Employee Enrollment Application
Southern Ohio Chamber Alliance Benefit Plan

Administered by:

Anthem BlueCross BlueShield

Southern Ohio Chamber Alliance Benefit Plan

INSTRUCTIONS:

Please read carefully, complete electronically, or in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply only to this employer.

Section 1: Employer/group use – Required. To be filled out by employer.

Employer name		Employer address	
Group no.	Sub-group no.	Requested effective date	Employee no./dept. name

Section 2: Reason for application – Required

- ☐ New enrollment
- ☐ Annual open enrollment
- ☐ Add dependent (Fill in section 3)
- ☐ New hire
- ☐ Rehire date:
- ☐ COBRA – Qualifying event: _____
  - Event date:
- ☐ State Continuation
- ☐ Waiver (To decline ALL benefits skip to section 11)

Section 3: Status change/event – Required, if you checked "Add dependent" option in section 2.

Event date:

- ☐ Marriage
- ☐ Birth
- ☐ Adoption (Attach legal documentation)
- ☐ Legal guardianship (Attach legal documentation)
- ☐ Loss of benefits (reason): _____
- ☐ Terminated employment
- ☐ Other: _____

Section 4: Employee information – Required

Last name	First name	M.I.	Date of birth	Age	Social Security no. (Required)

Sex ☐ M ☐ F	☐ Single ☐ Married ☐ Divorced	Height	Weight	Home phone	Business phone	Email address

Address	City	State	ZIP code

County	Retired: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No Hospitalized: ☐ Yes ☐ No

Occupation	Full-time hire date	Hours working per week

Income reported by: ☐ W-2 ☐ 1099 ☐ Other: _____

Section 5: Plan/type of benefits – Required. To decline a plan type, check "No benefits". If you are waiving all benefits, go to section 11.

Medical

☐ Blue Access® PPO ☐ Blue Access Options PPO ☐ Lumenos® HSA PPO

Type of benefits

☐ Employee only ☐ Employee+spouse ☐ Employee+child(ren) ☐ Family benefits ☐ No benefits

Employee name: _____ Social Security no. _____

Section 6: Family information — Required. List only dependents you wish to enroll, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under section 9, Significant Terms, Conditions and Authorizations, prior to answering the questions in section 6.

Spouse

Last name	First name	M.I.	Social Security no. (Required)

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled?
			☐ M ☐ F	Spouse	☐ Yes ☐ No If yes, give reason: _____

If spouse address is different than employee, please provide full address

Dependent

Last name	First name	M.I.	Social Security no.	Full-time student
				☐ Yes ☐ No

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled?
			☐ M ☐ F	☐ Child ☐ Other_____	☐ Yes ☐ No If yes, give reason: _____

Court ordered health care coverage	If dependent address is different than employee, please provide full address
☐ Yes ☐ No (If yes, attach legal documentation)	

Dependent

Last name	First name	M.I.	Social Security no.	Full-time student
				☐ Yes ☐ No

Date of birth	Height	Weight	Sex	Relationship to employee	Currently hospitalized or disabled?
			☐ M ☐ F	☐ Child ☐ Other_____	☐ Yes ☐ No If yes, give reason: _____

Court ordered health care coverage	If dependent address is different than employee, please provide full address
☐ Yes ☐ No (If yes, attach legal documentation)	

Section 7: Other health coverage — Required

Do you and/or your dependents have other health coverage? ☐ Yes ☐ No If yes, complete below.

On the day your benefits begin, list family members, including yourself, who will be covered by any other health coverage

Provide name, phone number and address of the HMO or insurance company	Policy/certificate no.	Effective date

Policy/certificate holder name	Social Security no.	Date of birth	Relationship to employee

Are you and/or your dependents enrolled in Medicare or Medicaid? ☐ Yes ☐ No If yes, complete below.

Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date

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 ☐ ESRD and disability ☐ End Stage Renal Disease (ESRD)

Employee name: _____ Social Security no. _____

Section 8: Prior health coverage – Required

Have you and/or your dependents had prior health coverage? ☐ Yes ☐ No **If yes, complete below.**

Have you been covered by Anthem within the past two (2) years ☐ Yes ☐ No	Policy/certificate no.	
Group name/ID no.	Date policy in effect	Date policy terminated

Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years ☐ Yes ☐ No

List prior carrier(s)	Date policy in effect	Date policy terminated

Please check the type of prior coverage

☐ Employee ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Employee+Spouse+Child(ren)

Termination reason

☐ Divorce/legal separation ☐ Employment terminated ☐ Employer/group contribution ceased ☐ Other
☐ Death of spouse ☐ COBRA/State Continuation coverage exhausted ☐ Group plan terminated

Section 9: Significant 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 Anthem program.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium equivalent rate for the benefits applied for.
3. I am asking for the benefits 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 understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for benefits and that no right is created by my application for benefits.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.
6. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for these benefits.
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.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of benefits. 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 benefits or premium equivalent rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of benefits. 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.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 10: Signature – Required, if you are applying for benefits. Please review your application for errors or omissions.

Read section 9 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

Employee name: _____ Social Security no. _____

Section 11: Waiver of benefits — Complete for yourself and/or any eligible dependents. Check all that apply.

Waived for	Name	Reason for waiving (already protected by coverage)	
☐ Self ☐ Spouse ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or carrier name and ID no.

Check if applicable:

☐ I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield benefits and after careful consideration, have decided not to take advantage of this offer. If I want to apply for such benefits at a later date, 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. If enrollment is not requested within 31 days, my dependents or I are not eligible to enroll in this plan until the next open enrollment. 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 dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependents 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.

Signature — Required, if you want to waive benefits for yourself and your dependents.

Employee signature	Date
X	

Employee Health Questionnaire

Anthem BlueCross BlueShield

Employee name	Social Security no.	Group name

Spouse name	Benefits
	☐ Employee only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Dependent 1	Dependent 2	Dependent 3

Dependent 4	Dependent 5	Dependent 6

Please answer the following questions for yourself AND any eligible dependents

Please note that no one will be denied benefits on an individual basis due to answers provided below.

1. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past five years, is currently hospitalized or been advised that medical treatment, diagnostic testing, surgery, or hospitalization is necessary with the exception of AIDS/HIV? ..... ☐ Yes ☐ No
   If "Yes", please explain below.

2. Is anyone currently being treated or been advised to seek treatment or counseling for any of the following? ..... ☐ Yes ☐ No
   If "Yes ", please check condition(s) that apply.

   ☐ Cancer
   ☐ Chemical dependency
   ☐ Blood disorders
   ☐ Obesity
   ☐ High blood pressure
   ☐ Kidney disorder
   ☐ Transplants
   ☐ Currently pregnant? If, yes, due date: ____
   ☐ Heart disease
   ☐ Crohn's Disease/ulcerative colitis
   ☐ Liver disease
   ☐ Diabetes
   ☐ Chemical dependency/alcoholism
   ☐ Brain tumor
   ☐ Back/spinal disorder
   ☐ Stroke
   ☐ Chronic respiratory disease
   ☐ Muscular disorder
   ☐ Mental illness
   ☐ Nervous system disorders
   ☐ Other: _____

   If "Yes", please explain below.

3. Do you or your dependents regularly take medication? ..... ☐ Yes ☐ No
   If "Yes", please explain below.

4. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? ..... ☐ Yes ☐ No
   If "Yes", please explain below.

Explain "Yes " answer to any question. Give complete details to avoid delay. *(Attach a separate sheet of paper if necessary)*

Question no.	Individual name	Diagnosis	Treatment	Medication	Onset date	Treatment date(s)	Hospitalized	Surgery	Recovered
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Employee name: _____ Social Security no. |_|_|_|_|_|_|_|_|_|

I represent that all answers on this Questionnaire are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to benefits or premium equivalent rates. Material misrepresentations or significant omissions in this application may result in increased premium equivalent rates, or benefits being denied, rescinded or cancelled.

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.

3904.04 NOTICE OF INFORMATION PRACTICES: 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 C.F.R. Parts 160 and 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.

3904.06 I understand that the length of time such authorization shall remain valid shall be no longer than 30 months from the date the authorization is signed.

I agree that this executed Questionnaire will become part of the application and any contract issued on it.