Employee Change Form
For 2–50 Employee Small Groups
Virginia

Anthem BlueCross BlueShield

And Its Affiliate HealthKeepers, Inc.

Health care plans offered by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. PPO health care plans are insurance products offered by Anthem Blue Cross and Blue Shield; HMO health care plans are health maintenance organization products offered by HealthKeepers, Inc.

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 blue or 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 ID/HCID/Social Security no.

Section B: Employee Information – Required

Reason for change – Required. Check all that apply.

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

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.

☐ Open enrollment ☐ 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

Birthdate (MM/DD/YYYY)	Sex	Marital status	Primary phone no.	Secondary phone no.
	☐ Male ☐ Female	☐ Single ☐ Married		

Email address

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 ☐ 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 last name	First name	M.I.	Social Security no.

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

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

Does the spouse 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

Section C: Family Information – Continued

☐ Add ☐ Change ☐ Cancel

Event reason – Required. Check all that apply.
☐ Open enrollment ☐ 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.

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 ☐ 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.

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 ☐ 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.

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**

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, we 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 ☐ Employee + child(ren) ☐ Family

2. Dental Coverage

Product plan name	Contract code, if known

Member dental coverage – select one: ☐ Employee only ☐ Employee + Spouse ☐ 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 ☐ Employee + child(ren) ☐ Family

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:

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 HealthKeepers 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 younger than age 26, 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. 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 intellectual disability 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.

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 all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that:

I certify that 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.

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 or HealthKeepers with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem or HealthKeepers with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem or HealthKeepers with a written request to revoke my authorization at any time.

Coverage Option

If your employer/group offers health maintenance organization 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 Anthem Blue Cross and Blue Shield, HealthKeepers or by another carrier.

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