# Employer Enrollment Application
## For 2–50 Employee Small Groups
## Kentucky

Anthem BlueCross BlueShield
**Anthem Health Plans of Kentucky, Inc.**

AnthemLife
**Anthem Life Insurance Company**

Please complete in blue or black ink only and use extra sheets of paper if necessary.
For more information about Anthem, its products and services, visit anthem.com.

**Section A: Company Information**

| | | | |
|---|---|---|---|
| Company name | | | Employer tax ID no. (required) |
| Company street address | | | |
| City | County | State | ZIP code |
| Billing address – If different from above | | | |
| City | County | State | ZIP code |

Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Government unit/agency ☐ Limited Liability Company (LLC) ☐ Labor union trust
☐ Other: _____

| | | |
|---|---|---|
| SIC code – Required only if applying for Life and Disability coverage | Type of business (be specific) | Date business established |
| Head of firm | Company contact name | |
| Title | Primary phone no. | Fax no. |
| Email address | | |
| Additional company contact name | Title | |
| Primary phone no. | Fax no. | |
| Email address | | |

Does group have a cafeteria plan under IRS Section 125? ☐ Yes ☐ No

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal revenue Code Section 414? ☐ Yes ☐ No
If yes, please give the legal names, federal tax ID no. and number of employees employed by each.

_____

_____

**Open Enrollment**

Our standard open enrollment period is 30 days before the Group's renewal date and 30 days after, which is held no more often than once in any 12 consecutive months. The open enrollment period does not apply to Life & Disability products.

**Section B: Application Type**

| | |
|---|---|
| ☐ New enrollment | Requested effective date (MM/DD/YYYY) |

Employer tax ID no. (required)

## Section C: Type of Coverage

**1. Medical Coverage — check all that apply**

| PPO Plans | Anthem Platinum | Anthem Gold | Anthem Silver | Anthem Bronze |
|---|---|---|---|---|
| Blue Access | | ☐ 1000/20%/5000<br>☐ 1500/20%/4000<br>☐ 1500/20%/6000<br>☐ 2000/20%/3500<br>☐ 2000/40%/4000<br>☐ 3000/0%/3500<br>☐ 4000/0%/4000<br>☐ 500/20%/5000<br>☐ 500/20%/5500<br>☐ 5000/0%/5000<br>☐ 750/20%/5500 | ☐ 1000/30%/5500<br>☐ 1300/30%/5000 w/HSA<br>☐ 1500/20%/6500<br>☐ 1500/30%/5000 Plus<br>☐ 1500/30%/6000<br>☐ 1750/40%/6350<br>☐ 1750/40%/6350 2a<br>☐ 2000/20%/6350 w/HSA<br>☐ 2000/30%/6000<br>☐ 2000/30%/6350<br>☐ 2000/40%/6350<br>☐ 2000/50%/6350<br>☐ 2500/20%/4500 w/HSA<br>☐ 2800E/20%/4000 w/HSA<br>☐ 500/40%/6350<br>☐ 5000/20%/6350 | ☐ 3000/50%/6350 w/HSA<br>☐ 4000E/20%/6350 w/HSA<br>☐ 6300E/0%/6300 w/HSA |
| Pathway | ☐ 15/10%/3500 Plus | ☐ 500/20%/5000 Plus<br>☐ 500/20%/5000 Plus w/Dental | ☐ 1500/30%/5000 Plus<br>☐ 2500/20%/5000 Plus<br>☐ 2500/20%/6350 Plus<br>☐ 3000/0%/3000 Plus w/HSA<br>☐ 5000/0%/6000 Plus<br>☐ 5000/0%/6000 Plus w/Dental | ☐ 4500E/20%/6350 Plus w/HSA<br>☐ 5500/0%/5500 Plus w/HSA<br>☐ 5900/0%/6600 Plus<br>☐ 6000/30%/6600 Plus<br>☐ 6300/0%/6300 Plus w/Dental w/HSA<br>☐ 6300/0%/6300 Plus w/HSA |

| HMO Plans | Anthem Platinum | Anthem Gold | Anthem Silver | Anthem Bronze |
|---|---|---|---|---|
| Pathway | | ☐ 1500/20%/4000 | ☐ 2000/30%/6350<br>☐ 2800E/20%/4000 w/HSA | |

**Choose your medical contribution for each month**

**Note:** Group contribution level for health 50% of single fee premium; at least 25% of total premium.

We will contribute _____% per employee.

**For Health Savings Account (HSA) plans:**

☐ Group will establish Health Savings Account (HSA) with Anthem facilitating with a banking services provider.

☐ Group will establish Health Savings Account (HSA) but does not want Anthem to facilitate in the creation of the account.

| HSA administrator name | Phone no. | Email address |
|---|---|---|
| | | |

**Riders/Optional Benefits — select additional optional benefits**

☐ Calendar Year ☐ Plan Year

**Contract Codes — indicate the contract codes for the plan(s) selected. The codes can be found on the proposal/quote output.**

| Contract Code | Contract Code | Contract Code |
|---|---|---|
| 1. | 4. | 7. |
| 2. | 5. | 8. |
| 3. | 6. | 9. |

**2. Dental Coverage — check all that apply**

☐ Anthem Dental Family ☐ Anthem Dental Family Enhanced ☐ Anthem Dental Pediatric ☐ None

**Choose your dental contribution for each month**

_____% per employee.

**3. Vision Coverage — check one plan option**

☐ Contributory ☐ Voluntary

| Full Service | | | Materials Only Plans |
|---|---|---|---|
| ☐ Anthem Blue View Vision A1<br>☐ Anthem Blue View Vision A2<br>☐ Anthem Blue View Vision A3<br>☐ Anthem Blue View Vision A4<br>☐ Anthem Blue View Vision A5 | ☐ Anthem Blue View Vision B1<br>☐ Anthem Blue View Vision B2<br>☐ Anthem Blue View Vision B3<br>☐ Anthem Blue View Vision B4 | ☐ Anthem Blue View Vision C1<br>☐ Anthem Blue View Vision C2<br>☐ Anthem Blue View Vision C3<br>☐ Anthem Blue View Vision C4 | ☐ Anthem Blue View Vision MO1<br>☐ Anthem Blue View Vision MO2<br>☐ None |

**Choose your vision contribution for each month**

_____% per employee.

Employer tax ID no. (required)

## 4. Life and Disability Coverage – check all that apply.

| Life Products | Disability Products |
|---|---|
| **Choose Life Product and Group Contribution Percentage:** | **Choose Disability Product and Group Contribution Percentage:** |

**Life Products**

Product choice

| ☐ None | Percentage | Contract code |
|---|---|---|
| ☐ Basic Life & AD&D | _____% | _____ |
| ☐ Basic Dependent Life | _____% | _____ |
| ☐ Optional/Voluntary Life* | _____% | _____ |
| ☐ Optional/Voluntary AD&D* | _____% | _____ |
| ☐ Optional/Voluntary Dependent Life* | _____% | _____ |

*Available for Groups of 20+

**Disability Products**

Product choice

| ☐ None | Percentage | Contract code |
|---|---|---|
| ☐ Short Term Disability | _____% | _____ |
| ☐ Long Term Disability | _____% | _____ |
| ☐ Voluntary Short Term Disability* | _____% | _____ |
| ☐ Voluntary Long Term Disability* | _____% | _____ |

*Available for Groups of 20+

## Prior Coverage

Has this group had coverage within 63 days of this application's signature date? ☐ Yes ☐ No

| Will this plan replace current | If yes, carrier name | Termination date |
|---|---|---|
| Life coverage ☐ Yes ☐ No | | |
| Disability coverage ☐ Yes ☐ No | | |

## Not Actively At Work Requirements for Life & Disability Products

The employees listed below are not presently actively-at-work and/or are not expected to be actively-at-work on the requested group effective date. Anthem Life may make an exception and assume liability, subject to Underwriting approval, for certain employees. Unless this exception is applied for and granted as indicated below, they will not be covered until they return to active work. To qualify for this exception, the following conditions must all be satisfied. 1) The employee's absence must be due to illness or injury. 2) The employee must be covered by the prior carrier on the day immediately prior to Anthem Life's effective date of coverage for your group. 3) The employee must not be eligible to have coverage continued or extended by the prior carrier after that policy/contract terminates. In no event will the actively-at work requirement be waived for coverage which provides benefits due to total disability, such as short term disability, waiver of premium or extension of benefits. In no event will any increase in coverage or any additional coverage become effective until the employee returns to work. Coverage approved below will end when your group's coverage under Anthem Life's policy ends or at the end of any time period shown below, whichever occurs first. (Attach additional sheet if necessary.)

| Employee name | Amount of insurance | Date of birth | Last date worked | Reason not working | Date expected to return | Insured by prior carrier | Request actively at work waiver | Waiver request approved | Underwriter approval |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | |
| | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | |

Employer tax ID no. (required)

## Section D: Eligibility

1. Total number of employees (including employed owners/officers): _____
2. Number of eligible full-time employees (minimum 30 hours per week): _____
3. Number of employees enrolling in:

   Medical: _____ Dental: _____

   Vision: _____ Life/Disability: _____
4. Number of eligible DECLINING employees: _____
5. Number of INELIGIBLE employees (part time/seasonal): _____
6. Probationary period/waiting period for **new employees**:

   ☐ None ☐ First of month after hire date

   ☐ 30 days ☐ 60 days ☐ 90 days
7. New eligible enrollees will become effective on:

   ☐ First of month following completion of waiting period/probationary period

   ☐ Day following completion of waiting period/probationary periods (required for 90 day waiting period)

   **The standard effective date is first of the month following the waiting period/probationary period.**
8. Employees currently in their waiting period will have coverage effective:

   ☐ On group's effective date

   ☐ Same waiting period that applies to new persons or on group effective date, whichever is later
9. Do you wish to offer coverage for domestic partners? ☐ Yes ☐ No
10. Under the Medicare Secondary Payer rules, which one applies for your group?

    ☐ Medicare is primary (less than 20 employees)

    ☐ Anthem Blue Cross and Blue Shield is primary (20 or more employees)

    Anthem Blue Cross and Blue Shield is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.
11. Is your company currently subject to COBRA? (Employed 20 or more total employees on at least 50% of the working days in the previous calendar year?

    ☐ Yes ☐ No
12. Do you want an Anthem affiliate to administer Cobra for your group?

    ☐ Yes, please complete and sign the COBRA agreement

    ☐ No

Employer tax ID no. (required)

## Section F: General Agreement

**Please read this section carefully before signing the application.**

**Please check the box that applies:**

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employee Retirement Income Security Act of 1974), apply to obtain the coverage indicated.

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employee Retirement Income Security Act of 1974) and therefore not subject to ERISA, apply to obtain the coverage indicated.

To the best of our knowledge and belief, all information on this application is true and complete, and Anthem Blue Cross and Blue Shield and/or Anthem Life may rely on this application in deciding whether to provide coverage. If the application is not complete, Anthem Blue Cross and Blue Shield and/or Anthem Life reserve(s) the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Anthem Blue Cross and Blue Shield and/or Anthem Life, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We understand that the premium rates calculated for the employer are contingent on the accuracy of eligibility data submitted on employees and covered dependents to Anthem Blue Cross and Blue Shield and/or Anthem Life. Any misstatements on the employees' applications or failure to report new medical information prior to the employee's effective dates may result in a material change to the group's coverage or premium rates as of the effective date of the group coverage. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing by Anthem Blue Cross and Blue Shield and/or Anthem Life and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Anthem Blue Cross and Blue Shield and/or Anthem Life.

If we decide to cancel our group coverage after coverage has been issued, we understand that the cancellation will become effective on the last day of the month in which Anthem Blue Cross and Blue Shield and/or Anthem Life received the written notification of cancellation, and that no premiums will be refunded for any period between Anthem's receipt of the notification and the last day of the month when the cancellation takes effect. If there are any premiums after the cancellation date, we understand that Anthem Blue Cross and Blue Shield and/or Anthem Life will refund these premiums after 45 days from the premium deposit date.

The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits. The IRS has not yet issued HSA or high deductible health plan regulations or determined that Anthem Blue Cross and Blue Shield and/or Anthem Life high deductible plans are qualifying high deductible health plans. Consultation with a tax advisor is recommended.

**HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.**

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.**

| Sign here | Company officer signature<br>X | Printed name | Title | Date (MM/DD/YYYY) |
|---|---|---|---|---|
| Accepted by Anthem Blue Cross and Blue Shield and/or Anthem Life authorized representative | | Printed name | | Date (MM/DD/YYYY) |

Employer tax ID no. (required)

## Section G: Agent Certification

1. I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.
2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Anthem Blue Cross and Blue Shield and/or Anthem Life to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Anthem Blue Cross and Blue Shield and/or Anthem Life reviews and approved the application and the employer receives a written notice from Anthem Blue Cross and Blue Shield and/or Anthem Life.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Anthem shall be paid to an agent/broker/producer not appointed/approved by Anthem Blue Cross and Blue Shield and/or Anthem Life.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Anthem Blue Cross and Blue Shield and/or Anthem Life that the coverage being applied for by this application is accepted.

| **Writing Agent** | | | **%** | **Second writing Agent** | | | **%** |
|---|---|---|---|---|---|---|---|
| Agency name | Agency ID no. | | | Agency name | Agency ID no. | | |
| Agent name | | | | Agent name | | | |
| Agent ID no. | | | | Agent ID no. | | | |
| Agent ID no. if different | | | | Agent ID no. if different | | | |
| Street address | | | | Street address | | | |
| City | State | ZIP code | | City | State | ZIP code | |
| Phone no. | Fax no. | | | Phone no. | Fax no. | | |
| Email address | | | | Email address | | | |
| Signature | Date (MM/DD/YYYY) | | | Signature | Date (MM/DD/YYYY) | | |

**For General Agent use only**

| General Agent | Agent ID no. | | |
|---|---|---|---|
| Street address | City | State | ZIP code |

**Sales Representative**

| Sales representative name | Sales representative ID no. |
|---|---|

| **ANTHEM USE ONLY** | Group no. | Tracking no. | Effective date (MM/DD/YYYY) |
|---|---|---|---|