Employee Change Form
For 1-50 Employee Small Groups
Ohio

Anthem BlueCross BlueShield

Underwritten by Community Insurance Company

AnthemLife

Instructions:

If you are cancelling coverage for a dependent or changing a name, please provide a reason in the designated sections. Complete electronically, or in black ink and return to your employer. Please use extra sheets of paper if necessary. NOTE: Some changes may be made by accessing anthem.com.

Section A: General Information

Employer name	Group no.	Employee life class

Employee last name	Employee first name	M.I.	Employee Social Security no.* (required)

Section B: Employee Information – Required

Reason for change – Required. Check all that apply.

☐ Address change ☐ Add spouse/Domestic Partner or dependent ☐ Change life classification ☐ Cancel coverage
☐ Name change ☐ Cancel spouse/Domestic Partner or dependent ☐ Enrollment in Medicare (Fill in Section E)
☐ Benefit change ☐ Change Primary Care Physician (PCP) ☐ Other: _____

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: _____

Event date/Requested effective date – Required _____ (MM/DD/YYYY)

Home address – Street and PO Box if applicable	City	State

ZIP code	County	Birthdate (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Domestic Partner

Primary phone no.	Secondary phone no.	Email address

Primary Care Physician (PCP) name	PCP ID no.	Existing patient? ☐ Yes ☐ No

Section C: Family Information – Spouse and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: _____

Event date/Requested effective date – Required _____ (MM/DD/YYYY)

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.* (required)

Sex ☐ Male ☐ Female	Disabled? ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner

PCP name	PCP ID no.	Existing patient? ☐ Yes ☐ No

Does the spouse/Domestic Partner have a different address? ☐ Yes ☐ No
If yes, please enter: _____

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Life and Disability products underwritten by Anthem Life Insurance Company. Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association.
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Employee name	Social Security no.

Section C: Family Information – Continued

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ______

Event date/Requested effective date – Required ______ (MM/DD/YYYY)

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled?	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? ______

PCP name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter: ______

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ______

Event date/Requested effective date – Required ______ (MM/DD/YYYY)

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled?	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? ______

PCP name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter: ______

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other – please explain: ______

Event date/Requested effective date – Required ______ (MM/DD/YYYY)

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled?	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Child ☐ Other If other, what is relationship? ______

PCP name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter: ______

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

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

Employee name	Social Security no.

Section D: Plan/Type of Coverage

1. Medical Coverage

Enter network name, product plan name and contract code selected:

Network name	Product plan name	Contract code, if known

Note for Health Savings Account (HSA) enrollees:
If you enroll in an HSA plan, Anthem will facilitate the opening of a Health Savings Plan in your name, if directed by your employer.

Member medical coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

2. Dental Coverage

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

☐ I am enrolling in my Employer's vision plan, if any.	Contract code, if known

Member vision coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family

4. Life and Disability Coverage – A minimum of two employees must enroll.

☐ Basic Life and AD&D
☐ Basic Dependent Life
☐ Optional Supplemental/Voluntary Life and AD&D $ _____ (employee amount)
☐ Optional Supplemental/Voluntary Dependent Life Spouse $ _____ (spouse amount)
☐ Optional Supplemental/Voluntary Dependent Life Child $ _____ (child amount)

☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income	Life and Disability class no.

Primary Beneficiary – Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage
Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Contingent Beneficiary – Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage
Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Employee name	Social Security no.

Section E: Other Group Coverage

Is anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If yes, give name: _____

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply)
			☐ Age ☐ Disability ☐ ESRD: Onset date:

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date

Is anyone applying for coverage covered by other health coverage? ☐ Yes ☐ No If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policy holder name	Dates (if applicable)
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:
	☐ Individual ☐ Group	☐ Health ☐ Dental					Start: End:

Employee name	Social Security no.

Section F: Terms, Conditions and Authorizations

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 Blue Cross and Blue Shield (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 do not work the required number of hours per week described above.

Eligible dependent:

- Employee's spouse, 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 children will end on the last day of the month in which the children reach age 26.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity 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 handicap 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.

As an eligible employee, I am requesting coverage for myself and all eligible 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. Any person who, with intent to defraud or knowing that he 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. I understand all benefits are subject to conditions stated in the Group Agreement and coverage document.

In signing this application I represent that:

I certify each Social Security number listed on this application is correct.

I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

By signing below, I (primary applicant) agree to receive my plan-related communications either by email or electronically. This may include my certificate, evidence of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my plan. I agree to provide and update Anthem with my current email address. I know that at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Anthem. Such authorization shall remain valid no longer than thirty months from the date the authorization is signed. A photocopy of this application will be treated in the same manner as the original document.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

Ohio: 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.

Any person who, with intent to defraud or knowing that he 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.

Sign here	Applicant signature X	Date (MM/DD/YYYY)

Employee name	Social Security no.

Underwritten by Community Insurance Company

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-748-1808). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-748-1808). (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-748-1808). (TDD/TTY: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-748-1808)請求免費協助。(TTY/TDD: 711)

Dutch
Als u hulp nodig heeft om dit document te begrijpen in een andere taal, mag u daar zonder aanvullende kosten om vragen door te bellen met het ledenservicenummer (855-748-1808). (TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-748-1808. (TTY/TDD: 711)

German
Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (855-748-1808). (TTY/TDD: 711)

Italian
Se ha bisogno di assistenza per la comprensione del presente documento in un'altra lingua, può richiederla senza alcun costo aggiuntivo chiamando il numero dedicato ai Servizi per i membri (855-748-1808). (TTY/TDD: 711)

Japanese
この書面を他の言語で理解するための支援が必要な場合には、メンバーサービス番号（855-748-1808）に電話して支援を求めることができます。追加費用はかかりません。(TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-748-1808)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Oromo
Sanada kana afaan kan biroodhaan hubachuuf yoo gargaarsa barbaadde lakkoofsa bilbilaa tajaajila miseensaa (Member Services) (855-748-1808) waraqaa eenyummaa kee irra jiru irratti bilbiluudhaan kaffaltii dabalataa malee gaafachuu dandeessa. (TTY/TDD: 711)

Pennsylvania Dutch
Wann du Helfe brauchscht um selle Document zu verschtehe in en annere Schprooch, du kannscht fer sell frooge um nix zu bezaahle. Ruff Member Services Nummer (855-748-1808) aa. (TTY/TDD: 711)

Romanian
Dacă aveți nevoie de asistență pentru a înțelege acest document într-o altă limbă, puteți solicita aceasta în mod gratuit apelând numărul departamentului de servicii destinate membrilor (855-748-1808). (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-748-1808). (TTY/TDD: 711)

Ukrainian
Якщо ви не розумієте цього документа й вам потрібна допомога з його перекладом на іншу мову, ви маєте право безкоштовно отримати цю послугу. Для цього зателефонуйте на номер служби підтримки учасників програми страхування (855-748-1808). (TTY/TDD: 711)

Vietnamese
Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-748-1808). (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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