

Check company and write in product that applies

Application completed for:

- Anthem Blue Cross and Blue Shield**
Product _____
- HealthKeepers, Inc.**
Product _____
- Peninsula Health Care, Inc.**
Product _____
- Priority Health Care, Inc.**
Product _____

EMPLOYEE ENROLLMENT APPLICATION

APP		
Effective Date		
M	D	Y

THE SHADED AREAS BELOW MUST BE COMPLETED BY GROUP ADMINISTRATOR

GROUP NAME	GROUP NUMBER
Date of hire ____/____/____ Eligible date of coverage ____/____/____ COBRA coverage requested <input type="checkbox"/>	
Number of hours worked/week _____	Employer/Group Administrator signature _____ Daytime phone () _____
Social Security Number ____-____-____ Date of birth ____/____/____	

A. EMPLOYEE INFORMATION							
Last name	First name	MI	Marital status	Male	Female		
			<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/>	<input type="checkbox"/>	
Address Street		City	State	Zip	Daytime phone () _____		

B. TYPE OF COVERAGE (CHECK ONE)					
<input type="checkbox"/> SELF ONLY	<input type="checkbox"/> SELF-SPOUSE	<input type="checkbox"/> SELF-ONE CHILD	<input type="checkbox"/> SELF-CHILDREN	<input type="checkbox"/> SELF-FAMILY	

C. ENROLLMENT INFORMATION

List yourself and all family members applying for coverage. List additional dependents on a separate sheet and attach it to the application. Please indicate the relationship between you and each covered dependent and provide the Social Security Number for each covered dependent.

First name, last name if different	Relationship Social Security #	Date of birth M D Y	Full-time student?	Disabled before 23?	If applying for coverage that requires a Primary Care Physician, list the PCP for each enrollee	Current patient?	Office use only
Self					PCP:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Spouse				PCP:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Son <input type="checkbox"/> Daughter		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	PCP:	<input type="checkbox"/> Yes <input type="checkbox"/> No	

D. PROOF OF PRIOR COVERAGE

Please list any health care plan/HMO that you or your family members were covered by within the past **24 months** including Medicare, Medicaid, CHAMPUS, or other publicly-sponsored programs. Attach copies of any certification of coverage your previous health care plans or employers gave you.

Who was covered?	Was the coverage through an employer?	Effective date	Cancellation date	Policy/ID number	Health Care Plan, City, State
<input type="checkbox"/> Self	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ Mo. Day Year	____/____/____ Mo. Day Year	_____	_____
<input type="checkbox"/> Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ Mo. Day Year	____/____/____ Mo. Day Year	_____	_____
<input type="checkbox"/> Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ Mo. Day Year	____/____/____ Mo. Day Year	_____	_____
<input type="checkbox"/> Child	<input type="checkbox"/> Yes <input type="checkbox"/> No	____/____/____ Mo. Day Year	____/____/____ Mo. Day Year	_____	_____

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. Anthem Blue Cross and Blue Shield, HealthKeepers, Inc., Peninsula Health Care, Inc., and Priority Health Care, Inc. are independent licensees of the Blue Cross and Blue Shield Association.

E. COORDINATION OF BENEFITS INFORMATION

Will you, your spouse or any dependent children continue to be covered under another health plan/policy in addition to the coverage offered by this group?

NO YES If YES, then provide the following information about that coverage.

If coverage includes children and parents are divorced, which parent has custody? Father Mother

Does divorce decree establish medical responsibility? No Yes If yes, please indicate who is responsible Father Mother

<input type="checkbox"/> SELF	Health plan name and address	ID (Policy) number	Effective date
Name of Insured	_____	_____	____ ____ ____
		Policyholder name	

		Coverage:	<input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision
<input type="checkbox"/> SPOUSE	Health plan name and address	ID (Policy) number	Effective date
Name of Insured	_____	_____	____ ____ ____
		Policyholder name	

		Coverage:	<input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision
<input type="checkbox"/> CHILD	Health plan name and address	ID (Policy) number	Effective date
Name of Insured	_____	_____	____ ____ ____
		Policyholder name	

		Coverage:	<input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision
<input type="checkbox"/> CHILD	Health plan name and address	ID (Policy) number	Effective date
Name of Insured	_____	_____	____ ____ ____
		Policyholder name	

		Coverage:	<input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision

F. MEDICARE COVERAGE

Covered person (Name)	HIC number	Effective date of Part A	Effective date of Part B	65 or over <input type="checkbox"/> Working <input type="checkbox"/> Retired
_____	_____	____ ____ Mo. Year	____ ____ Mo. Year	
Eligible for Medicare due to:	<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease (ESRD)	<input type="checkbox"/> Disability & Current ESRD		
Covered person (Name)	HIC number	Effective date of Part A	Effective date of Part B	65 or over <input type="checkbox"/> Working <input type="checkbox"/> Retired
_____	_____	____ ____ Mo. Year	____ ____ Mo. Year	
Eligible for Medicare due to:	<input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease (ESRD)	<input type="checkbox"/> Disability & Current ESRD		

G. CERTIFICATION: This section must be read and completed.

I understand that if the entity checked on page one of this application is Anthem Blue Cross and Blue Shield, then Anthem Blue Cross and Blue Shield may deny claims and void my coverage or may increase the premium charged to my employer if it finds that I misrepresented information on my application. When false or misleading information is discovered, Anthem Blue Cross and Blue Shield may void my coverage without advance notice and refund my premium back to the effective date shown on this application or may adjust the group's premium retroactively to my effective date shown on this application, if the discovery is made within two years after such effective date. Any claims paid during periods when the coverage was not in force will be deducted from any premium refund. If the amount of benefits paid by Anthem Blue Cross and Blue Shield exceeds the premium paid, I agree to refund any excess amount to Anthem Blue Cross and Blue Shield.

I understand that if the entity checked on page one is HealthKeepers, Inc., Peninsula Health Care, Inc. or Priority Health Care, Inc., the health maintenance organization (HMO) may cancel my coverage without advance notice if it finds within two years of the effective date of my coverage that I misrepresented information on my application.

I have read or have had read to me the definition of an eligible employee that appears on page 4 of this application. By submitting this application I declare that I meet the requirements to enroll.

I understand that completing this application is not a guarantee of coverage. I understand that the coverage applied for is only available if the application is accepted by the insurer or HMO and the appropriate premium is paid.

Employee Signature _____ Date _____

Medical Profile

Employer/Group Name

Group Number

MO. Effective Date DAY YEAR

MP

Employee Name: (First) (M.I.) (Last) Male Female

Social Security Number: Date of Birth:

Spouse Name: (First) (M.I.) (Last)

Social Security Number: Date of Birth:

Address: Street City State Zip

Indicate the type of coverage you are applying for: Employee Only Employee-One Child Employee-Children
 Employee-Family Employee-Spouse

Employee: Height ____ft.____inches Spouse: Height ____ft.____inches
Weight ____lbs. Weight ____lbs.

1. Has any person to be covered by this plan had indications of, been diagnosed with, treated for or had treatment recommended for any of the following conditions? No Yes, if Yes, then place a check beside the condition and provide details in the Medical Details Section.

- Benign tumor
- Blood or circulatory problems
- Cancer
- Connective Tissue Disease
- Heart attack
- Heart disease, Angina
- Liver condition
- Stroke

2. Has any person to be covered by this plan had indications of, been diagnosed with, treated for or had treatment recommended for any of the following conditions within the last 5 years? No Yes, if Yes then place a check beside the condition and provide details in the Medical Details Section.

- A.** Colitis or intestinal condition Gall bladder disease or gall stones Paralysis
 Disease of eyes, ears, nose, or throat Kidney disease or kidney stones Thyroid or goiter
 Disorders of spine, discs, joints Lung condition or tuberculosis Ulcers or other stomach condition
Surgery: Yes No Muscle/nervous system disorder
Date of surgery _____

- B.** Alcohol or Drug Abuse/Addiction: _____ Emotional or mental conditions:
 Inpatient Outpatient Dates treated _____ Reason for treatment _____
 Arthritis or Rheumatism: Inpatient Outpatient Dates treated _____
Type _____ Degree of severity _____ Medication used within the last 12 months _____
Medication used within the last 12 months _____ Medication was prescribed by: Psychiatrist Family Physician
 Asthma or Other respiratory conditions: _____ Date medication last used _____
Frequency of attacks _____ Date of last attack _____ Epilepsy or Seizures:
Dates of any hospitalizations _____ Type and date of last seizure _____
Medication used within the last 12 months _____ Medication used within the last 12 months _____
How often taken _____ High blood pressure:
 Diabetes: Last reading and date _____
 Diet Oral medication or Insulin controlled Medication used within the last 12 months _____
 Lupus: Systemic Discoid

3. Has any person to be covered by this plan been diagnosed with AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)?

No Yes If Yes, then provide details on back in the Medical Details Section.

4. Has any person to be covered by this plan been advised to have future medical treatment or surgery?

No Yes If Yes, then provide details on back in the Medical Details Section.

5. Has any person to be covered by this plan been examined or treated by a physician, psychotherapist, counselor, or other medical professional or taken any prescription drugs within the past 5 years for any illness, injury or condition not already noted (exclude colds, flu and routine exams not related to a medical condition)?

No Yes If Yes, then provide details on back in the Medical Details Section.

MEDICAL PROFILE CERTIFICATION: This section must be read and completed.

I (and my agent if applicable) certify that I have read, or have had read to me, the completed medical profile, and I realize that any false statement or misrepresentation in the medical profile may result in loss of coverage under the policy.

Applicant Signature _____ Date _____ Daytime Phone Number _____

Broker/Agent Signature _____ Date _____ Daytime Phone Number _____