENT USE ONLY	
General Agent Name	Agent ID No.
Address	City, State, ZIP code

Final Check

☐ Please check to make sure all requested information has been provided. Incomplete applications will be returned, which may increase processing time.

☐ Include a copy of your most recent Quarterly Tax and Wage Statement (or payroll or applicable tax records if you don't file Quarterly Tax and Wage Statements).

- Indicate on the document whether each employee listed is full-time, part-time or terminated.
- Write in the names of any newly hired employees (not listed on the document) and the number of their weekly work hours.
- Send us a copy of your prior carrier bill or bills (if applicable).
- Include all of the original employee applications.
- Include a signed proposal for all lines of coverage for which you're applying.
- If you are applying as a business group of one, please include copies of your most recent business tax return.

☐ Include a check for the first month's premium, payable to Anthem Blue Cross and Blue Shield.

☐ If applicable, include a completed P.O.P. enrollment form and a separate check in the amount of $125 payable to Anthem Blue Cross and Blue Shield.

☐ Submit all required forms and documentation to your agent or to the address below:

Anthem Blue Cross and Blue Shield
P. O. Box 172466
Denver, CO 80217-2446

Thank you for your time and trust.

For more information online, please visit **anthem.com**.