

# Managed Care Member Enrollment/Member Change Form



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 contract no., if any		Social security no. *(required)	
Last name	First name	M.I.	
Home address or P.O. box	City	State	ZIP code
Phone no.	Email address		

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

## SECTION 2: REASON FOR MEMBER ENROLLMENT - Please check the reason below and date if required

<input type="checkbox"/> New hire	<input type="checkbox"/> New group (Initial enrollment)	<input type="checkbox"/> COBRA - start date: _____	<input type="checkbox"/> Retiree - date of retirement: _____
<input type="checkbox"/> Rehire	<input type="checkbox"/> Open enrollment	<input type="checkbox"/> COBRA - event date: _____	<input type="checkbox"/> Life event: _____
<input type="checkbox"/> Waive coverage (go to Section 6)	<input type="checkbox"/> Other: _____	Date: _____	

## SECTION 3: CHANGE STATUS - Please check type and date of change below

<input type="checkbox"/> Name change	<input type="checkbox"/> Add dependent	<input type="checkbox"/> Delete dependent	<input type="checkbox"/> Address change	<input type="checkbox"/> PCP change	Date of change (MM/DD/YYYY)
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Reason for change			
<input type="checkbox"/> Adoption	<input type="checkbox"/> Covered by Medicaid	<input type="checkbox"/> Divorce	<input type="checkbox"/> Marriage
<input type="checkbox"/> Annual enrollment	<input type="checkbox"/> Court order	<input type="checkbox"/> Domestic partner	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Birth	<input type="checkbox"/> Death	<input type="checkbox"/> Entrance to the Military	<input type="checkbox"/> Voluntary cancellation
<input type="checkbox"/> Civil union	<input type="checkbox"/> Discharge from the Military	<input type="checkbox"/> Loss of coverage	

## SECTION 4: MEMBERSHIP CHOICES

<input type="checkbox"/> Access Blue New England	<input type="checkbox"/> Blue Choice New England with HSA*	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Blue Choice	<input type="checkbox"/> Blue View Vision (see Section 10) _____	
<input type="checkbox"/> Blue Choice New England	<input type="checkbox"/> HMO Blue New England	
<input type="checkbox"/> Blue Choice New England with HRA	<input type="checkbox"/> Matthew Thornton Blue <sup>SM†</sup>	*Confirm with your employer which HSA custodian was selected.

## SECTION 5: EMPLOYER INFORMATION

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

\*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 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 <b>X</b>	Date

**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.* (required)	Birthdate (MM/DD/YYYY)	Full-time student?	Primary Care Physician (PCP)	Current Patient
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Self	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No				Name PCP no.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Ex/Legal spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Civil union	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No				Name PCP no.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	Name PCP no.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	Name PCP no.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	Name PCP no.	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

**SECTION 8: PRIOR COVERAGE INFORMATION – This section must be completed**

Have you or any other family member had health insurance coverage in the 63 days prior to your date of hire or the effective date of your new policy?

Yes  No If yes, please complete the following:

	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
					<input type="checkbox"/> Age 65 <input type="checkbox"/> Disability <input type="checkbox"/> ESRD
					<input type="checkbox"/> Age 65 <input type="checkbox"/> Disability <input type="checkbox"/> 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.

**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 <b>X</b>	Print name	Date
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## 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:

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

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

### 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 Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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

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