Employer Enrollment Application
For 1-50 Employee Small Groups
Ohio

Anthem BlueCross BlueShield

Underwritten by Community Insurance Company

AnthemLife

Please complete in blue or black ink only.

Section A: Company Information

Company name			Employer tax ID no. (required)
Company street address			
City	County	State	ZIP code
Billing address – If different from above			
City	County	State	ZIP code

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

If yes, association name: _____

Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Government unit/agency ☐ Limited Liability Company (LLC) ☐ Labor union trust ☐ Other: _____

SIC code – Required	Type of business (be specific)	Date business established
Head of firm	Company contact name	
Company contact 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. The open enrollment period does not apply to Life and Disability products.

Section B: Application Type

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

Reset Form Save and Print

Employer tax ID no. (required)

Section C: Type of Coverage

1. Medical Coverage – check all that apply

PPO Plans	Anthem Gold	Anthem Silver	Anthem Bronze
Blue Access	☐ 500/20%/3500 ☐ 1000/20%/3750 ☐ 1000/20%/4500 ☐ 1000/30%/4500 Plus ☐ 1500/20%/4000 ☐ 1750/0%/3425 w/HSA ☐ 2000/0%/2500 w/HSA ☐ 2000/20%/4000 ☐ 2500/0%/3500 ☐ 2500/20%/4250 ☐ 3500/0%/4250 ☐ 3750/0%/4750 ☐ 1000/20%/4000 Focus ☐ 2000/0%/3000 Focus w/HSA ☐ 2250/0%/2250 Plus w/HSA	☐ 2000/50%/6350 ☐ 2000/50%/6350 P2 ☐ 2600E/20%/4500 Plus w/HSA ☐ 2600EC/30%/5000 w/HSA ☐ 3000EC/0%/3500 w/HSA ☐ 3000/20%/6850 ☐ 3000/30%/6500 Plus ☐ 3500E/0%/3500 w/HSA ☐ 3500E/0%/4500 w/HSA ☐ 3500E/0%/5000 w/HSA ☐ 5000/20%/6850 ☐ 6000/0%/6850 ☐ 2600E/30%/4750 w/HSA ☐ 3000/20%/6800 Focus ☐ 5000/0%/6800 Focus ☐ 5000/20%/6800 Focus	☐ 3500E/50%/6450 w/HSA ☐ 5000EC/20%/6350 w/HSA ☐ 5000EC/20%/6450 w/HSA ☐ 5000EC/20%/6550 Plus w/HSA ☐ 5250EC/0%/6550 Plus w/HSA ☐ 5500E/0%/6450 w/HSA ☐ 6000E/0%/6000 w/HSA ☐ 6550E/0%/6550 w/HSA ☐ 4500E/50%/6350 Focus w/HSA ☐ 5500EC/30%/6500 Focus w/HSA ☐ 6300/30%/6850 Focus

Other: _____

Choose your medical contribution for each month – only **one** choice is allowed.

Contribution option 1: Traditional option – We will contribute (50% to 100%): _____% per employee _____% per dependent (optional)

Contribution option 2: Percentage of plan option – We will contribute: _____% to _____ plan)

For Health Savings Account (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

Riders/Optional Benefits – select additional optional benefits

☐ Calendar Year ☐ Plan Year ☐ Alliances

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

Contract Code	Contract Code	Contract Code
1.	4.	7.
2.	5.	8.
3.	6.	9.

Employer tax ID no. (required)

2. Dental Coverage — check all that apply

PPO dental plans — These plans include Pediatric Dental Essential Health Benefits.

☐ Anthem Dental Family ☐ Anthem Dental Family Enhanced ☐ Anthem Dental Pediatric
☐ Other: _____

Choose your dental contribution for each month: _____% per employee _____% per dependent (optional)

PPO Dental Prime and Dental Complete plans — These plans do NOT include Pediatric Dental Essential Health Benefits.

Value	Classic		Enhanced	Voluntary
☐ Value Prime OH-1A ☐ Other: _____	☐ Classic Prime OH-2A ☐ Classic Prime OH-2B ☐ Classic Prime OH-2C ☐ Classic Prime OH-2D ☐ Classic Prime OH-2E ☐ Classic Prime OH-2F ☐ Classic Prime OH-2G ☐ Classic Prime OH-2H ☐ Classic Prime OH-2J ☐ Classic Prime OH-2K ☐ Classic Prime OH-2L ☐ Classic Prime OH-2M ☐ Classic Complete OH-2AA ☐ Classic Complete OH-2AB ☐ Classic Complete OH-2AC ☐ Classic Complete OH-2AD	☐ Classic Complete OH-2AE ☐ Classic Complete OH-2N ☐ Classic Complete OH-2P ☐ Classic Complete OH-2Q ☐ Classic Complete OH-2R ☐ Classic Complete OH-2S ☐ Classic Complete OH-2T ☐ Classic Complete OH-2U ☐ Classic Complete OH-2V ☐ Classic Complete OH-2W ☐ Classic Complete OH-2X ☐ Classic Complete OH-2Y ☐ Classic Complete OH-2Z ☐ Other: _____	☐ Enhanced Prime OH-3A ☐ Enhanced Prime OH-3B ☐ Enhanced Complete OH-3C ☐ Enhanced Complete OH-3D ☐ Enhanced Complete OH-3E ☐ Enhanced Complete OH-3F ☐ Enhanced Complete OH-3G ☐ Enhanced Complete OH-3H ☐ Enhanced Complete OH-3J ☐ Enhanced Complete OH-3K ☐ Enhanced Complete OH-3L ☐ Enhanced Complete OH-3M ☐ Enhanced Complete OH-3N ☐ Enhanced Complete OH-3P ☐ Other: _____	☐ Voluntary Prime OH-4B ☐ Voluntary Complete OH-4A ☐ Voluntary Complete OH-4C ☐ Voluntary Complete OH-4D ☐ Voluntary Complete OH-4E ☐ Voluntary Complete OH-4F ☐ Voluntary Complete OH-4G ☐ Other: _____

Contract Codes — Indicate the contract code(s) for the dental plan(s) selected.

Contract code:	1.	2.	

Is this plan intended to replace any existing group dental coverage? ☐ Yes ☐ No
If yes, please complete the information below for each group dental insurance plan you now have.

Insurer	Type of plan (DHMO, PPO)	Effective date	Proposed termination date

Voluntary plan participation

5–50 Eligible Employees: A minimum of five employees must enroll (there is no participation-percentage requirement).
Dual Option is not available for Voluntary plans.

Value, Classic and Enhanced plan participation

2–4 Eligible Employees: 100% of eligible employees not covered by another dental plan (and a minimum of two employees) are required to enroll.

5–50 Eligible Employees: A minimum of 75% of employees not covered by another dental plan are required to enroll. A minimum of two must enroll.
For orthodontia, a minimum of ten (10) employees must enroll. Dual Option (employer can select two plans to offer to employees) is available for groups with at least 15 net eligible employees. A minimum of five employees must enroll in each of the two options and the two plans offered must have a 20% premium differential.

Medical Lock (Packaged Enrollment): All members enrolled in an Anthem medical plan must enroll in Anthem dental. Dental tiering must be identical on the medical and dental plans. Example: enrollees with Single medical coverage must also have Single dental coverage; enrollees with Family medical coverage must also have Family dental coverage.

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 A6	☐ Anthem Blue View Vision B1 ☐ Anthem Blue View Vision B2 ☐ Anthem Blue View Vision B3 ☐ Anthem Blue View Vision B4 ☐ Anthem Blue View Vision B5 ☐ Anthem Blue View Vision B6	☐ Anthem Blue View Vision C1 ☐ Anthem Blue View Vision C2 ☐ Anthem Blue View Vision C3 ☐ Anthem Blue View Vision C4 ☐ Anthem Blue View Vision C5	☐ Anthem Blue View Vision C6 ☐ Anthem Blue View Vision C7 ☐ Anthem Blue View Vision C8 ☐ Anthem Blue View Vision C9	☐ Anthem Blue View Vision MO1 ☐ Anthem Blue View Vision MO2 ☐ Anthem Blue View Vision MO3 ☐ Anthem Blue View Vision MO4 ☐ Anthem Blue View Vision MO5 ☐ Anthem Blue View Vision MO6 ☐ None

Choose your vision contribution for each month: _____% per employee _____% per dependent (optional)

Contract Code — Indicate the contract code for the vision plan selected.

Contract code:	1.	

Employer tax ID no. (required)

4. Life and Disability Coverage — check all that apply. A minimum of two subscribers must enroll.					
Life Products			Disability Products		
Choose Life Product and Group Contribution Percentage:			**Choose Disability Product and Group Contribution Percentage:**		
Product choice			Product choice		
☐ None	Percentage	Contract code	☐ None	Percentage	Contract code
☐ Basic Life & AD&D	_______%	____________	☐ Short Term Disability	_______%	____________
☐ Basic Dependent Life	_______%	____________	☐ Long Term Disability	_______%	____________
☐ Optional/Voluntary Life*	_______%	____________	☐ Voluntary Short Term Disability*	_______%	____________
☐ Optional/Voluntary AD&D*	_______%	____________	☐ Voluntary Long Term Disability*	_______%	____________
☐ Optional/Voluntary Dependent Life*	_______%	____________	*Available for Groups of 20+		
*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 ☐ Yes ☐ No	Request actively at work waiver ☐ Yes ☐ No	Waiver request approved ☐ Yes ☐ No	Underwriter approval

Employee name			Amount of insurance
Date of birth	Last date worked	Reason not working	Date expected to return
Insured by prior carrier ☐ Yes ☐ No	Request actively at work waiver ☐ Yes ☐ No	Waiver request approved ☐ Yes ☐ No	Underwriter approval

Employee name			Amount of insurance
Date of birth	Last date worked	Reason not working	Date expected to return
Insured by prior carrier ☐ Yes ☐ No	Request actively at work waiver ☐ Yes ☐ No	Waiver request approved ☐ Yes ☐ No	Underwriter approval

Employee name			Amount of insurance
Date of birth	Last date worked	Reason not working	Date expected to return
Insured by prior carrier ☐ Yes ☐ No	Request actively at work waiver ☐ Yes ☐ No	Waiver request approved ☐ Yes ☐ No	Underwriter approval

Employer tax ID no. (required)

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**:

   ☐ None ☐ First of month after hire date
   ☐ 30 days ☐ 60 days ☐ 90 days
7. New eligible enrollees will become effective on:

   ☐ First of month following completion of waiting period/probationary period

   ☐ Day following completion of waiting period/probationary periods (required for 90 day waiting period)

   The standard effective date is first of the month following the waiting period/probationary period.
8. Do you wish to offer coverage for domestic partners?

   ☐ Yes ☐ No
9. 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 is primary (20 or more employees)

   Anthem Blue Cross and Blue Shield 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.
10. 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

Eligibility and Waiting Period

Is the eligibility period for Life and/or Disability the same as the Anthem medical policy eligibility period? ☐ Yes ☐ No

Enter the Life and Disability eligibility period below if it differs from the Anthem medical policy eligibility period.

Eligible full-time employees must be actively at work, and must satisfy any applicable waiting period. Minimum work hours required for eligible full-time employees is 30 hours unless otherwise indicated.

The waiting period for individuals employed **on or before** the effective date will be:

☐ None

☐ ____ days of continuous employment

☐ First premium due date following ____ days of continuous employment

The waiting period for individuals employed **on or after** the effective date will be:

☐ None

☐ ____ days of continuous employment

☐ First premium due date following ____ days of continuous employment

Does any class(es) have a different waiting period? ☐ Yes ☐ No

If yes, please describe: _____

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

Employer tax ID no. (required)

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.

Employer understands and certifies 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 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 or their designated agent(s), any information required in connection with administration of the coverage.
4. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.
5. That statements of medical history will be required of employees, and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem.
6. That approval for this coverage may cancel any prior contracts and/or coverage with Anthem effective immediately preceding the effective date of the employer's coverage.
7. To pay Anthem 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, to assume responsibility for handling the COBRA and state-mandated continued group coverage and/or conversion process, if applicable.
8. That claims filed by or on behalf of members may, at Anthem's option, be suspended if premiums are not timely received.
9. If applicable, employer will receive on behalf of members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.
10. The advance premium check does not create temporary or interim coverage and that receipt and deposit of that payment does not guarantee issuance of coverage. Rather, issuance of coverage is expressly conditioned on Anthem'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 except to refund the payment. The employer will be responsible for returning to individual
11. That in order for Anthem 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, 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 may be different than the coverage applied for herein. In that event, Anthem shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.
12. 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 by the employer. Anthem reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any misstatements on employees' application or failure to report new medical information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rates as of the effective date of coverage.
13. The entire application for Group coverage 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.
14. All employees applying for coverage are employees of the employer and receive salary or wages documented on state and/or federal payroll reports. Eligible full-time employees must work at least 30 hours per week, must be actively at work, must have satisfied any applicable eligible waiting period.
15. The requested coverage is not in effect unless and until this application is approved by Anthem, that approval of coverage shall be evidenced by issuing Group 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.
16. The employer acknowledges that he has signed the attached benefit proposals indicating the coverages requested.
17. The broker listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.
18. This small group off-exchange product is not eligible for a premium tax credit.
19. The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits.

Fraud Notice

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Sign here	Company officer signature X	Printed name	Title	Date (MM/DD/YYYY)
Accepted by Anthem Blue Cross and Blue Shield and/or Anthem Life authorized representative		Printed name		Date (MM/DD/YYYY)

Employer tax ID no. (required)

Section G: Agent/Producer/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 Blue Cross and Blue Shield and/or 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 Blue Cross and Blue Shield and/or Anthem Life reviews and approves the application and the employer receives a written notice from Anthem Blue Cross and Blue Shield and/or Anthem Life.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Anthem shall be paid to an agent/broker/producer not appointed/approved by Anthem Blue Cross and Blue Shield and/or Anthem Life.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Anthem Blue Cross and Blue Shield and/or Anthem Life that the coverage being applied for by this application is accepted.

Writing payable/sub-agent/producer/broker			**%**	**Second writing payable/sub-agent/producer/broker**			**%**
Agency name		Agency ID no.		Agency name		Agency ID no.	
Agent/producer/broker name				Agent/producer/broker name			
Agent/producer/broker ID no.				Agent/producer/broker ID no.			
Payable/sub-agent/producer/broker ID no. if different				Payable/sub-agent/producer/broker ID no. if different			
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)	

For General Agent/Producer/Broker use only			
General agent/producer/broker name		Agent/producer/broker ID no.	
Street address	City	State	ZIP code

Sales Representative and Account Manager			
Sales representative name		Sales representative ID no.	
Street address	City	State	ZIP code
Account manager name		Account manager ID no.	

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

Underwritten by Community Insurance Company

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