

Employee Change Form Application



Anthem provides administrative claims payment services only, and does not assume any financial risk or obligation with respect to claims.

Please complete this form ONLY when making changes to your existing coverage. If you are APPLYING for coverage or ADDING a dependent(s), complete the "Anthem Enrollment Application" instead of this form. When completing section 2, be sure to include the date of the event causing the change(s). If you are cancelling coverage for a dependent, changing a PCP, or changing a name, please provide a reason in the designated sections.

Complete in ink and return to your employer, using extra sheets of paper if necessary.

NOTE: Some changes may be made by accessing www.anthem.com. Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through www.anthem.com.

1. Employer Use: Employer Name and Address: Diocese of Gary 9292 Broadway, Merrillville, IN 46410		Group # 00083915		Sub-group #		Request Effective Date / /		Applicant #/Dept. name				
Anthem use: Plan		Health Effective Date / /		Dental Effective Date / /		Vision Effective Date / /		PCP <input type="checkbox"/> Yes <input type="checkbox"/> No				
								COB <input type="checkbox"/> Yes <input type="checkbox"/> No				
								Pre-ex (date) / /				
2. Reason for Change Event date / /				3. Type of Coverage/Plan								
<input type="checkbox"/> Address <input type="checkbox"/> Enrollment in Medicare <input type="checkbox"/> Cancel / Waiving Coverage (see section 8) <input type="checkbox"/> Conversion <input type="checkbox"/> Benefit change <input type="checkbox"/> Cancel dependent <input type="checkbox"/> PCP change <input type="checkbox"/> Name change <input type="checkbox"/> Other _____				Health Coverage <input type="checkbox"/> HMO* (not applicable to Ohio) <input checked="" type="checkbox"/> PPO <input type="checkbox"/> EPO (Ohio only) <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage <input type="checkbox"/> POS* <input type="checkbox"/> Blue Traditional* <input type="checkbox"/> Traditional (Indiana and Ohio only) <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage								
				Dental Coverage		Vision Coverage						
				<input type="checkbox"/> PPO <input type="checkbox"/> Traditional (Indiana and Ohio only)		<input type="checkbox"/> Vision						
				<input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage		<input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage						
4. Employee Information *Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.												
Last name			First name, M.I.			Date of birth / /		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Social Security #		
Home address				City		State		Zip code		County (KY residents include Municipality)		
Hours worked per week		Anthem-PCP name and address*				Anthem-PCP ID number*		New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If PCP is a change, please indicate the reason for the change:												
5. Family Information Spouse and dependents to be changed/cancelled. (Attach a separate sheet if necessary)* Only complete Primary Care Physician (PCP) information for HMO or POS products.												
1 <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Last name			First name, M.I.							
Date of birth / /		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Social Security #		Relationship to employee <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other _____		Reason for change				
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)												
Anthem-PCP name and address*				Anthem-PCP ID number*				New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If PCP is a change, please indicate the reason for the change:												
2 <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Last name			First name, M.I.							
Date of birth / /		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Social Security #		Relationship to employee <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other _____		Reason for change				
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)												
Anthem-PCP name and address*				Anthem-PCP ID number*				New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If PCP is a change, please indicate the reason for the change:												
3 <input type="checkbox"/> Change <input type="checkbox"/> Cancel		Last name			First name, M.I.							
Date of birth / /		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Social Security #		Relationship to employee <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Other _____		Reason for change				
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)												
Anthem-PCP name and address*				Anthem-PCP ID number*				New patient? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If PCP is a change, please indicate the reason for the change:												

Signature required on the reverse side of this form.

6. Other Health Coverage <i>Please check one:</i> <input type="checkbox"/> YES (complete below) <input type="checkbox"/> NO On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.				
Provide name, phone number and address of the HMO or insurance company			Policy/certificate number	Effective date / /
Policy/certificate holder's name	Social security number - -	Date of birth / /	Relationship to applicant	
If you and/or your dependents are enrolled in Medicare or Medicaid, complete the following.				
Enrollee's name(s)	Medicare/Medicaid ID #	Medicare Part A effective date / /	Medicare Part B effective date / /	ESRD onset date / /
Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date / /	Medicare Part D term date / /	
Reason for Medicare entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD & Disability <input type="checkbox"/> End Stage Renal Disease (ESRD)				
7. Read these Significant Terms, Conditions and Authorizations carefully before signing. Please review your application for errors or omissions.				
1. I may not assign any payment under my Anthem Blue Cross and Blue Shield administered benefit plan. 2. I authorize deduction from my wages/pension, if necessary for the required payment for the benefit for which I, or any dependents have applied. 3. I am applying for the benefit selected on this application. If I select a coverage, or combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application. 4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions. 5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits. 6. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.		I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of enrollment in the benefit plan. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to benefit rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission of cancellation of my benefits. Kentucky: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.		
Applicant Signature				Date / /
8. Waiver of coverage for employee and/or any eligible dependent not enrolling				
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All				
Name of person waiving			Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None	
Employer name		Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)		
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All				
Name of person waiving			Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None	
Employer name		Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)		
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All				
Name of person waiving			Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None	
Employer name		Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)		
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> All				
Name of person waiving			Already protected by coverage of <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None	
Employer name		Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)		
I certify that I have been given an opportunity to apply for the employer's health benefits plan, and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such benefits hereafter, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group benefit booklet, if a dependent or I are late enrollees. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.				
Applicant signature				Date / /

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.
 In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.
 In Wisconsin, Blue Cross Blue Shield of Wisconsin ("BCBSWI") administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation ("CompCare") administers the HMO and POS policies;
 In Missouri: Anthem Blue Cross and Blue Shield is the trade name RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC) and HMO Missouri, Inc. use to do business in most of Missouri.
 RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc.
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