Anthem

Enrollment and Membership Change Form

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

2. New Membership

☐ NEW HIRE
☐ OPEN ENROLLMENT
☐ COBRA/C G.S. 38a-538
DATE OF QUALIFYING EVENT ____/____/____
REASON ____ SEE INTRUCTION SHEET
☐ NEW GROUP (ORIG ENROLLMENT)

3. Change Membership

CHANGE
☐ ADDRESS
☐ NAME
INDICATE FORMER NAME
☐ OTHER
REASON
DATE OF QUALIFYING EVENT ____/____/____

To Be Completed By Employer

Requested Effective Date ____/____/____

Firm Division No. 068965-015

Health Benefit Plan

For Office Use Only

4. Your Membership Choices

	Individual	Two Person	Family
☐ BLUECARE PLAN NAME	☐	☐	☐
☐ CENTURY PREFERRED/PPO	☐	☐	☐
☐ DENTAL PLAN NAME	☐	☐	☐
☐ HMO-NEW ENGLAND	☐	☐	☐
☐ OTHER PLAN NAME	☐	☐	☐

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 PART TIME HIRE ____/____/____ | DATE OF REHIRE ____/____/____

6. List Members To Be Added/Cancelled

SEX	NAME (FIRST/MIDDLE/LAST NAME)	Add	Cancel	Social Security Number	Date of Birth (MM/DD/YYY)	Full Time Student Age 19 or Over (Circle Yes or No)	BELOW PLEASE INDICATE NAME OF RECOGNIZED INSTITUTION FOR FULL TIME STUDENTS
☐ M ☐ F	Self				/ /		
☐ M ☐ F	Spouse				/ /		
DEPENDENTS: Children over 19 may be eligible if disabled, or unmarried full-time students. Please circle disabled dependent.							
☐ M ☐ F	Dependent				/ /	Y N	
☐ M ☐ F	Dependent				/ /	Y N	
☐ M ☐ F	Dependent				/ /	Y N	

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

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

Name (Dependent)	Is person actively at work? ☐ YES ☐ NO	Retirement Date ___/___/___	Name (Self)	Are you actively at work ☐ YES ☐ NO	Retirement Date ___/___/___
Medicare No.	Medicare A (Hospital) Effective Dates ___/___/___	Medicare B (Medical) ___/___/___	Medicare No.	Medicare A (Hospital) Effective Dates ___/___/___	Medicare B (Medical) ___/___/___

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 / /

WHITE - ANTHEM BCBS YELLOW - ANTHEM BCBS PINK - EMPLOYER COPY BLUE - EMPLOYEE COPY