

**Employer information**

Employer name		Business phone no.	Federal tax ID no.	
Street address	City	County	State	ZIP code
Name of any affiliate companies/subsidiaries				
Current carrier				

**Prior medical coverage — Describe all medical plans offered during the last five years.**

Carrier name	Type of coverage (PPO, HMO, Indemnity, deductibles/copays)	Period in effect

Is your company currently enrolled in a self-funded (ASO) or level-funded arrangement?  Yes  No

If you are currently ASO, we will also need claims experience, large claimant listing, breakdown of fee/claim components, fully insured equivalent rates, etc.

**Eligibility, participation and contribution**

State in which the company is headquartered: _____
Is your company part of a PEO/Employee Leasing Arrangement, Healthcare Alliance, or Association? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list the name: _____
Total number of full-time employees working a minimum of 30 hours: _____
Total number of part-time and seasonal employees: _____
Did you employ an average of less than 50 total employees during the preceding calendar year? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many? _____
Do you (the employer) fund more than 50% of the member deductible, out-of-pocket costs (e.g., copays or coinsurance), or any bank account to fund those costs for the members covered under your plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain what you fund here: _____

**Certification**

The prospective applicant hereby certifies that the above information is complete and true to the best of his or her knowledge. Any person who, with the 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.	
Name of Anthem Blue Cross and Blue Shield sales representative	
Printed broker name	Broker agency