Employer Enrollment Application
For 2–50 Employee Small Groups
Virginia

And Its Affiliate HealthKeepers, Inc.

INSTRUCTIONS

Health care plans offered by Anthem Blue Cross and Blue Shield and HealthKeepers, Inc. Anthem plans are insurance products offered by Anthem Blue Cross and Blue Shield (Anthem). Anthem HealthKeepers plans are offered by HealthKeepers, Inc (HealthKeepers). Disability and Life plans are offered by Anthem Life Insurance Company (Anthem Life).

Please complete in blue or black ink only.

Section A: Company Information

Company name	Head of firm	Employer tax ID no. (required)

Company street address	City	City/County	State	ZIP code

Billing address – If different from above	City	State	ZIP code

Is this for coverage as a member of an association plan? ☐ Yes ☐ No

If yes, association name: ____________________

Association code (For Internal Use Only)

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

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 at least 31 days before the Group's renewal date and 31 days after, which is held no more often than once in any 12 consecutive months. If you want a different open enrollment period, please enter the start and end dates. The open enrollment period does not apply to Life & Disability products.	Start date (MM/DD/YYYY)	End date (MM/DD/YYYY)

Section B: Application Type

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

Life and Disability products underwritten by **Anthem Life Insurance Company. Anthem Health Plans of Virginia, Inc.** trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. Anthem Blue Cross and Blue Shield and its affiliated HMO **HealthKeepers, Inc.** are independent licensees of the Blue Cross Blue Shield Association.

®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Section C: Type of Coverage				
1. Medical Coverage — check all that apply				
PPO Plans	**Anthem Premier**	**Anthem Preferred**	**Anthem Essential**	**Anthem Core**
KeyCare	☐ DirectAccess – gwaa ☐ DirectAccess – gyaa	☐ DirectAccess – gaaf ☐ DirectAccess – gbia ☐ DirectAccess – gcga ☐ DirectAccess – ghfa ☐ DirectAccess – gjba ☐ DirectAccess – gkfa ☐ DirectAccess – gpqa ☐ DirectAccess – gqqa ☐ DirectAccess – grqa ☐ DirectAccess – gtga ☐ DirectAccess – gyha ☐ DirectAccess – gzha ☐ DirectAccess w/HRA – ggra ☐ DirectAccess w/HRA – ghra ☐ DirectAccess w/HRA – gmra ☐ DirectAccess w/HSA – gtqa ☐ DirectAccess w/HSA – gxqa	☐ DirectAccess – ghia ☐ DirectAccess – gvia ☐ DirectAccess w/HRA – ggta ☐ DirectAccess w/HSA – gdsa ☐ DirectAccess w/HSA – gjsa ☐ DirectAccess w/HSA – gjta ☐ DirectAccess w/HSA – gkta ☐ DirectAccess w/HSA – gpsa	☐ DirectAccess w/HSA – gmua ☐ DirectAccess w/HSA – gyua
POS Plans	**Anthem Premier**	**Anthem Preferred**	**Anthem Essential**	**Anthem Core**
HealthKeepers		☐ Guided Access Plus – gnbf ☐ Guided Access Plus – gtoa ☐ Guided Access Plus w/HSA – gsab ☐ Guided Access Plus w/HSA – gvab ☐ Guided Access Plus w/HRA – gbbb ☐ Guided Access Plus w/Dental – gtoa	☐ Guided Access Plus – gbpa ☐ Guided Access Plus – gcpa ☐ Guided Access Plus – gobf ☐ Guided Access Plus – gyoa ☐ Guided Access Plus w/Dental – gcpa ☐ Guided Access Plus w/HRA – gpcb ☐ Guided Access Plus w/HSA – gqeb ☐ Guided Access Plus w/HSA – gybb ☐ Guided Access Plus w/HSA – gzeb	☐ Guided Access Plus – gwnb ☐ Guided Access Plus – gznb ☐ Guided Access Plus w/Dental w/HSA – gkdb ☐ Guided Access Plus w/HSA – ggdb ☐ Guided Access Plus w/HSA – ghdb ☐ Guided Access Plus w/HSA – gkdb ☐ Guided Access Plus w/HSA – grgb
HealthKeepers Open Access	☐ DirectAccess – gwaa ☐ DirectAccess – gyaa	☐ DirectAccess – gaaf ☐ DirectAccess – gbia ☐ DirectAccess – gcga ☐ DirectAccess – ghfa ☐ DirectAccess – gjba ☐ DirectAccess – gkfa ☐ DirectAccess – gpqa ☐ DirectAccess – gqqa ☐ DirectAccess – grqa ☐ DirectAccess – gtga ☐ DirectAccess – gyha ☐ DirectAccess – gzha ☐ DirectAccess w/HRA – ggra ☐ DirectAccess w/HRA – ghra ☐ DirectAccess w/HRA – gmra ☐ DirectAccess w/HSA – gtqa ☐ DirectAccess w/HSA – gxqa	☐ DirectAccess – ghia ☐ DirectAccess – gvia ☐ DirectAccess w/HRA – ggta ☐ DirectAccess w/HSA – gdsa ☐ DirectAccess w/HSA – gjsa ☐ DirectAccess w/HSA – gjta ☐ DirectAccess w/HSA – gkta ☐ DirectAccess w/HSA – gpsa	☐ DirectAccess w/HSA – gmua ☐ DirectAccess w/HSA – gyua

Medical Contribution:
We will contribute (50% to 100%): _____% per employee _____% per dependent (optional).

For Health Reimbursement Accounts (HRA):
HRA Employer Contributions Amount: Single $______________ Family $______________. Maximum rollover amount is 2X the annual contribution.

For Health Savings Accounts (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

2. Dental Coverage – check all that apply

You must enroll in a pediatric dental option unless you are enrolled in a medical plan or dental plan that includes pediatric dental that meets the Essential Health Benefits requirements.

- If enrolling in a medical plan with Dental in Section C.1., the pediatric dental requirements are included. No additional purchase is required.
- If purchasing a Family plan listed below, it meets the pediatric dental requirements.
- If purchasing an Adult plan below, it does not include pediatric dental, and a pediatric plan must also be purchased.
- If enrolled in a standalone dental plan with another insurer that has been certified by your state Exchange to meet the pediatric dental requirements, please check here_________. No additional purchase is required.

☐ Anthem Dental Adult ☐ Anthem Dental Adult Enhanced	☐ Anthem Dental Family ☐ Anthem Dental Family Enhanced	☐ Anthem Dental Pediatric ☐ Anthem Dental Pediatric Enhanced

Dental Contribution (optional)

_____% per employee _____% per dependent

3. Vision Coverage – select one plan option

Full Service			Materials Only Plans
☐ Anthem Blue View Vision A1 ☐ Anthem Blue View Vision A2 ☐ Anthem Blue View Vision A3 ☐ Anthem Blue View Vision A4 ☐ Anthem Blue View Vision A5	☐ Anthem Blue View Vision B1 ☐ Anthem Blue View Vision B2 ☐ Anthem Blue View Vision B3 ☐ Anthem Blue View Vision B4	☐ Anthem Blue View Vision C1 ☐ Anthem Blue View Vision C2 ☐ Anthem Blue View Vision C3 ☐ Anthem Blue View Vision C4	☐ Anthem Blue View Vision M01 ☐ Anthem Blue View Vision M02

Vision Contribution

We will contribute (50% to 100%): ___________% per employee ____________% per dependent (optional)

Riders/Optional Benefits – select additional optional benefits

☐ Calendar Year (Standard) ☐ Plan Year ☐ Bariatric surgery ☐ Religious contraceptive exemption (Must qualify and be approved)

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

Medical Plan Contract Codes	Dental Plan Contract Code	Vision Plan Contract Code
1.	1.	1.
2.		
3.		

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

Life Products	Disability Products
Choose Life Product and Group Contribution Percentage: ☐ None ☐ Basic Life & AD&D_______% ☐ Basic Dependent Life_______% ☐ Optional/Voluntary Life*_______% ☐ Optional/Voluntary AD&D*_______% ☐ Optional/Voluntary Dependent Life*_______% *Available for Groups of 20+	**Choose Disability Product and Group Contribution Percentage:** ☐ None ☐ 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 30 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	

Life and Disability Authorization — Read carefully before signing

The undersigned employer and/or authorized representative hereby requests that it be approved for insurance coverage through Anthem Life Insurance Company (Anthem Life). Employer understands and represents to the best of his knowledge and belief the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Anthem Life trust policy(ies), if applicable;
2. To make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed;
3. To maintain records and furnish to Anthem Life or their designated agent(s), any information required in connection with administration of the insurance coverage;
4. To provide notice of applicable conversion rights to eligible employees and eligible dependents;
5. That approval for this insurance may cancel any prior contracts and/or coverage with Anthem Life effective immediately preceding the effective date of the employer's coverage;
6. To pay Anthem Life by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership;
7. That claims filed by or on behalf of members may, at Anthem Life's option, be suspended if premiums are not received timely;
8. Employer will receive, on behalf of members, all notices delivered by Anthem Life, and immediately forward such notices to persons involved, at their last known address, including certificates of coverage;
9. The advance premium check does not create temporary or interim insurance coverage and that receipt and deposit of that payment does not guarantee issuance of insurance coverage. Rather, issuance of insurance coverage is expressly conditioned on Anthem Life's determination that the group is an acceptable risk based on their current underwriting practices and procedures Unless these Conditions are met, there shall be no liability on the part of Anthem Life except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees;
10. That in order for Anthem Life to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem Life, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem Life may be different than the coverage applied for herein. In that event, Anthem Life shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued;
11. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem Life by the employer. Anthem Life reserves the right to review such rates upon receipt of all individual applications and modify the rates, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the group's coverage or premium rate as of the effective date of coverage;
12. The entire application for Group Insurance has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief;
13. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work full-time (unless otherwise approved by Anthem Life in writing) and meet any other eligibility requirements for coverage;
14. The requested coverage is not in effect unless and until this application is approved by Anthem Life, that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem Life.

ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM

Company officer signature	City where signed	State	Date (MM/DD/YYYY)
X			

Printed name	Title

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: ____________
6. Probationary period/waiting period for **new employees**:
   ☐ Date of Hire (DOH)
   ☐ First of the month (FOM) following DOH
   ☐ FOM following 30 days from DOH
   ☐ FOM following 60 days from DOH
   ☐ 30 days from DOH
   ☐ 60 days from DOH
   ☐ 90 days from DOH
7. 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/HealthKeepers is primary (20 or more employees)

   Anthem Blue Cross and Blue Shield/HealthKeepers 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.
8. 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
9. Termination effective date: ☐ End of month ☐ End of day

Section E: Ownership

Please account for 100% of the ownership, regardless of eligibility. Insert an additional sheet if necessary.

Last name	First name	M.I.	Percentage of ownership	Eligible
			______%	☐ Yes ☐ No
			______%	☐ Yes ☐ No
			______%	☐ Yes ☐ No
			______%	☐ Yes ☐ No

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, HealthKeepers and Anthem Life may rely on this application in deciding whether to provide coverage. If the application is not complete, Anthem, HealthKeepers and 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, HealthKeepers and 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, HealthKeepers and Anthem Life. Any misstatements on the employees' applications 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, HealthKeepers and 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, HealthKeepers and Anthem Life. We shall comply with all provisions of the contract(s) issued.

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, HealthKeepers and 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, HealthKeepers and Anthem Life will refund these premiums after 45 days from the premium deposit date.

Sign here	Company officer signature X	Printed name	Title	Date (MM/DD/YYYY)

Accepted by Anthem, HealthKeepers and Anthem Life authorized representative	Printed name	Date (MM/DD/YYYY)

Section G: Agent/Broker 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, HealthKeepers and 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, HealthKeepers and Anthem Life reviews and approves the application and the employer receives a written notice from Anthem, HealthKeepers and Anthem Life.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Anthem, HealthKeepers and Anthem Life that the coverage being applied for by this application is accepted.

Writing agent/broker			**%**	**Second writing agent/broker**			**%**
Agency name		Agency ID no.		Agency name		Agency ID no.	
Agent/broker name				Agent/broker name			
Agent/broker ID no.				Agent/broker ID no.			
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)	

Sales Representative			
Sales representative name	Sales representative code no.		
Street address	City	State	ZIP code

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

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