

1. Tell Us About You	Current Anthem BCBS Contract Number, if any _____	2. New Membership	To Be Completed By Employer
Last Name _____	First Name _____ M.I. _____	<input type="checkbox"/> NEW HIRE	Requested Effective Date _____ MM / DD / YR
Home Address: Number and Street or P.O. Box _____	Apt. # _____	<input type="checkbox"/> OPEN ENROLLMENT	Firm Division No. _____
City _____	State _____ Zip Code _____	<input type="checkbox"/> COBRA/C.G.S. 38a-538	Health Benefit Plan _____
Home Telephone () _____	Work Telephone () _____	DATE OF QUALIFYING EVENT MM / DD / YR	For Office Use Only
MARITAL STATUS	<input type="checkbox"/> Single <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	REASON _____ SEE INSTRUCTION SHEET	
		<input type="checkbox"/> NEW GROUP (ORIG ENROLLMENT)	
		3. Change Membership	
		CHANGE: <input type="checkbox"/> ADDRESS <input type="checkbox"/> NAME INDICATE FORMER NAME _____	
		<input type="checkbox"/> OTHER REASON _____	
		DATE MM / DD / YR	

4. Your Membership Choices

	Individual	Two Person	Family
<input type="checkbox"/> BLUECARE <small>PLAN NAME</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> CENTURY PREFERRED/PPO	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> DENTAL <small>PLAN NAME</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> HMO--NEW ENGLAND	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumenos H.S.A.*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumenos H.R.A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumenos H.I.A.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lumenos H.I.A. Plus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<small>*Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.</small>			
<input type="checkbox"/> OTHER <small>PLAN NAME</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are you or any other eligible dependent listed on this form currently confined to a hospital or other healthcare facility, totally disabled or physically impaired? YES NO

5. Where You Work COMPANY NAME _____

ARE YOU ACTIVELY AT WORK? YES NO / (IF NO) REASON SICK INJURED OTHER _____

ARE YOU CURRENTLY CLAIMING WORKERS' COMP. MEDICAL BENEFITS? YES NO

DO YOU WORK 30 OR MORE HOURS PER WEEK? YES NO

DATE OF FULL TIME HIRE MM / DD / YR	DATE OF PART TIME HIRE MM / DD / YR	DATE OF REHIRE MM / DD / YR
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6. List Members To Be Added/Cancelled

SEX	NAME (FIRST/MIDDLE/LAST NAME)	Add	Cancel	Social Security Number	Date of Birth (MM/DD/YYYY)	Full Time Student Age 19 or Over	BELOW PLEASE INDICATE NAME OF RECOGNIZED INSTITUTION FOR FULL TIME STUDENTS	Primary Care Physician (PCP) Name (Refer to Provider Directory or www.anthem.com) <small>Check <input checked="" type="checkbox"/> the box if you currently use this physician.</small>
<input type="checkbox"/> M	Self				/ /	(Circle Yes or No)		Name _____ PCP Provider No. <input type="checkbox"/>
<input type="checkbox"/> F								City _____
<input type="checkbox"/> M	Spouse				/ /			Name _____ PCP Provider No. <input type="checkbox"/>
<input type="checkbox"/> F								City _____

DEPENDENTS: Children over 19 may be eligible if disabled, or unmarried full-time students. Please circle disabled dependent.

<input type="checkbox"/> M	Dependent				/ /	Y N		Name _____ PCP Provider No. <input type="checkbox"/>
<input type="checkbox"/> F								City _____
<input type="checkbox"/> M	Dependent				/ /	Y N		Name _____ PCP Provider No. <input type="checkbox"/>
<input type="checkbox"/> F								City _____
<input type="checkbox"/> M	Dependent				/ /	Y N		Name _____ PCP Provider No. <input type="checkbox"/>
<input type="checkbox"/> F								City _____

7. Tell Us About Your Other Insurance Do you or any other member of your family have any other medical, dental, or Anthem BCBS coverage? YES NO

If yes, please fill in the information below. Self Spouse Children

Name of Other Insurance Company _____	Name of Subscriber (Policyholder) _____	Policy or ID No. _____	Reason For Termination _____	First and Last Date of Coverage _____
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8. Medicare/Medicaid Do you or any covered member have Medicare/Medicaid coverage? YES NO

Have you or any covered member applied for Medicare/Medicaid disability? YES NO

Name (Self)	Are you actively at work? <input type="checkbox"/> YES <input type="checkbox"/> NO	Retirement Date MM / DD / YR	Name (Dependent)	Is this person actively at work? <input type="checkbox"/> YES <input type="checkbox"/> NO	Retirement Date MM / DD / YR
Medicare No. _____	Medicare A (Hospital) _____	Effective Dates _____	Medicare B (Medical) _____	Medicare No. _____	Medicare A (Hospital) _____
		MM / DD / YR			MM / DD / YR
					MM / DD / YR

I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

9. Employee Signature _____ Date _____
MM / DD / YR