Anthem

Enrollment and Membership Change Form — Local 3144 & Executive Management & Confidential

1. Tell Us About You

Current Anthem BCBS Contract Number, if any

Last Name | First Name | M.I.

Home Address: Number and Street or P.O. Box | Apt.#

City | State | Zip Code

Home Telephone | Work Telephone

Marital Status
☐ Single ☐ Legally Separated ☐ Widowed
☐ Married ☐ Separated ☐ Divorced

Email address

2. New Membership

☐ NEW HIRE
☐ OPEN or RE- ENROLLMENT
☐ OTHER QUALIFYING EVENT
MM/ DD/ YY
Reason_____

3. Change Membership

CHANGE:
☐ ADDRESS (indicate **NEW** address at left)
☐ NAME (Indicate **Former** Name below & new name at left in Section 1)
_____
☐ OTHER REASON (Birth, Marriage, Divorce, Loss of Coverage Event etc.) _____
_____

EVENT DATE MM/ DD/ YY

To Be Completed By Employer

Requested Effective Date
MM/DD/YY

Firm Division No

Health Benefit Plan

For Office Use Only

Form revised 09//2018

4. Your Membership Choices – 3144 / EM

	Individual	Two Person	Family
☐ Century Preferred PPO	☐	☐	☐
☐ Bluecare POE	☐	☐	☐
☐ CentPref Comp Mix (CPCM)	☐	☐	☐
☐ Lumenos HD-HSA	☐	☐	☐
☐ DENTAL	☐	☐	☐

Are you or any other eligible dependent listed on this form currently confined to a hospital or healthcare facility, totally disabled or physically impaired? ☐ YES ☐ NO

5. Where You Work

Department / Division / School Name

ARE YOU ACTIVELY AT WORK?
☐ YES ☐ NO/ (IF NO) REASON ☐ SICK ☐ INJURED ☐OTHER

ARE YOU CURRENTLY CLAIMING WORKERS COMP. MEDICAL BENEFITS?
☐ YES ☐ NO

DO YOU WORK 30 OR MORE HOURS PER WEEK ☐ YES ☐ NO

DATE OF FULL TIME HIRE | DATE OF PART TIME HIRE | DATE OF REHIRE

6. List Members to Be Included / Added / Cancelled

Gender	Name (First/Middle/Last)	Add	Cancel	Social Security Number	Date of birth (MM/DD/YY)	**Primary Care Physician (PCP) Name & PCP #** Check ☒ the box if you currently use this physician
☐M ☐F	Self					☐Name City PCP#
☐M ☐F	Spouse					☐Name City PCP#
☐M ☐F	Dependent					☐Name City PCP#
☐M ☐F	Dependent					☐Name City PCP#
☐M ☐F	Dependent					☐Name City PCP#
☐M ☐F	Dependent					☐Name City PCP#

7. Tell Us About Your Other Insurance

Do you or any other member of your family have any other medical, dental, or Anthem BCBS coverage?
If yes, please fill in the information below ☐ Self ☐ Spouse ☐ Children

Name of Other Insurance Company | Name of Subscriber (Policy Holder) | Policy or ID No. | Reasons For Termination | First and Last Date of Coverage

8. Medicare/Medicaid

Do you or any covered member have Medicare/Medicaid coverage? ☐ YES ☐ NO
Have you or any covered member applied for Medicare/Medicaid disability? ☐ YES ☐ NO

Name (self)	Are you actively at work? ☐ YES ☐ NO	Retired Date MM/DD/YY	Name (Dependent)	Is this person actively at work? ☐ YES ☐ NO	Retirement Date MM/DD/YY

Medicare No.	EFFECTIVE DATES Medicare A (Hospital)	Medicare B (Medical)	Medicare No.	EFFECTIVE DATES Medicare A (Hospital)	Medicare B (Medical)
	MM/DD/YY	MM/DD/YY		MM/DD/YY	MM/DD/YY

I understand that false and or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

9. Employee Signature

Date MM / DD / YY

If you enroll in the group health benefits (medical, prescription, dental, vision) available to you as an employee of the City of New Haven, your share of premiums will be deducted from your pay tax-free. However, participation is voluntary. You may elect to not participate in the tax free premium feature of the plan before your benefits begin by signing a waiver form and returning it to the Human Resources office. You may renew or change your election at each open enrollment.

Anthem

INSTRUCTIONS
Please print all information

THANK YOU FOR CHOOSING OUR PLAN

How to Fill out This Form – Press Firmly – Please Use Ballpoint Pen

Please read the instructions before filling out he attached Enrollment and Membership Change Form. Here's what you need to fill out, so we can enroll you without delay.

For membership changes, complete:
Section 1. "Tell Us About You"
Section 3. "Change Membership"
In addition, when adding/canceling eligible dependents, or changing a primary care physician (PCP), complete:
Section 6. "List Family Members"

1. Tell Us About You

Please complete all information in this section.

2. New Membership

Please check the appropriate box. If you are enrolling as a COBRA or C.G.S. 38a – 538 extension of coverage member, please indicate the date of the qualifying event, and also the Reason Code.

REASON CODE	QUALIFYING EVENT	REASON CODE	QUALIFYING EVENT
01	Divorce	04	Dependent child no longer eligible under terms of employer's contract
02	Termination of employment	05	Reduction in hours/no longer meet group eligibility requirements
03	Spouse of deceased employee		

3. Change Membership

Please check the appropriate box if you are changing membership. Please indicate the reason and date. Some examples include:

ADDRESS	MARRIED	DEPENDENT
PCP	LEGALLY SEPARATED	BIRTH
NAME	DIVORCE	ADOPTION

4. Your Membership Choices

A. Tell us the plan name in which you are enrolling. To do this, check the appropriate box next to your selection choice(s). If you choose "BlueCare", "Dental", or "Other", please be sure to write the name of the plan as instructed by your benefits coordinator.
B. Please Check Individual, two person, or family for each plan choice.

5. Where You Work

Please complete all information in this section

6. List Members to Be Added/Cancelled

A. Please be sure to complete all information in this section including social security numbers, and the name(s) of recognized institution(s) for full time student dependent(s) age 19 or over.
B. Indicate Last name if different
C. If any dependent(s) listed are disabled, please circle that dependent and attach the appropriate application which may be obtained from your benefits coordinator.
D. A Primary Care Physician (PCP) must be selected for all members. Each member may choose a different PCP. Specialists cannot be selected as PCP's. Please also write in the city or town where the PCP's office is located, and the PCP provider number.
An asterisk (*) next to a physicians name in the provider listing means that the physician can only be seen by a current patient. If you are a current patient and that physician wants to be your PCP, please check the box next to the physicians name on the application.

7. Tell Us About Your Other Insurance

Please be sure to note any other insurance information in this section

8. Medicare/Medicaid

Please complete all information in this section if you or an enrolled member is covered by Medicare or Medicaid, or have applied for Medicare/Medicaid disability.

9. Employee Signature

Please sign and return the completed application to your benefits coordinator. Save a copy of this form for your records until you receive you identification card(s). A copy of this application is provided to you as part of your Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein.