



An Anthem Company



An Anthem Company



### EMPLOYER APPLICATION /CHANGE FORM

Complete in ink and return to the sales representative. Answer all questions completely. Retain the Employer Master Contract and a copy of this application for your records. If any information is omitted, this application will be returned which may delay delivery of certificates and ID cards. For information about Anthem and its products and services, please visit [www.anthem.com](http://www.anthem.com).

Reason for Application <input type="checkbox"/> New <input type="checkbox"/> Change	Effective Date	Coverage Applied For <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision	State <input type="checkbox"/> Colorado <input type="checkbox"/> Nevada	<b>Anthem/HMO Colorado/HMO Nevada USE ONLY:</b>				
				Health Group No.	Corp No.	Dental / Vision Group No.	Auto ID No.	Anniversary Month

**Check all boxes that apply for desired coverage and/or changes. If no change is indicated, the previous application will remain in effect.**

**1. Employer information**

Applicant (legal name of employer)		Name of Association (if applicable)	
DBA Name (if applicable)		Group Administrator	
Physical Address		City, State ZIP code	Fax Number (include area code)
Billing Address (if different from above)		City, State ZIP code	Phone Number (include area code)
Nature of Business (please be specific)	Standard Industry Code (SIC)	Type of Organization <input type="checkbox"/> Corporation <input type="checkbox"/> Proprietorship <input type="checkbox"/> Partnership	<input type="checkbox"/> Government Unit/Agency <input type="checkbox"/> Labor Union <input type="checkbox"/> Other _____ Organization Exempt from Income Tax
No. of Years in Business			

Affiliates/Subsidiaries/Division to be Included (List names, locations and number employed at each location). Attach a separate page listing separate billing addresses.

**2. Health Coverage Applied For (If multiple options are purchased, indicate each benefit plan below):**

HMO or HMO/POS: Indicate copayments, deductible and RX level.		PPO/EPO: Indicate plan name and RX level.	
<input type="checkbox"/> HMO Plan _____ # enrolled _____	<input type="checkbox"/> HMO/POS Plan _____ # enrolled _____	<input type="checkbox"/> PPO Plan _____ # enrolled _____	<input type="checkbox"/> EPO Plan _____ # enrolled _____
<input type="checkbox"/> Basic or Standard (circle one) Plan; HMO or PPO (circle one) # enrolled _____		<input type="checkbox"/> Other _____ # enrolled _____	

**Optional HMO and HMO/POS Employer Benefit Programs for Colorado Employers Only (Available only to employer with 51 or more eligible enrollees):**

Chemical Dependency Rehabilitation       Chiropractic Rider

<b>3. Dental Coverage Applied For</b> (Indicate plan name, annual maximum, deductible and copayment levels)	<b>4. Vision Coverage Applied For</b> (Indicate plan design and copayment): <b>Attach signed copy of Anthem Vision rate plan.</b>
<input type="checkbox"/> Anthem Blue Dental PPO _____ # enrolled _____	<input type="checkbox"/> Employer Paid _____ # enrolled _____
<input type="checkbox"/> Anthem Blue Dental PPO Plus _____ # enrolled _____	<input type="checkbox"/> Voluntary _____ # enrolled _____

**5. Classification of Eligible Employees**

The employer requires that all eligible employees have a regular work week of at least \_\_\_\_\_ hours per week (a minimum of 24 hours per week for Colorado employers, and a minimum of 30 hours per week for Nevada employers is required). Eligible employees do not include those employed on a temporary or substitute basis. Is coverage restricted to certain classification(s) of employees?

Yes  
 No    If Yes, explain \_\_\_\_\_

**6. Eligibility**

Total Number of Full time Employees (including those in a waiting period) Working at Least the Minimum Number of Hours required per Week: 24 for Colorado and 30 for Nevada (Companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of state taxation shall be considered one employer.)	Number Enrolling for Coverage	Total number of Employees Residing/Working Outside of Colorado or Nevada (Attach a separate page listing location(s) and number of employees at each location)
Number Enrolled with Other Group Coverage Elsewhere	Total Number of Employees Who Have Met Waiting Period	Number with No Other Coverage or Individual Product Coverage

If the group has 50 or fewer full-time employees attach a copy of the employer's most recent Quarterly Tax and Wage Statement, or payroll, or applicable tax records (if Quarterly Tax and Wage Statements are not filed). Indicate on the document submitted whether each employee is full-time, part-time or terminated. Also write in the names of any newly hired employees (not listed on the document) and include the weekly hours worked for the employer.

Groups of two or more are not required to respond to the following question: If you are a business group of one, is your prior health care coverage group or individual?  
 Group     Individual  
If prior coverage is individual coverage, indicate length of time covered \_\_\_\_\_

**7. Contribution and Minimum Enrollment Percentage Requirements (for Health Groups Only)**

The employer must contribute a minimum of 50percent toward the employee's single membership premiums or 50percent toward the employee's portion of the family- membership premiums. For all size groups to apply for and retain group coverage and rates if we are the sole carrier, the employer agrees to maintain the following enrollment percentage requirements, based on *total eligible employees*:

- For groups of 50 or fewer employees 75percent enrollment must be based on *net eligible employees*.
- For groups of 51 or more employees 75percent enrollment must be based on *net eligible employees*, with enrollment no less than 50percent of the *total eligible employees*.

To arrive at *net eligible employees*, employees covered elsewhere with the following types of group insurance may be excluded, unless such coverage is offered through the employer: A Blue Cross and Blue Shield Plan, a Health Maintenance Organization, the Federal Employees Health Benefit Program, Indian Health Services, the Federal Peace Corps, or CoverColorado or through another commercial carrier.

In all cases the employer must meet the minimum enrollment and eligibility requirements according to the applicable Anthem, HMO Colorado or HMO Nevada underwriting regulations and policies and Colorado or Nevada state law. If an employer with 51 or more eligible employees does not meet the minimum enrollment requirements, we reserve the right to accept this application with prior underwriting approval. If the number of eligible Employees enrolled does not meet the required percentage, we reserve the right to cancel the Contract upon 30-day advance written notice.

If we are a dual carrier (products with both carriers must be comparable, i.e. two HMO products), to apply for and retain group coverage and rates, a minimum of 75percent of the Employees must be enrolled at all times. Employees with group-sponsored coverage provided by a carrier other than Anthem, HMO Colorado or HMO Nevada will be counted against the enrollment percentage.

<b>8. Dependents</b>				
Unmarried dependent children are covered until the end of the month in which they become age 19, or 24 if financially dependent upon the parent.				
<input type="checkbox"/> Other eligibility rules imposed by the employer (not available for employers with fewer than 51 employees)				
<b>9. Effective /New Hire Policy (Effective dates for enrollment eligibility and coverage)</b>				
Check the box that indicates when employees are eligible to enroll for coverage and when coverage begins:				
<input type="checkbox"/> After ___days ___month(s) of employment with coverage effective on the next 1 <sup>st</sup> day of the month.		<input type="checkbox"/> On the date of hire with coverage effective on the date of hire		
<input type="checkbox"/> On the date of hire with coverage to be effective on the next 1 <sup>st</sup> day of the month		<input type="checkbox"/> Other _____		
Employers with fewer than 51 employees may not waive selection of a New Hire Policy, (unless the group has no prior carrier). Employers with 51 or more employees, with or without prior carrier may waive selection of a New Hire Policy. Employees must enroll based on employer New Hire Policy selected, or wait until the group's open enrollment if HMO or HMO/POS or until the group's next anniversary date for PPO or EPO.				
<input type="checkbox"/> Waive New Hire Policy for initial enrollment				
<b>10. Other Information</b>				
Has your group been declined for coverage in the last 12 months?		If yes, by whom, when and why?		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Name of prior health care carrier(s) within the last five years (If more than one carrier, include length of time covered by each)				
Will any other insurance carrier(s) in addition to Anthem, HMO Colorado, or HMO Nevada also provide health care coverage as part of the employer's employee benefit plan?		If yes, list the carrier name(s), premium amount(s) and product(s)		
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Is the employer subject to COBRA?		If yes, does the employer want Anthem or HMO Colorado to perform limited COBRA Administration duties? Available to Colorado employers only.	Is the employer subject to State Continuation?	If yes, we will perform limited State Continuation administration duties. Available to Nevada employers only. Colorado employers perform such duties.
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Total number of enrollees with COBRA or State Continuation coverage		Total number of disabled enrollees (applies only to groups 20+ )		
Attach a separate page listing all employees and dependents on COBRA or State Continuation Coverage and their coverage end dates)		Attach a separate page listing employees and dependents who are totally disabled and their COBRA or State Continuation end dates		
<b>11. Remarks</b>				
For Colorado Employers Only				
<b>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.</b>				
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.				
<b>12. General Agreement</b>				
The undersigned employer and/or authorized representative hereby request(s) approval for insurance coverage by Anthem, HMO Colorado, and/or HMO Nevada. Our signature below will indicate that Anthem, HMO Colorado, and/or HMO Nevada 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, HMO Colorado, or HMO Nevada, 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, HMO Colorado, or HMO Nevada,				
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's, HMO Colorado's, or HMO Nevada's determination that the employer is an acceptable risk based on its current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem, HMO Colorado, or HMO Nevada 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, HMO Colorado, or HMO Nevada to accept this application, all the information requested on this application must be completed. If the application is not complete, Anthem, HMO Colorado or HMO Nevada or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem, HMO Colorado, or HMO Nevada may be different from the coverage applied for herein. If Anthem, HMO Colorado, or HMO Nevada notifies the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.				
<b>13. Signatures (attach check)</b>				
Signature of Authorized Employer Representative		Printed Name and Title		Date
Accepted by Officer of Anthem, HMO Colorado, or HMO Nevada				Date
Broker Certification – I hereby certify:				
1. I have reviewed the attached employee and employer applications and waivers for completeness and accuracy.				
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, HMO Colorado or HMO Nevada 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, HMO Colorado or HMO Nevada reviews and approves the application and the employer receives a written notice from Anthem, HMO Colorado or HMO Nevada.				
5. I am the appointed broker and am receiving commissions for the submission of this client. No portion of my commission payments from Anthem shall be paid to a broker/producer not appointed/approved by Anthem.				
Broker Name		Broker Signature		Date
Address		City, State ZIP Code		
Anthem Broker ID number		Tax ID Number to be Paid	Broker Phone Number	Broker Fax Number
Broker Status	Agency Name (if applicable)	Anthem, HMO Colorado, or HMO Nevada Sales Representative	Rep ID No.	Regional Office
<input type="checkbox"/> New				
<input type="checkbox"/> Existing				