

# Employee Change Form

## For 2-50 Employee Small Groups

### Virginia



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.			
<input type="checkbox"/> Address change	<input type="checkbox"/> Add spouse or dependent	<input type="checkbox"/> Enrollment in Medicare (Fill in Section E)	<input type="checkbox"/> Cancel coverage
<input type="checkbox"/> Name change	<input type="checkbox"/> Cancel spouse or dependent	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Benefit change	<input type="checkbox"/> Change Primary Care Physician (PCP)		
Event reason – Required. Check all that apply.			
<input type="checkbox"/> Add	<input type="checkbox"/> Open enrollment	<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth of child
<input type="checkbox"/> Change	<input type="checkbox"/> Other insurance	<input type="checkbox"/> Death	<input type="checkbox"/> Divorce
<input type="checkbox"/> Cancel	<input type="checkbox"/> Adoption of child		
	<input type="checkbox"/> Involuntary loss of coverage		
	<input type="checkbox"/> 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.
	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	
Secondary phone no.			
Email address			
PCP name		PCP ID no.	Existing patient?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Section C: Family Information – Spouse and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.			
Event reason – Required. Check all that apply.			
<input type="checkbox"/> Add	<input type="checkbox"/> Open enrollment	<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth of child
<input type="checkbox"/> Change	<input type="checkbox"/> Other insurance	<input type="checkbox"/> Death	<input type="checkbox"/> Divorce
<input type="checkbox"/> Cancel	<input type="checkbox"/> Adoption of child		
	<input type="checkbox"/> Involuntary loss of coverage		
	<input type="checkbox"/> 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
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No		Spouse
PCP name		PCP ID no.	Existing patient?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the spouse have a different address?			
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please enter: _____			
Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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: Family Information – Continued**

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel		<b>Event reason – Required. Check all that apply.</b> <input type="checkbox"/> Open enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Other insurance <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Other – please explain: _____			
		<b>Event date/Requested effective date – Required</b> _____ (MM/DD/YYYY)			
Dependent last name		First name		M.I.	Social Security no.
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)		Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other   If other, what is relationship? _____	
PCP name			PCP ID no.		Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, please enter: _____					
Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> No					

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel		<b>Event reason – Required. Check all that apply.</b> <input type="checkbox"/> Open enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Other insurance <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Other – please explain: _____			
		<b>Event date/Requested effective date – Required</b> _____ (MM/DD/YYYY)			
Dependent last name		First name		M.I.	Social Security no.
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)		Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other   If other, what is relationship? _____	
PCP name			PCP ID no.		Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, please enter: _____					
Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> No					

<input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Cancel		<b>Event reason – Required. Check all that apply.</b> <input type="checkbox"/> Open enrollment <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child <input type="checkbox"/> Involuntary loss of coverage <input type="checkbox"/> Other insurance <input type="checkbox"/> Death <input type="checkbox"/> Divorce <input type="checkbox"/> Other – please explain: _____			
		<b>Event date/Requested effective date – Required</b> _____ (MM/DD/YYYY)			
Dependent last name		First name		M.I.	Social Security no.
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)		Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other   If other, what is relationship? _____	
PCP name			PCP ID no.		Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, please enter: _____					
Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? <input type="checkbox"/> Yes <input type="checkbox"/> 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
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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
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**Member dental coverage – select one:**  Employee only  Employee + Spouse  Employee + child(ren)  Family

**3. Vision Coverage**

<input type="checkbox"/> I am enrolling in my Employer’s vision plan, if any.	Contract code, if known
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**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) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> 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)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Health <input type="checkbox"/> Dental					Start:                     End:
	<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Health <input type="checkbox"/> Dental					Start:                     End:
	<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Health <input type="checkbox"/> Dental					Start:                     End:
	<input type="checkbox"/> Individual <input type="checkbox"/> Group	<input type="checkbox"/> Health <input type="checkbox"/> 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.

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