Managed Care
Member Enrollment/Member Change Form

Anthem BlueCross BlueShield

Anthem use only

Member ID no.	Firm no.	Effective date (MM/DD/YYYY)

Section 1: Member/applicant information

Current Anthem Blue Cross and Blue Shield (Anthem) contract no., if any		Social Security no.[1] (required)	
Last name	First name		M.I.
Home address or P.O. Box	City	State	ZIP code
Phone no.	Email address		

Section 2: Reason for member enrollment — Please check the reason below and date if required

☐ New hire ☐ New group (Initial enrollment) ☐ COBRA – start date: ☐ COBRA – event date: ☐

☐ Rehire ☐ Open enrollment ☐ Retiree – date of retirement: ☐ Life event: _____

☐ Waive coverage (go to section 6) ☐ Other: _____ Date: ☐

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 (MM/DD/YYYY)

Reason for change

☐ Adoption ☐ Covered by Medicaid ☐ Divorce ☐ Marriage
☐ Annual enrollment ☐ Court order ☐ Domestic partner ☐ Other: _____
☐ Birth ☐ Death ☐ Entrance to the military ☐ Voluntary cancellation
☐ Civil union ☐ Discharge from the military ☐ Loss of coverage

Section 4: Membership choices

☐ Access Blue New England
☐ Access Blue New England with HRA
☐ Access Blue New England with HSA[2]
☐ Blue Choice New England
☐ Blue Choice New England with HRA
☐ Blue Choice New England with HSA[2]
☐ BlueChoice Open Access POS
☐ Elements Choice
☐ HMO Blue New England
☐ HMO Blue New England Choice
☐ Matthew Thornton Blue
☐ Matthew Thornton Blue with HSA[2]
☐ Blue View Vision (see Section 10): _____
☐ Other: _____
[2]HSA Custodian: _____

Section 5: Employer information

Company name			Firm no./Health benefit plan
Date of hire[3]	Date of rehire (if applicable)[3]	Date eligible	No. hours worked per week

Section 6: Election not to enroll

I do not wish to enroll in a plan. Please check one:

☐ I do not have any other coverage. I understand that the opportunity to enroll at any future date will be subject to any group requirements, Anthem policies and NH RSA 420-G:8.

☐ I have other coverage.

Name of policyholder	Insurance company

Signature	Date
X	

1 Anthem is required by the Internal Revenue Service to collect this information.
2 Confirm with your employer which HSA custodian you selected.
3 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 7: Applicant and member information — List only family members you wish to enroll, delete or change

For HMO Plans: You must fill in PCP information for each member. For current listing of valid PCP(s) go to https://www.anthem.com/health-insurance/provider-directory/searchcriteria. If you are on a tiered-benefit plan be sure to review your PCP's tier designation as cost-shares may be different. For other benefits selections do not complete this section. In order to be eligible for the highest level of benefits available through your coverage, you and your dependents must choose a Primary Care Provider from the Network Directory on https://www.anthem.com/health-insurance/provider-directory/searchcriteria and write the provider's code number in the Primary Care Provider/PCP code box(es) or call the Customer Service toll-free telephone number listed on page 3, Section 7 of this form. Before selecting a provider designated as "Current Patients Only" in the directory, be sure to contact the provider's office to verify your status as a current patient.

Note: If electing Dependent Coverage, please list all eligible children/stepchildren and complete all required forms according to your employer's guidelines.
If your Group Health Benefit Plan includes covering Domestic Partners, a completed affidavit of Domestic Partnership must be attached to this enrollment form.

Medical	Vision	Name(s) of person(s) (Last name, first name, M.I.)	Sex	Has other insurance	Social Security no.[1] (required)	Birthdate (MM/DD/YYYY)	Full-time student?	Primary Care Physician (PCP)	Current Patient
☐ Yes ☐ No	☐ Yes ☐ No	Self	☐ M ☐ F	☐ Yes ☐ No				Name PCP no.	☐ Yes ☐ No
☐ Yes ☐ No	☐ Yes ☐ No	☐ Ex/Legal spouse ☐ Domestic partner ☐ Civil union	☐ 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

Section 8: Prior coverage information — This section must be completed

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

Section 9: 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 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 ☐ Disability ☐ ESRD
					☐ Age 65 ☐ Disability ☐ ESRD

Section 10: Employee 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 to the best of my knowledge and belief. 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.

Electronic Communications

☐ I affirmatively agree to receive my plan-related communications either by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

W-9 Certification Language: I certify each Social Security number listed on this application is correct.

The following applies if you selected Blue View Vision in Section 4:

Limited benefit disclosure: The policy/certificate provides vision benefits only. Review your policy/certificate carefully.

Employee signature	Print name	Date
X		

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

Welcome to Anthem Blue Cross and Blue Shield

Please follow the instructions below to complete your Enrollment Application. Please check with your employer's Benefit Administrator for further information.

Section 1: Member/applicant information
The current Anthem Identification Number should only be completed if you are changing, updating or terminating an existing policy. You will not have an Anthem ID Number if this is a new enrollment.

Section 2: Reason for member enrollment
This is required information if you are a New Hire, Rehire, New Enrollee, COBRA participant or a Retiree.

Section 3: Change status
This is required information if you are an existing member changing your membership status. New subscribers are not required to complete this information.

Section 4: Membership choices
This information is mandatory for New Enrollment. It is optional for all other changes.

Anthem consumer-driven plan descriptions:

Access Blue New England with HRA = Access Blue New England with Health Reimbursement Account

Access Blue New England with HSA = Access Blue New England with Health Savings Account

Blue Choice New England with HRA = Blue Choice New England with Health Reimbursement Account

Blue Choice New England with HSA = Blue Choice New England with Health Savings Account

Matthew Thornton Blue with HSA = Matthew Thornton Blue with Health Savings Account

Section 5: Employer information
The Company Name, Firm Division Number and Health Benefit Plan Number are mandatory when completing this application. The Date of Hire/Rehire is mandatory for New Members Only. The first day the individual performs services for wages or any other form of compensation is the Date of hire/rehire.

Section 6: Election not to enroll
Complete this box only if you are waiving coverage.

Section 7: Applicant and member information
This is required information for New Members, Dependent Removal/Additions, Primary Care Physician (PCP) Changes, Date of Birth Changes/Updates and Dependent Name Changes. It is not required for Address Changes or Terminating the Entire Policy.

For the most recent Tier 1 and Tier 2 provider list, please visit [https://www.anthem.com/health-insurance/provider-directory/searchcriteria] or call Customer Service at the toll-free telephone number listed below:

Please call [1-800-870-3122] for:
Access Blue New England
BlueChoice New England
BlueChoice New England with Health Savings Accounts
BlueChoice New England with Health Reimbursement Account
HMO/Network Blue New England

Please call [1-800-870-3057] for:
Matthew Thornton Blue Members

Please call [1-888-224-4896] for:
Matthew Thornton Blue with Health Savings Account

Section 8: Prior coverage information
This information is required when enrolling as a new member or when a member is added to your existing policy. Your application will be returned if this information is not completed.

Section 9: Medicare beneficiaries information
This information is required for any member on this policy who is over 65 years of age or eligible for Medicare.

Note: Each year, Anthem saves millions of dollars for our members and groups through Coordination of Benefits. Other Insurance and/or Medicare information helps to ensure that you receive all the benefits to which you are entitled. By dividing health care expenses appropriately between your plans, we can better control health care costs.

Section 10: Employee signature
Employee must sign the application for it to be valid. If you are a Benefit Administrator terminating a Subscriber please sign your name in the space provided.

Completed applications may be returned to Anthem by one of two methods:

Mail: Anthem Blue Cross and Blue Shield
1155 Elm Street, Suite 200
Manchester, NH 03101

Fax: 1-877-651-7949