Employee Enrollment Supplemental Application For 2-100 Employee Small Groups[1] Colorado

Anthem BlueCross BlueShield

This form is to accompany the *Colorado Uniform Employee Application for Small Group Health Benefit Plans.*
You, the employee, must fill out this enrollment form. You must be sure that all information is correct and that you fill out all the sections that relate to you. To make sure you are enrolled as soon as possible, please answer all questions and then sign and date the form.

Please fill out in black ink only.

Section A: Employee Information

Last name	First name	M.I.	Social Security no.[1] (required)

Home address - Street and PO Box if applicable

City	County	State	ZIP code

Marital status ☐ Single ☐ Married ☐ Domestic Partner	Main phone no.	Secondary phone no.

Employee email address

Employer name	Group no. (if known)

Employer street address

City	County	State	ZIP code

Employment status: ☐ Full-time ☐ Part-time ☐ Disabled ☐ Retired

Date of hire (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins (MM/DD/YYYY)	Re-hire date (MM/DD/YYYY)	No. of hours worked per week

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other — please specify: _____
Do you read and write English? ☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability

Section B: Enrollment Type

Choose one

☐ New enrollment
☐ Open enrollment (not applicable for Life and Disability)
☐ Rehire –
Rehire Date

☐ COBRA -
Select qualifying event
☐ Left employment
☐ Loss of dependent child status
☐ Medicare
☐ Reduction in hours
☐ Divorce or legal separation
☐ Covered employee's Medicare entitlement
☐ Loss of other coverage
☐ Death

COBRA qualifying event date	COBRA start date	CCOBRA end date	Effective date of qualifying event

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

Employee name: _____ Social Security no.: _____

1. Dental Coverage - Please ask your employer which dental options are available before making your selection.
Note that our Small Group Off Exchange medical plans provide pediatric dental coverage to meet ACA requirements.

Anthem Dental Family and Anthem Dental Family Enhanced plans include certified pediatric dental essential health benefits. All other plans including Anthem Dental Prime, and Anthem Dental Complete with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.

Member dental coverage – choose one:
☐ Employee only ☐ Employee + Spouse/Domestic Partner/Civil Union Partner ☐ Employee + Child(ren) ☐ Family ☐ No coverage
If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Contract code - Please indicate the contract code for the dental plan chosen. Your employer will advise you of your plan options and contract codes.
Contract code: _____

2. Vision Coverage - Choose one plan option.

Member vision coverage - choose one:
☐ Employee only ☐ Employee + Spouse/Domestic Partner/Civil Union Partner ☐ Employee + Child(ren) ☐ Family
If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Contract code - Please indicate the contract code for the vision plan chosen. Your employer will advise you of your plan options and contract codes.
Contract code: _____

3. Life and Disability Coverage - A minimum of two employees must enroll.

☐ Basic Life & 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.

Primary Beneficiary - Attach a separate sheet if necessary.

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	
Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	

Contingent Beneficiary

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	
Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.	Relationship to applicant
Address				Percentage to be paid to beneficiary	

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.

Domestic Partner / Civil Union Partner Affidavit – Signature required.

We depose and attest to the following:

1. We are both at least 18 years of age, and we are mentally competent to contract.
2. Neither of us is legally married to another person, nor is either of us a member of another domestic/civil union partnership.
3. We are sole Domestic Partners/Civil Union Partners and have been so (whether recognized by the state) for at least 12 months preceding the date of this Affidavit. We have been sole Domestic Partners/Civil Union Partners living together continuously since (MM/DD/YYYY), and we intend to remain sole Domestic Partners/Civil Union Partners indefinitely.
4. We are not related by blood closer than permitted by state law or marriage.
5. If applying as Domestic Partners/Civil Union Partners, we are jointly responsible for each other's common welfare as evidenced through, for example, a joint deed, joint mortgage, joint lease, joint credit card, joint bank account, designation of the other as beneficiary for a life insurance or retirement contract, designation of the other as primary beneficiary in the individual's will, and/or powers of attorney authorizing each of us to act on behalf of the other.
6. We understand that a Domestic partner/Civil Union Partner enrolled as a dependent ceases to be an eligible member as early as the termination of such Domestic/Civil Union partnership and that the Employee is required to submit an Enrollment Application/Change Form within 31 days of the termination of the Domestic/Civil Union partnership or within the time specified in the Employee's certificate.

Employee Signature X	Date (MM/DD/YYYY)

Common-law Affidavit – Signature required.

We the undersigned, being of lawful age, attest to the following facts:

- We have lived together continuously, in Colorado, as husband and wife from _____ (MM/DD/YYYY) to the present.
- We are free to contract a valid ceremonial marriage, i.e., are not already married to someone else.
- We hold ourselves as husband and wife, consent to the marriage, cohabit and have the reputation in the community as being husband and wife.
- We understand that a common-law marriage, in the state of Colorado, is valid for all purpose, the same as a ceremonial marriage, and can only be terminated by death or divorce.

Employee Signature X	Date (MM/DD/YYYY)

Section C: Coverage Information - All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner/Civil Union Partner, your children or your spouse's, domestic partner's/Civil Union Partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the oldest. If waiving coverage for employee and/or any eligible family members, you must complete Section F.

Employee last name			First name	M.I.
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant Self	

Coverage Selected: ☐ Medical ☐ Dental* ☐ Vision*

*Primary Applicant must be included for Spouse/Domestic Partner/Civil Union Partner and/or Dependent coverage eligibility.

Spouse/Domestic Partner/Civil Union Partner last name			First name	M.I.	Social Security no.
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Ex/Legal spouse ☐ Domestic Partner /Civil Union Partner		
Coverage Selected ☐ Dental* ☐ Vision* *Primary Applicant must be included for Spouse/Domestic Partner/Civil Union Partner and/or Dependent coverage eligibility.					

Dependent last name			First name	M.I.	Social Security no.
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?_____		
Coverage Selected ☐ Dental* ☐ Vision* *Primary Applicant must be included for Spouse/Domestic Partner/Civil Union Partner and/or Dependent coverage eligibility.					
Does this dependent have a different address? ☐ Yes ☐ No If yes, please enter: _____					

Dependent last name			First name	M.I.	Social Security no.
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?_____		
Coverage Selected ☐ Dental* ☐ Vision* *Primary Applicant must be included for Spouse/Domestic Partner/Civil Union Partner and/or Dependent coverage eligibility.					
Does this dependent have a different address? ☐ Yes ☐ No If yes, please enter: _____					

Dependent last name			First name	M.I.	Social Security no.
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?_____		
Coverage Selected ☐ Dental* ☐ Vision* *Primary Applicant must be included for Spouse/Domestic Partner/Civil Union Partner and/or Dependent coverage eligibility.					
Does this dependent have a different address? ☐ Yes ☐ No If yes, please enter: _____					

Section D: Prior and Other Group Coverage

Are you or 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 (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date _____

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date (MM/DD/YYYY)

On the day your coverage starts, will you or a family member be covered by Medicare? ☐ Yes ☐ No

On the day your coverage starts, will you or a family member be covered by other dental coverage? ☐ Yes ☐ No

If yes to any of these questions, please provide the following. If any coverage will remain in force once you enroll with Anthem, leave the End date blank.

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.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Individual ☐ Group ☐ Medicare	☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Individual ☐ Group ☐ Medicare	☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Individual ☐ Group ☐ Medicare	☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Individual ☐ Group ☐ Medicare	☐ Dental ☐ Orthodontia				**Start:** **End:**

Employee name: _____ Social Security no.: _____

Section E: Waiver/Declining Coverage	
Dental coverage declined for - check all that apply:	☐ Myself ☐ Spouse/Domestic Partner/Civil Union Partner ☐ Dependent(s)
Vision coverage declined for - check all that apply:	☐ Myself ☐ Spouse/Domestic Partner/Civil Union Partner ☐ Dependent(s)
Life/AD&D coverage declined for: Spouse, Domestic Partner/Civil Union Partner and Dependent coverage not available if life coverage is waived/declined.	☐ Myself
Dependent Life coverage declined for:	☐ Spouse/Domestic Partner/Civil Union Partner and Dependents
Short Term Disability coverage declined for:	☐ Myself
Long Term Disability coverage declined for:	☐ Myself
Optional Supplemental/Voluntary coverage declined for:	☐ Myself
Optional Supplemental/Voluntary Dependent Life coverage declined for:	☐ Spouse/Domestic Partner/Civil Union Partner and Dependents
Voluntary Short Term Disability coverage declined for:	☐ Myself
Voluntary Long Term Disability coverage declined for:	☐ Myself
Reason for declining coverage - check all that apply:	☐ Covered by Spouse's/Domestic Partner's/Civil Union Partner's group coverage ☐ Enrolled in other Insurance – Please provide company name and plan: _____ ☐ Enrolled in individual coverage ☐ Spouse/Domestic Partner/Civil Union Partner's covered by employer's group coverage ☐ Other - please explain:_____

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Today's date (MM/DD/YYYY)
X		

Employee name: _____ Social Security no.: _____

Section F: Terms, Conditions and Authorizations

Please read this section carefully before signing the enrollment form.

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 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 don't 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 a child who cannot support himself or herself because of mental or physical handicap 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.

Life and Disability Coverage Conditions:

- 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.
- These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.

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 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 a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Agreement and coverage document.

In signing this enrollment form I represent that:

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

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

Electronic Communications

☐ I affirmatively agree to receive any vision and dental 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.

Sign here	Employee Signature X	Today's date (MM/DD/YYYY)

Get help in your language

Curious to know what all this says? We would be too. Here's the English version:
You have the right to get this information and help in your language for free. Call the Member Services number on your ID card for help. (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 customer service telephone number on the back of your ID card.

Spanish
Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda. (TTY/TDD: 711)

Amharic
ይህንን መረጃ እና እገዛ በቋንቋዎ በነጻ እገዛ የማግኘት መብት አልዎት። ለእገዛ በመታወቂያዎ ላይ ያለውን የአባል አገልግሎቶች ቁጥር ይደውሉ።
(TTY/TDD: 711)

Arabic
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خدمات الأعضاء الموجود على بطاقة التعريف الخاصة بك للمساعدة
.(TTY/TDD:711)

Bassa
Ǹ ɓéɖé dyí-ɓèɖèìn-ɖèò ɓé m̀ ké bɔ̌ nìà kɛ kè gbo-kpá- kpá dyé ɖé m̀ ɓíɖí-wùɖùǔn ɓó pídyi. Đá méɓà jè gbo-gmɔ̀ Kpòè nɔ̀ɓà nìà nì Dyí-dyoìn-bɛ̃̂ɔ̃ kɔ̃ɛ ɓé m̀ ké gbo-kpá-kpá dyé. (TTY/TDD: 711)

Chinese
您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi
شما این حق را دارید که این اطلاعات و کمکها را به صورت رایگان به زبان خودتان دریافت کنید. برای دریافت کمک به شماره مرکز خدمات اعضاء که بر روی کارت شناسایی‌تان درج شده است، تماس بگیرید. (TTY/TDD: 711)

French
Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour cela, veuillez appeler le numéro des Services destinés aux membres qui figure sur votre carte d'identification. (TTY/TDD: 711)

German
Sie haben das Recht, diese Informationen und Unterstützung kostenlos in Ihrer Sprache zu erhalten. Rufen Sie die auf Ihrer ID-Karte angegebene Servicenummer für Mitglieder an, um Hilfe anzufordern. (TTY/TDD: 711)

Igbo
Ị nwere ikike ịnweta ozi a yana enyemaka n'asụsụ gị n'efu. Kpọọ nọmba Ọrụ Onye Otu dị na kaadị NJ gị maka enyemaka. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Nepali
तपाईंले यो जानकारी तथा सहयोग आफ्नो भाषामा निःशुल्क प्राप्त गर्ने तपाईंको अधिकार हो। सहायताको लागि तपाईंको ID कार्डमा दिइएको सदस्य सेवा नम्बरमा कल गर्नुहोस्।(TTY/TDD: 711)

Oromo
Odeeffanoo kana fi gargaarsa afaan keetiin kaffaltii malee argachuuf mirga qabda. Gargaarsa argachuuf lakkoofsa bilbilaa tajaajila miseensaa (Member Services) waraqaa enyummaa kee irratti argamu irratti bilbili. (TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Vietnamese
Quý vị có quyền nhận miễn phí thông tin này và sự trợ giúp bằng ngôn ngữ của quý vị. Hãy gọi cho số Dịch Vụ Thành Viên trên thẻ ID của quý vị để được giúp đỡ. (TTY/TDD: 711)

Yoruba
O ní ẹ̀tọ́ láti gba ìwífún yìí kí o sì ṣèrànwọ́ ní èdè rẹ lọ́fẹ̀ẹ́. Pe Nọ́mbà àwọn ìpèsè ọmọ-ẹgbẹ́ lórí káàdì ìdánimọ̀ rẹ fún ìrànwọ́. (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.