

Enrollment Application



Group size 2-50 eligible employees

Lang Insurance Service, Inc.; (636) 441-0211; www.langinsurance.com

Anthem Blue Cross and Blue Shield is used collectively as the trade name for RightChoice Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), HMO Missouri, Inc., and Anthem Life Insurance Company (ALIC). HALIC underwrites PPO and traditional health coverages; HMO Missouri, Inc. underwrites HMO and POS coverages; and ALIC underwrites Life, Accidental Death and Dismemberment, Short Term Disability and Long Term Disability coverages.

KS Residents only: Coverage applied for:

PPO/Traditional (Healthy Alliance Life Insurance Company) Life & Disability (Anthem Life Insurance Company)

Please complete in black or blue ink for employee and all dependents enrolling with us and return to your employer. Use extra sheets of paper if necessary. Please provide complete details to avoid delay. If you have creditable coverage, we will give you credit for your prior coverage, and pre-existing condition limitations will be reduced or excluded for any conditions listed below. Please note that no one will be denied health coverage on an individual basis due to the answers provided below. *All information given should apply to this employer.*

1. TYPE OF COVERAGE REQUESTED: Employee Only Employee+Spouse Employee+Child(ren) Family Life Only No coverage

2. ENROLLMENT INFORMATION Single Divorced Married

Relationship	Last Name, First Name, M.I.	Social Security No. SSN required for Lumenos. Health Savings Account	Sex	Full Time Student?	Age	Date of birth	Height/Weight	Current tobacco user?	Disabled?
Employee			<input type="checkbox"/> M <input type="checkbox"/> F			/ /	/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse			<input type="checkbox"/> M <input type="checkbox"/> F			/ /	/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Child <input type="checkbox"/> Other _____			<input type="checkbox"/> M <input type="checkbox"/> F	<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"/> Child <input type="checkbox"/> Other _____			<input type="checkbox"/> M <input type="checkbox"/> F	<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"/> Child <input type="checkbox"/> Other _____			<input type="checkbox"/> M <input type="checkbox"/> F	<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"/> Child <input type="checkbox"/> Other _____			<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No		/ /	/	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee Home Address: Street, City, State, ZIP Code County

Employee Home Phone () Employee Work Phone () Employee Email Address

Dependent Home Address: Street, City, State, ZIP Code (if different from employee) Dependent Name(s)

3. MEDICAL INFORMATION (If yes, circle condition)

- Do you or your dependents regularly take medication? Yes No
- Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? Yes No
- Are you or any of your dependents currently pregnant? Yes No
If yes, name _____ due date ___/___/___
- In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor/growth; disorder of the blood or immune system; stroke, aneurysm, high blood pressure, diabetes (**list age of onset below**); mental/nervous disorder; Parkinson's disease; migraine/cluster headaches; seizures/epilepsy; depression; alcohol or drug abuse/dependency; kidney disease; kidney stones; liver or pancreas disorder; digestive/intestinal disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; muscular dystrophy; infertility/reproductive organ disorder; congenital disease or birth defect; cerebral palsy? Yes No
- In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? Yes No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest. #	Name of Individual	Diagnosis	Treatment	Medication	Onset Date	Date(s) of Treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			

4. SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) Please read this section carefully before signing the application.

I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers in sections 1 through 3 above and in sections 5 through 10 on page 2 and 3 are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem Blue Cross and Blue Shield in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to coverage or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being rescinded or cancelled.

READ THE TERMS SECTIONS 4 AND 11 CAREFULLY BEFORE SIGNING. PLEASE REVIEW YOUR APPLICATION FOR ERRORS OR OMISSIONS.

Applicant Signature Please Print Name Date / /

ANTHEM USE ONLY
Coordination of Benefits? Yes No Pre-ex (date)

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10. Life and Disability Insurance					
<input type="checkbox"/> Basic Life	<input type="checkbox"/> Basic AD&D	<input type="checkbox"/> Short Term Disability	<input type="checkbox"/> Anthem By Design Short Term Disability-BUY UP	Life Class	
<input type="checkbox"/> Dependent Life	<input type="checkbox"/> Optional AD&D	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Anthem By Design Long Term Disability-BUY UP		
Optional Life: _____ x annual earnings OR \$ _____			<input type="checkbox"/> Anthem By Design Basic Life-BUY UP		
Current Income: \$ _____ <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			(Complete separate election form)		

Primary Beneficiary	Last name	First name, M.I.	Social Security #	Relationship to applicant	Age
			- -		
Contingent Beneficiary	Last name	First name, M.I.	Social Security #	Relationship to applicant	Age
			- -		

11. SIGNIFICANT TERMS, CONDITIONS AND (UNDERWRITES LIFE AND DISABILITY COVERAGES ONLY) AUTHORIZATIONS (TERMS) Please read this section carefully before signing the application in Section 4.

- I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
- I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied (Anthem Life Insurance Company (underwrites life and disability coverages only) may accept certain persons or conditions for coverage. If accepted, my plan may exclude coverage for pre-existing conditions (Not applicable to MO HMO and Life insurance).
- I understand that Anthem imposes a pre-existing condition exclusion. The pre-existing exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period (90 days in Kansas) prior to enrollment. This exclusion may last up to 12 months (90 days in Kansas) from the first day of coverage, or if in a waiting period, from the first day of the waiting period. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 31 days of birth, adoption or placement for adoption. I understand the pre-existing exclusion waiting period is reduced by the number of days of prior creditable coverage provided there has not been a break in coverage of more than 63 days. To reduce the pre-existing exclusion waiting period, Anthem must receive a copy of the certificate of prior creditable coverage from the prior Health Insurance Carrier. (Not applicable to MO HMO products.)
- If I am declining enrollment for myself or my dependent(s) (including my spouse) because of other health insurance or group health plan coverage, I understand that I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards my coverage or my dependent's other coverage). However, I must request enrollment within 31 days after my coverage or my dependent's other coverage ends (or after the employer stops contribution toward the other coverage). In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent(s) provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.
- Life and disability products are underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross Blue Shield Association.

Your health coverage will be provided by one of the following companies:

Anthem Blue Cross and Blue Shield is the trade name RightCHOICE Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), and HMO Missouri, Inc. use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. Life and disability products are underwritten by Anthem Life Insurance Company (ALIC). RIT, HMO Missouri, Inc., HALIC and ALIC are independent licensees of the Blue Cross and Blue Shield Association.

By signing Section 4, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms. I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative. **Thank you for choosing Anthem Blue Cross and Blue Shield.**