Employee Change Form
For 1-50 Employee Small Groups[1]
Connecticut

Consult the Certificate of Coverage for complete coverage terms and conditions.

Instructions: Complete electronically or in black ink and return to your employer. Please use extra sheets of paper if necessary.

Section A: General Information

Employer name	Group no.	Employee life class

Employee last name	Employee first name	M.I.	Employee Social Security no.[2] (required)

Section B: Employee Information — Required

Reason for change — Required. Select all that apply.

☐ Address change ☐ Add Spouse/Domestic Partner or dependent ☐ Cancel Coverage
☐ Name change ☐ Cancel Spouse/Domestic Partner or dependent ☐ Cancel product(s)
☐ Benefit change ☐ Change Primary Care Physician (PCP) ☐ Enrollment in Medicare (Fill in Section E)
☐ Change Life and/or Disability classification from Class _____to Class _____ ☐ Other:_____

Event reason — Required. Select all that apply.

☐ Open enrollment (not applicable for Life and Disability products) ☐ Marriage ☐ Birth of child ☐ Adoption of child
☐ Divorce ☐ Involuntary loss of coverage ☐ Other insurance ☐ Death ☐ Termination
☐ Court ordered coverage ☐ 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 (DP)

Primary phone no.	Email address	Occupation

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

Section C: Family Information — Spouse/Domestic Partner and dependents to be added/changed/cancelled. Attach a separate sheet if necessary. Domestic Partner coverage is not available in Life or Disability plans.

☐ Add
☐ Change
☐ Cancel

Event reason — Required. Select all that apply.

☐ Open enrollment (not applicable for Life and Disability products) ☐ Marriage ☐ Birth of child ☐ Adoption of child
☐ Divorce ☐ Involuntary loss of coverage ☐ Other insurance ☐ Death
☐ Other- please explain: _____

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

Spouse/Domestic Partner or Dependent Last name	First name	M.I.	Social Security no.[2](required)

Sex ☐ Male ☐ Female	Disabled? ☐ Yes ☐ No	Birthdate (MM/DD/YYYY) _____/____/_____	Relationship to applicant: ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Other If other, what is the relationship?_____

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

Does the Spouse/Domestic Partner or Dependent have a different address? ☐ Yes ☐ No
If yes, please enter:

1 A small group must have at least one eligible employee, in addition to the business owner. A spouse cannot be the only eligible employee.
2 Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Section D: Plan/Type of Coverage

1. Medical Coverage

Medical product plan name:	Contract code, if known:

Member medical coverage — select one: ☐ Employee only ☐ Employee + child(ren) ☐ Employee + Spouse/Domestic Partner ☐ Family

2. Dental Coverage

Dental product plan name:	Contract code, if known:

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

3. Vision Coverage

Vision product plan name:	Contract code, if known:

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

4. Life, Accidental Death & Dismemberment (AD&D), and Disability Coverage

☐ I am enrolling in my Employer's Life and/or Disability plan(s), if any.

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

Current annual income: $	Life and Disability class no.:

If selecting Short Term Disability coverage: Do you work in New York? ☐ Yes ☐ No Do you work in New Jersey? ☐ Yes ☐ 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

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above.

Spousal/Domestic Partner Consent for Community Property States Only (Note: The insurance company is not responsible for the validity of a Spouse's/Domestic Partner's consent for designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV,TX, WA and WI), your state may require you to obtain the signature of your Spouse/Domestic Partner if your Spouse/Domestic Partner will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your Spouse/Domestic Partner read and sign the following. I am aware that my Spouse/Domestic Partner, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior Spousal/Domestic Partner consent or waiver under this plan.

Sign here	**Spouse/Domestic Partner signature** X	**Date (MM/DD/YYYY)** / /
	Spouse/Domestic Partner name X	**Date (MM/DD/YYYY)** / /

Section E: Prior and 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 (MM/DD/YYYY)	Part B effective date (MM/DD/YYYY)	Medicare eligibility reason (select all that apply)
	/ /	/ /	☐ Age ☐ Disability ☐ ESRD 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 coverage? ☐ Yes ☐ 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**	**Insurer phone no.**	**Policy ID no.**	**Dates (if applicable)** (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** ____/_____/______ **End:** ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** ____/_____/______ **End:** ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** ____/_____/______ **End:** ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** ____/_____/______ **End:** ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				**Start:** ____/_____/______ **End:** ____/_____/______

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 or Anthem Life 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 30 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, eligible 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 children will end on the renewal date of the group when the child reaches 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. 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 a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract 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 understand that intentionally false and/or intentionally incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

For myself and any dependents, I'm signing here because, I agree to get information about my benefits 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 benefits, 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 also understand that by signing, information about my dependents may also be sent by email or electronically. I know I can change my mind at any time and request a free copy of specific materials by mail. To do either, I (or my enrolled dependents) will update our communication preferences by going to anthem.com or calling Member Services.

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.

Coverage Option
If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, Anthem or by another carrier.

Life and/or Disability Authorization Section — Read carefully before signing.

1. I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., to Anthem Life Insurance Company (Anthem Life), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem Life will advise such entities that such information must be kept confidential to the extent required by applicable law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that Anthem Life may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life.
2. Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.
3. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
4. I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan. I am acting as their agent and representative. This authorization, for purposes of processing this enrollment form, is valid for a period of 24-30 months from the date signed unless revoked by me in writing, which I may do at any time by contacting Anthem. A photocopy is as valid as the original.

Employee signature X		**Date (MM/DD/YYYY)** / /
Sign here	**Applicant signature** X	**Date (MM/DD/YYYY)** / /
	Spouse/Domestic Partner signature X	**Date (MM/DD/YYYY)** / /

Get help in your language

Language Assistance Services

Anthem BlueCross BlueShield

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 (855-738-6644). (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 (855-738-6644). (TTY/TDD: 711)

Albanian
Nëse ju nevojitet ndihmë për ta kuptuar këtë dokument në një gjuhë tjetër, mund ta kërkoni pa kosto shtesë duke telefonuar në numrin e shërbimeve për anëtarët (855-738-6644). (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 (855-738-6644). (TTY/TDD: 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(855-738-6644)請求免費協助。(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 : 855-738-6644. (TTY/TDD: 711)

Greek
Αν χρειαστείτε βοήθεια για να κατανοήσετε το παρόν έγγραφο σε άλλη γλώσσα, μπορείτε να τη ζητήσετε χωρίς πρόσθετο κόστος καλώντας τον αριθμό του Τμήματος Υπηρεσιών Μέλους (855-738-6644). (TTY/TDD: 711)

Haitian
Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (855-738-6644). (TTY/TDD: 711)

Hindi
अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-738-6644) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (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 (855-738-6644). (TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-738-6644)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Polish
Jeśli potrzebujesz pomocy w zrozumieniu niniejszego dokumentu w innym języku, możesz ją uzyskać bez ponoszenia dodatkowych kosztów, dzwoniąc do Działu Obsługi Klienta pod numer (855-738-6644). (TTY/TDD: 711)

Portuguese-Europe
Se necessitar de ajuda para compreender este documento noutro idioma, poderá solicitá-la gratuitamente ligando para o número dos Serviços para Membros (855-738-6644). (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 (855-738-6644). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-738-6644). (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 (855-738-6644). (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.