Employee Change Form Application

Anthem.

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 #	Sub-group #	Request Effective Date	Applicant #/Dept. name			
00083915		/ /				
Anthem use: Plan	Health Effective Date / /	~~Dental Effective Date~~ / /	~~Vision Effective Date~~ / /	~~PCP~~ ☐ Yes ☐ No	~~COB~~ ☐ Yes ☐ No	~~Pre-ex (date)~~ / /

2. Reason for Change
Event date ___/___/___
- ☐ Address
- ☐ Enrollment in Medicare
- ☐ Cancel / Waiving Coverage
- ☐ Benefit change
- ☐ Cancel dependent
- ~~☐ PCP change~~
- ☐ Name change
- ☐ Other _____

3. Type of Coverage/Plan

Health Coverage
PPO – Blue Access
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family coverage
- ☐ No coverage

Dental Coverage
- ☐ PPO _____
- ☐ Traditional (Indiana and Ohio only)
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family coverage
- ☒ No coverage

Vision Coverage
- ☐ Vision _____
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family coverage
- ☒ 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 ☐ M ☐ F	Social Security # – –	☐ Single ☐ Divorced ☐ Married
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?~~ ~~☐ Yes ☐ 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 ☐ Change ☐ Cancel	Last name	First name, M.I.	
Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Relationship to employee ☐ Spouse ☐ Daughter ☐ Son ☐ Other _____	Reason for change
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)			
~~Anthem PCP name and address*~~		~~Anthem PCP ID number*~~	~~New patient?~~ ~~☐ Yes ☐ No~~
~~If PCP is a change, please indicate the reason for the change.~~			

2 ☐ Change ☐ Cancel	Last name	First name, M.I.	
Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Relationship to employee ☐ Spouse ☐ Daughter ☐ Son ☐ Other _____	Reason for change
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)			
~~Anthem PCP name and address*~~		~~Anthem PCP ID number*~~	~~New patient?~~ ~~☐ Yes ☐ No~~
~~If PCP is a change, please indicate the reason for the change.~~			

3 ☐ Change ☐ Cancel	Last name	First name, M.I.	
Date of birth / /	Sex ☐ M ☐ F	Social Security # - -	Relationship to employee ☐ Spouse ☐ Daughter ☐ Son ☐ Other _____	Reason for change
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)			
~~Anthem PCP name and address*~~		~~Anthem PCP ID number*~~	~~New patient?~~ ~~☐ Yes ☐ 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 — *Please check one:* ☐ YES *(complete below)* ☐ 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:

☐ Age ☐ Disability ☐ ESRD & Disability ☐ 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 / /