Anthem

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 INSTRUCTION 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

Firm Division No.
068965M003
068965D003
068965V001

For Office Use On

4. Your Membership Choices

	Individual	Two Person	Family
☐ CENTURY PREFERRED/PPO	☐	☐	☐
☐ DENTAL	☐	☐	☐
☐ BLUE VIEW VISION	☐	☐	☐

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