Anthem

In Connecticut, Anthem Blue Cross and Blue Shield is a trade name of Anthem Health Plans, Inc., an independent licensee of the Blue Cross and Blue Shiels Association.
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INSTRUCTIONS

THANK YOU FOR CHOOSING OUR PLAN.

How to Fill Out This Form -

Please read these instructions before filling out the attached Enrollment and Membership Change Form

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, an 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 LEGALLY SEPARATED BIRTH NAME DIVORCED ADOPTION

When adding or cancelling members, please complete all information in Section 6.

4. Your Membership Choices

There is only one plan choice for type of coverage.
Please check the box for individual, two person or family coverage on each line.

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 birth dates. This information is required for all members in order to process your application.
B. Indicate last name if different
C. For domestic partnerships, please include the appropriate certification forms. See http://www.gme.uchc.edu/health_consortium/pdfs/bluedomestic.pdf for 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 or Medicaid disability.

9. Employee Signature

Please print, sign and scan or fax the completed application. To e-mail, scan and send securely using your uchc.edu e-mail address to CAHCGroup@UCHC.edu. **THIS WILL ENSURE PROTECTION OF YOUR PERSONAL INFORMATION.** To fax, send to 860-676-1303.

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Enrollment and Membership Change Form

1. Tell Us About You

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

2. New Membership

☐ NEW HIRE
☐ OPEN ENROLLMENT
☐ COBRA/C G.S. 38a-538

DATE OF QUALIFYING EVENT MM / DD / YR

REASON ________ SEE INTRUCTION SHEET

3. Change Membership

CHANGE
☐ ADDRESS
☐ NAME
INDICATE FORMER NAME
☐ OTHER
REASON
DATE OF QUALIFYING EVENT MM / DD / YR

To Be Completed By Employer

Requested Effective Date
07/01/2019

Firm Division No.
068965-015

For Office Use On

4. Your Membership Choices

	Individual	Two Person	Family
☐ **CENTURY PREFERRED/PPO**	☐	☐	☐
☐ **DENTAL**	☐	☐	☐

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

5. Where You Work

Capital Area Health Consortium
270 Farmington Avenue Suite 352
Farmington CT 06032-1994

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 REHIRE MM / DD / YR

6. List Members To Be Added/Cancelled

SEX	NAME (LAST NAME/FIRST/M.I.)	Add	Cancel	Social Security Number	Date of Birth (MM/DD/YYYY)
☐ M ☐ F	Self			___ ___ ___ ___ ___ ___ ___ ___ ___	MM / DD / YR
☐ M ☐ F	Spouse			___ ___ ___ ___ ___ ___ ___ ___ ___	MM / DD / YR
DEPENDENTS: Children over 19 may be eligible if disabled, or unmarried full-time students. Please circle disabled dependent.					
☐ M ☐ F	Dependent			___ ___ ___ ___ ___ ___ ___ ___ ___	MM / DD / YR
☐ M ☐ F	Dependent			___ ___ ___ ___ ___ ___ ___ ___ ___	MM / DD / YR
☐ M ☐ F	Dependent			___ ___ ___ ___ ___ ___ ___ ___ ___	MM / DD / YR

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? ☐ YES ☐ NO

If yes, please fill in the information below. ☐ Self ☐ Spouse ☐ Children

Name of Company	Name of Subscriber (Policyholder)	Policy or ID No.	Reason for Termination	First and Last Date of Coverage

8. Medicare/Medicaid

Do you or any other covered member have Medicare/Medicaid coverage? ☐ YES ☐ NO

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

Name(s) of Medicare Beneficiaries	Are you actively at work?	Retirement date (MM/DD/YY)	Health insurance claim no.	Medicare Part A effective date	Medicare Part B effective date	Medicare Part D effective date
	☐ YES ☐ NO	MM / DD / YR				
	☐ YES ☐ NO	MM / DD / YR				
	☐ YES ☐ NO	MM / DD / YR				

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 / YR

Graduate Medical Education
263 FARMINGTON AVENUE, LM068
FARMINGTON, CT 06030-1921
PHONE 860.679.2147
FAX 860.679.4624

Capital Area Health Consortium
270 FARMINGTON AVENUE, SUITE 352
FARMINGTON, CT 06032-1994
PHONE 860.676.1110
FAX 860.676.1303

MEDICAL/DENTAL WAIVER

I am declining Medical Insurance at this time ________

I am declining Dental Insurance at this time* ________

____

Print Name

_______________________________________ ____________________

Signature Date

*If Medical insurance is taken without Dental Insurance, you will not be able to enroll in the Dental plan until the next Open Enrollment, which is the month of June with a July 1 effective date.