

# Employee Enrollment Application For Small Groups New Hampshire



Consult the Booklet or Certificate of Coverage for complete coverage terms and conditions. For more information about Anthem Blue Cross and Blue Shield (Anthem), its products and services, visit [anthem.com](http://anthem.com). Please complete electronically or in black ink only and use extra paper if necessary. The employee who completes this application is solely responsible for its accuracy and completeness. Be sure to answer all questions and to sign and date your application.

## Section A: Application Type

<b>Select one:</b> <input type="checkbox"/> New Enrollment <input type="checkbox"/> Open enrollment <input type="checkbox"/> State Continuation <input type="checkbox"/> COBRA <input type="checkbox"/> Rehire date: (MM/DD/YYYY) ____/____/____		
<b>Select qualifying event</b> <input type="checkbox"/> Covered employee's Medicare entitlement <input type="checkbox"/> Death <input type="checkbox"/> Left employment <input type="checkbox"/> Loss of coverage <input type="checkbox"/> Loss of dependent child status <input type="checkbox"/> Medicare <input type="checkbox"/> Reduction in hours		
Effective date of qualifying event: (MM/DD/YYYY) ____/____/____		
COBRA qualifying event date: ____/____/____	COBRA start date: ____/____/____	COBRA end date: ____/____/____

## Section B: Employee Information

Last name		First name		M.I.	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Birthdate MM/DD/YYYY / /		Social Security no. <sup>1</sup> (required) - -	
Home address — Street or P.O. Box if applicable		City		State	ZIP code
County	Primary phone no. <sup>2</sup>		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		
Employer name				Group no. (if known)	
Employer street address			City	State	ZIP code
County	Occupation		Employment Status: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Disabled <input type="checkbox"/> Retired		
Date of hire (MM/DD/YYYY) / /	Date of full-time employment (MM/DD/YYYY) / /	Date waiting period begins (MM/DD/YYYY) / /	No. of hours worked per week		
Language choice (optional): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other — please specify: _____					

Employee email address: \_\_\_\_\_

I am providing my email address because I, and my enrolled dependents, want to receive information about our benefits electronically. These communications may include Identification (ID) Cards, Certificates of Coverage or Evidence of Coverage, grievance, appeals, and medical determination notifications, Explanation of Benefits, other required notices, and personalized information to help get the most out of the benefits. I understand I need to register on [anthem.com](http://anthem.com) or the Sydney Health mobile app to get the most out of my plan's digital tools, and I will make sure Anthem has my most up-to-date email address. I, and my enrolled dependents, understand that we can update our email addresses, change our communication preferences, and request free copies of any materials at any time by going to [anthem.com](http://anthem.com) or calling the Member Services number on my ID Card.

## Section C: Type of Coverage

<b>1. Medical Coverage</b> — Indicate the contract code for the medical plan selected. Your employer will advise you of your plan options and contract codes.	
Medical product plan name:	Contract code, if known:
<b>Member medical coverage — select one:</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + Child(ren) <input type="checkbox"/> Family	

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

2 Refer to Section H: Authorizations to learn how your phone number may be used

Employee name: \_\_\_\_\_ Social Security no.: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

**2. Dental Coverage** — Indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes. Note that our Small Group Off Exchange medical plans provide pediatric dental coverage to meet ACA requirements.

**Standalone dental plans do not include Essential Health Benefits.**

Dental product plan name:

Contract code, if known:

**Member dental coverage — select one:**  Employee only  Employee + Spouse/Domestic Partner  Employee + Child(ren)  Family

**3. Vision Coverage** — Indicate the contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.

Vision product plan name:

Contract code, if known:

**Member vision coverage — select one:**  Employee only  Employee + Spouse/Domestic Partner  Employee + Child(ren)  Family

**Section D: Family Information —**

All fields required. Attach a separate sheet if necessary. Complete this section for yourself and your dependents.

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's, 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. For HMO Plans: You must fill in Primary Care Physician (PCP) information for each member. For current listing of valid PCP(s) go to anthem.com. If you are on a tiered-benefit plan be sure to review your PCP's tier designation as cost-shares may be different.

<b>Employee</b> Last name		First name		M.I.	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Physician (PCP) name		PCP ID no.	PCP Location		Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Spouse/Domestic Partner</b> Last name		First name		M.I.	Social Security no. <sup>1</sup> (required) - -
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Birthdate (MM/DD/YYYY) / /	Relationship to applicant <input type="checkbox"/> Ex/Legal Spouse <input type="checkbox"/> Domestic Partner		
PCP name		PCP ID no.	PCP Location		Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Dependent Child</b> Last name		First name		M.I.	Social Security no. <sup>1</sup> (required) - -
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY) / /	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other <sup>3</sup> If other, what is relationship? _____	
PCP name		PCP ID no.	PCP Location		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: _____					

<b>Dependent Child</b> Last name		First name		M.I.	Social Security no. <sup>1</sup> (required) - -
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY) / /	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other <sup>3</sup> If other, what is relationship? _____	
PCP name		PCP ID no.	PCP Location		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: _____					

<sup>1</sup> Anthem is required by the Internal Revenue Service to collect this information.

<sup>3</sup> Eligibility subject to Booklet or Certificate of Coverage.

**Section E: Prior and Other Group Coverage — Attach a separate sheet if necessary.**

Is anyone applying for coverage currently enrolled in Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give name: _____					
Medicare ID no.	Part A effective date (MM/DD/YYYY) / /	Part B effective date (MM/DD/YYYY) / /	Medicare eligibility reason (select all that apply) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End-stage renal disease: Onset date (MM/DD/YYYY) ____/____/____		
Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date (MM/DD/YYYY) / /			
Is anyone applying for coverage covered by other health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following:					
Name of Person covered (Last, First, M.I.)	Type (select one)	Coverage (select all that apply)	Insurer name	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ____/____/____ End: ____/____/____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ____/____/____ End: ____/____/____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ____/____/____ End: ____/____/____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ____/____/____ End: ____/____/____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: ____/____/____ End: ____/____/____

**Section F: Waiver/Declining Coverage**

<b>Type of coverage/Declined for</b> — Select all that apply.	<b>Reason for declining/refusing coverage:</b> Select all that apply.
<input type="checkbox"/> Employee	<input type="checkbox"/> No coverage <input type="checkbox"/> Covered by Spouse's/Domestic Partner's group coverage <input type="checkbox"/> Spouse/Domestic Partner covered by their employer's group coverage <input type="checkbox"/> Enrolled in individual coverage <input type="checkbox"/> Medicare/Medicaid/VA <input type="checkbox"/> Enrolled in other Insurance — Please provide company name and plan: _____ <input type="checkbox"/> Other — please explain: _____
<input type="checkbox"/> Spouse/ Domestic Partner	
<input type="checkbox"/> Dependent(s) <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision List name of dependents to be waived: _____	

**Sign here only if you are declining coverage. DO NOT SIGN HERE IF YOU ARE APPLYING FOR COVERAGE.**

<b>Sign here to decline</b>	Applicant signature <b>X</b>	Applicant name (print)	Today's date (MM/DD/YYYY) / /
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**Section G: Terms and Conditions — Please read this section carefully before signing the application.**

**Eligible employee:**

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 31 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they don't work the required number of hours per week described above.

**Eligible dependent** (see Booklet or Certificate of Coverage for complete dependent eligibility terms):

- Employee's Spouse/Domestic Partner or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for a child will end on the last day of the month in which the child reaches age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of a child who cannot support himself or herself because of a mental or physical impairment that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of such mental or physical impairment and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under state or federal laws.

**Special Enrollment Rights for Medical Coverage Only** (see Booklet or Certificate of Coverage for complete enrollment rights):

If you declined enrollment for yourself or your dependent(s) (including a Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- Either your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

In these cases, you may be able to enroll yourself and your dependents provided that you request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

The following applies if you selected stand alone vision or dental in Section C:

- **Limited benefit disclosure: The Certificate provides vision benefits only. Review your Certificate carefully.**
- **Limited benefit disclosure: The Certificate provides dental benefits only. Review your Certificate carefully.**

**Section H: Authorizations — Please read this section carefully and then sign below.**

**In signing this application I represent that:**

- I have read, or have had read to me, the completed application. All statements and answers I have given are true and complete to the best of my knowledge and belief, and I realize any false statement or misrepresentation in the application may result in loss of coverage.
- I am an eligible employee and I am requesting coverage for myself and all eligible dependents listed on this application
- Each Social Security number listed on this application is correct.
- By providing a phone number, I agree and consent that Anthem and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits. I, and my enrolled dependents, understand that we can update our communication preferences by going to anthem.com or calling the Member Services number on my ID card.
- I authorize my employer to deduct any required contributions for this insurance from my wages.
- I authorize the Health Savings Account (HSA) financial custodian (provided I am enrolling in an HSA) to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA and that I may provide Anthem with a written request to revoke my authorization at any time.  Yes  No

I understand any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. §638:20; penalties may include imprisonment, fines or a denial of insurance benefits. I also understand all benefits are subject to conditions stated in the Group Contract and the Booklet or Certificate Coverage.

I give this authorization for myself and on behalf of my eligible dependents, including my Spouse/Domestic Partner, if covered by Anthem, and I am acting as their agent and representative. If my Spouse/Domestic Partner signs this application, he/she is giving this authorization on his/her own behalf. Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

<b>Sign here to enroll</b>	<b>Applicant signature</b> (or custodial parent's or guardian's signature if applicant is under 18) <b>X</b>	<b>Today's date (MM/DD/YYYY)</b> / /
	<b>Spouse/Domestic Partner signature</b> <b>X</b>	<b>Today's date (MM/DD/YYYY)</b> / /