

# Employer Enrollment Application/Change Form

## BeneFits for 1-50 Employee Small Groups in Colorado



- BeneFits Plans:**
- Hospital BeneFits
  - Hospital BeneFits Plus
  - Hospital BeneFits Preferred
  - Lumenos HSA 3000 100/70
  - PPO \$25 Copay - \$2,000 Deductible
  - PPO \$35 Copay GenRx
  - Classic HMOSelect™\*

- Hospitalization only benefits
  - Hospitalization plus limited doctor visit benefits
  - Hospitalization and limited doctor visit, dental and vision benefits
  - Comprehensive PPO coverage with a Health Savings Account
  - Comprehensive PPO coverage
  - Comprehensive PPO coverage with generic-only drug benefits
  - Comprehensive HMO coverage
- PPO Basic    PPO Standard    HMO Basic    HMO Standard

**OR** Colorado-mandated plan(s) (choose only one plan):

\*The Classic HMOSelect plan is only available in specific employer-based geographic areas.

Please complete using black ink/type, and return to your authorized Anthem Blue Cross and Blue Shield agent.

Purpose	Coverage Type(s)	Requested Effective Date
<input type="checkbox"/> Submit a new application <input type="checkbox"/> Request change(s) for group no. _____	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Life and Disability <input type="checkbox"/> Vision	(mm-dd-yyyy)

### 1. Please tell us about your company.

Company Name			Employer Tax ID Number	
Street Address	City	County	State	ZIP Code
Billing Address (if different than above)	City		State	ZIP Code
Employer Is: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Labor Union <input type="checkbox"/> Government Unit/Agency <input type="checkbox"/> Organization Exempt from Income Tax <input type="checkbox"/> Other (explain):	Standard Industrial Classification Code		Type of Business (be specific)	
Date Business Established (Mo/Yr)	Group Administrator Name	Phone Number (   )	Fax Number (   )	E-mail Address

### 2. Tell us about your monthly premium contribution and HSA arrangement.

Employer contribution (please fill in one option or the other, not both): \$ \_\_\_\_\_ (\$50 or more, in \$5 increments; excludes Colorado-mandated plans)

**OR** \_\_\_\_\_% (25% or more, in 5% increments; minimum of 50% for Colorado-mandated plans)

Employer dependent(s) contribution (optional) (please fill in one option or the other, or leave blank if not applicable):

\$ \_\_\_\_\_ (no minimum requirement)   **OR**   \_\_\_\_\_% (no minimum requirement)

Will employer establish a Mellon Health Savings Account?    Yes    No

### 3. Would you like to offer dental coverage?

<p>Please check one or both choices below if you would like to add dental coverage. (Note: The Hospital BeneFits Preferred plan includes dental coverage.)</p> <p><input type="checkbox"/> BeneFits PPO Dental Plan    <input type="checkbox"/> BeneFits Option 2 PPO Dental Plan</p>	<p>If you are adding dental coverage, please specify the percentage of employer contribution to monthly premiums:</p> <p>Employee dental: _____% (25% or more in 5% increments)</p> <p>Dependent dental: _____% (no minimum requirement)</p>
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### 4. Would you like to offer vision coverage?

<p>Please check one or both choices below if you would like to add vision coverage. (Note: The Hospital BeneFits Preferred plan includes vision coverage.)</p> <p><input type="checkbox"/> Blue View    <input type="checkbox"/> Blue View Plus</p>	<p>If you are adding vision coverage, please specify the percentage of employer contribution to monthly premiums:</p> <p>Employee vision: % _____ (25% or more in 5% increments)</p> <p>Dependent vision: % _____ (no minimum requirement)</p>
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Anthem Blue Cross and Blue Shield is the parent company of HMO Colorado, Inc.  
 Life and disability products are underwritten by Anthem Life Insurance Company.  
 Independent Licensees of the Blue Cross and Blue Shield Association.  
 Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc.  
 ® Registered marks Blue Cross and Blue Shield Association.  
 COSGBENEMP/COCFRM (Rev. 5/19/08)



**5. Life/Disability Benefit Selections...What employer contribution(s) and product(s) would you like to select?**

**Life Products** Employer Contributions

Per employee \_\_\_\_\_% (25% to 100%)  
 Per dependent \_\_\_\_\_% (optional)

**Term Life**  
 Check only one schedule. For schedules A and B, specify amount (at least \$15,000 in \$1,000 increments, with a maximum of \$200,000). For schedule C, specify the percentage of salary, to a maximum of \$200,000.

**Schedule A** - Benefit is the same for all job titles \$ \_\_\_\_\_

**Schedule B** - Benefit differs by job title  
 Class I, officers, managers, supervisors \$ \_\_\_\_\_  
 Class II, all other group members \$ \_\_\_\_\_  
 (Class I amount cannot exceed 2.5 times class II amount.)

**Schedule C** - Benefit is a percentage of salary; check one of the following for all employees:

1 x annual salary up to \$ \_\_\_\_\_  
 2 x annual salary up to \$ \_\_\_\_\_

Please provide list of employees and base salaries

**Supplemental Life**  
 Only available if other life options are also selected.

Check for supplemental life (100% employee-paid)

**Dependent Life**  
 Check only one (Please note that option 1 is only available if the employee life benefit is \$20,000 or more.)

Option 1: \$10,000 spouse; \$10,000 children 6 months to 19 years (through age 24 if full-time student); \$1,000 children under 6 months

Option 2: \$5,000 spouse; \$5,000 children 6 months to 19 years (through age 24 if full-time student); \$500 children under 6 months

**Disability Products** Employer Contributions (25% to 100%)

Long-term disability (LTD) \_\_\_\_\_%  
 Short-term disability (STD) \_\_\_\_\_%

**LTD and STD**  
 Check one of three options for LTD and/or one of six options for STD.

**LTD**

<input type="checkbox"/> Gold	<input type="checkbox"/> \$6,000 maximum/90-day elimination period
<input type="checkbox"/> Silver	<input type="checkbox"/> \$6,000 maximum/180-day elimination period
<input type="checkbox"/> Bronze	<input type="checkbox"/> \$3,000 maximum/180-day elimination period

**STD**

Percentage <sup>1</sup>	<input type="checkbox"/> 1/8/13 <sup>3</sup>	<input type="checkbox"/> 1/8/26 <sup>3</sup>	<input type="checkbox"/> 15/15/26 <sup>3</sup>
Flat amount <sup>2</sup>	<input type="checkbox"/> 1/8/13 <sup>3</sup>	<input type="checkbox"/> 1/8/26 <sup>3</sup>	<input type="checkbox"/> 15/15/26 <sup>3</sup>

<sup>1</sup>Percentage: 66.67% of weekly salary, \$750 maximum  
<sup>2</sup>Flat amount: \$200 per week  
<sup>3</sup>Day benefits begin: accident benefits/illness benefits/duration of benefits in weeks

**ProtectionPack** Employer Contributions (25% to 100%)

\_\_\_\_\_%

**ProtectionPack Option** (check one)

Basic     Essential     Enhanced  
 Deluxe     Premium

**6. Premium Only Plan...I am applying for P.O.P. administrative services.**

Yes     No    I want to set up a Premium Only Plan (P.O.P.) to be administered by Ceridian (an independent company not affiliated with Anthem Blue Cross and Blue Shield). I have read the P.O.P. brochure and am enclosing my completed P.O.P. enrollment form and a separate check payable to Anthem Blue Cross and Blue Shield for the first year's fee of \$125, if applicable, along with my application.



**7. Please tell us about your group's eligibility.**

A. Total number of employees (including employed owners/officers): \_\_\_\_\_

B. Number of eligible full-time employees (minimum of 24 hours per week, not including those working on a temporary or substitute basis): \_\_\_\_\_

C. How many work or live outside the state of Colorado? \_\_\_\_\_

D. How many have met the required probationary/waiting period? \_\_\_\_\_

E. Number of eligible ENROLLING employees: \_\_\_\_\_

F. Number of eligible employees DECLINING coverage: \_\_\_\_\_

G. Number of INELIGIBLE employees: \_\_\_\_\_

Reason for ineligibility: \_\_\_\_\_

H. Will coverage be restricted to a certain classification of employees or employees working a certain number of hours per week?  Yes  No

If yes, please explain what class(es) or number of work hours are required (must be at least 24 hours): \_\_\_\_\_

I. If you are a business group of one, was your prior health coverage Group or Individual?  Grp  Ind

If Individual:  
Please indicate the length of time covered: \_\_\_\_\_

J. Probationary waiting/period for new employees:  1st of month after hire date

<input type="checkbox"/> 1 month	<input type="checkbox"/> 4 months
<input type="checkbox"/> 2 months	<input type="checkbox"/> 5 months
<input type="checkbox"/> 3 months	<input type="checkbox"/> 6 months
<input type="checkbox"/> Other months	

K. Under TEFRA/DEFRA:  
Medicare is primary coverage for groups with fewer than 20 employees; Anthem Blue Cross and Blue Shield is primary coverage for groups with 20+ employees (based on total number of employees during 50% of the working days in the previous calendar year).

Which one applies for your group?  Medicare is primary (<20)  Anthem is primary (20+)

L. Is your group currently subject to state continuation coverage?  Yes  No  
(employed 1-19 eligible employees on at least 50% of its working days in the previous calendar year)

M. Is your group currently subject to COBRA?  Yes  No  
(employed 20 or more total employees on at least 50% of the working days in the previous calendar year)

**8. Please tell us about your group's health coverage history.**

Has this group had group health coverage within 90 days of this application's signature date?  Yes  No

Will this plan replace any existing group coverage?  Yes  No

If yes:  
Current carrier is: \_\_\_\_\_ Proposed termination date is: \_\_\_\_\_

**9. What about employee leaves of absence at your firm?**

Personal: number of months employees are eligible to continue group health coverage while on an employer-approved temporary personal leave of absence (maximum three months)

<input type="checkbox"/> None	<input type="checkbox"/> 2 Months
<input type="checkbox"/> 1 Month	<input type="checkbox"/> 3 Months

Medical: number of months employees are eligible to continue group health coverage while on an employer-approved temporary medical leave of absence (maximum six months)

<input type="checkbox"/> None	<input type="checkbox"/> 4 Months
<input type="checkbox"/> 1 Month	<input type="checkbox"/> 5 Months
<input type="checkbox"/> 2 Months	<input type="checkbox"/> 6 Months
<input type="checkbox"/> 3 Months	

**10. Reserved...Please skip this section unless special instructions are provided.**



**11. Employer Information...please read carefully**

**COLORADO INSURANCE LAW REQUIRES ALL CARRIERS IN THE SMALL GROUP MARKET TO ISSUE ANY HEALTH BENEFIT PLAN IT MARKETS IN COLORADO TO SMALL EMPLOYERS OF 2-50 EMPLOYEES, INCLUDING A BASIC OR STANDARD HEALTH BENEFIT PLAN, UPON THE REQUEST OF A SMALL EMPLOYER TO THE ENTIRE SMALL GROUP, REGARDLESS OF THE HEALTH STATUS OF ANY OF THE INDIVIDUALS IN THE GROUP. BUSINESS GROUPS OF ONE CANNOT BE REJECTED UNDER A BASIC OR STANDARD HEALTH BENEFIT PLAN DURING OPEN ENROLLMENT PERIODS AS SPECIFIED BY LAW.**

Employers with 10 or more eligible employees are entitled to a choice of composite rates or four-tier family, age-banded rates. Employers have the right to see premium quoted either way. The total premium will initially be the same based on the enrollment assumption used to prepare the quote. However, subsequent enrollment changes may result in premium differences depending on the rate method selected. Composite rates use average rates by coverage type, while age rates use the actual rates for each individual in the group based on the age of the employee.

**12. General Agreement**

The undersigned employer and/or authorized representative hereby request(s) approval for insurance coverage by Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado. Our signature below will indicate that Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado are approving coverage.

By signing this application, the undersigned employer agrees to be bound by the terms of the contract. The employer agrees that:

1. The requested coverage is not in effect until this application is approved by Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado; that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer; and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado. The employer must meet the minimum enrollment, participation and eligibility requirements according to the applicable Anthem or HMO Colorado underwriting policies and Colorado state law.
2. The advance premium check does not create temporary or interim insurance coverage, and receipt and deposit of that payment does not guarantee issuance of insurance coverage; rather, issuance of insurance coverage is expressly conditioned on Anthem Blue Cross and Blue Shield's, Anthem Life's and/or HMO Colorado's determination that the employer satisfies Anthem Blue Cross and Blue Shield's, Anthem Life's and/or HMO Colorado's current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado, except to refund the advance premium payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.
3. For Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado to accept this application, all the information requested on this application must be completed. If the application is not complete, Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado or their designated agent(s) are authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado may be different from the coverage applied for herein. If Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado notifies the employer of such different coverage, and the employer pays the appropriate premium, the employer will be deemed to have accepted the coverage as issued.

Name of Company Officer (please print)	Title of Company Officer
Signature of Company Officer X	Date (month/day/year)
Accepted by Officer of Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado	Date (month/day/year)



**13. Please ask your agent to complete the following:**

I hereby certify:

1. I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.
2. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado to attribute such additions or changes to me.
4. I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado reviews and approves the application and the employer receives a written notice from Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado.
5. I am the appointed agent and am receiving commissions for the submission of this client. No portion of my commission payments from Anthem shall be paid to an agent/producer not appointed/approved by Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado that the coverage being applied for by this application is accepted.

WRITING AGENT	%
Name	
Agent ID Number	
Sub-agent ID Number (if different)	
Address	
City, State, ZIP	
Phone	
Fax	
E-mail	
Date	
Signature	

SECOND WRITING AGENT	%
Name	
Agent ID Number	
Sub-agent ID Number (if different)	
Address	
City, State, ZIP	
Phone	
Fax	
E-mail	
Date	
Signature	

FOR GENERAL AGENT USE ONLY	
General Agent Name	Agent ID Number
Address	City, State, ZIP



## Final Check

- Please check to make sure you have provided all requested information. Incomplete applications may be returned, which could delay the processing of your application.
- Include a copy of your most recent *Quarterly Tax and Wage Statement* (or payroll or applicable tax records if you don't file *Quarterly Tax and Wage Statements*).
  - Indicate on the document whether each employee listed is full-time, part-time or terminated.
  - Write in the names of any newly hired employees (not listed on the document) and the number of their weekly work hours. Include a copy of each newly hired employee's *W-4*.
- Send us a copy of your most recent prior carrier bill or bills (if applicable).
- Include all original employee applications.
- Include a signed proposal for all lines of coverage for which you're applying.
- Provide a complete list of all eligible employees and their dependents.
- Include a check for the first month's premium payable to Anthem Blue Cross and Blue Shield.
- If applicable, include a completed P.O.P. enrollment form and a separate check in the amount of \$125 payable to Anthem Blue Cross and Blue Shield.
- Please mail all required forms and documentation to the address below:  
Anthem Blue Cross and Blue Shield  
P.O. Box 172466  
Denver, CO 80217-2466

Thank you for your time and trust.

For more information online, please visit [anthem.com](http://anthem.com).

