EMPLOYEE HEALTH INSURANCE ENROLLMENT APPLICATION

Please complete in ink and return to the Finance Department. Use extra sheets of paper if necessary for dependent information.

1. EMPLOYER GROUP USE ONLY

EFFECTIVE DATE **MM / DD / YYYY**	Group Number _____-000 **(Active Employee)**	Group Name **City of Hampton- OPTIMA HEALTH**
_____ / _____ / _____	Date of Hire _____/_____/_____	Did this employee have to satisfy an eligibility waiting period prior to enrollment? ☐ Yes ☐ No Beginning Date(hire date): __/__/____ Ending date (eligibility for coverage): __/__/____

Plan Selected: ☐ Optima Health

2. REASON FOR APPLICATION (Check as many as apply)

☐ New Enrollment ☐ Add Dependent ☐ Remove Dependent ☒ Change Plan ☐ COBRA

3. TYPE OF COVERAGE/PLAN

☐ Employee Only ☐ Employee & One Child ☐ Employee & Family

4. EMPLOYEE INFORMATION

Social Security #: - -	Date of Birth (MM/DD/YY): ______/______/______	Sex: ☐ Male ☐ Female	Daytime Phone Number: ( )	Evening Phone Number: ( )
Last Name:		**First Name:**		**Middle Initial:**
Street Address:				Apt. #
City:		State:		Zip:
Email:				

5. FAMILY INFORMATION (If electing Employee Only Coverage, skip to Section 6)

List 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 dependent and provide social security number and date of birth for each covered dependent. **In the event of adding a newborn for which their social security number is not available, please complete this application at this time and forward to Anthem their social security number within 90 days.** Also attach copies of birth certificates (proof of birth letter from hospital for newborns), adoption papers, or court-ordered custody papers to cover dependent children and a marriage certificate to cover your spouse.

Last Name:		First Name:	M.I.:	Sex: ☐ Male ☐ Female	
Relationship to Applicant: ☐Spouse ☐ Child	Social Security #: - -	Date of Birth (MM/DD/YY): _____/_____/_____	Full-time Student? ☐Yes ☐ No		Disabled/handicapped before age 23? ☐ Yes ☐No
Last Name:		First Name:	M.I.:	Sex: ☐ Male ☐ Female	
Relationship to Applicant: ☐ Child	Social Security #: - -	Date of Birth (MM/DD/YY): _____/_____/_____	Full-time Student? ☐ Yes ☐ No		Disabled/handicapped before age 23? ☐Yes ☐ No
Last Name:		First Name:	M.I.:	Sex: ☐ Male ☐ Female	
Relationship to Applicant: ☐ Child	Social Security #: - -	Date of Birth (MM/DD/YY): _____/_____/_____	Full-time Student? ☐ Yes ☐ No		Disabled/handicapped before age 23? ☐Yes ☐ No
Last Name:		First Name:	M.I.:	Sex: ☐ Male ☐ Female	
Relationship to Applicant: ☐ Child	Social Security #: - -	Date of Birth (MM/DD/YY): _____/_____/_____	Full-time Student? ☐ Yes ☐ No		Disabled/handicapped before age 23? ☐Yes ☐ No

6. TELL US ABOUT YOUR OTHER INSURANCE

Please list any health care plan/HMO that you or your family members have been covered by within the past 24 months, including Anthem. List additional information on a separate sheet and attach it to the application.

Other Carrier/plan name:	Policy/ID Number:	Effective Date: __/__/____

Please indicate whom this coverage applies to (check all that apply):	Do you intend to continue this coverage?
☐ Self ☐ Spouse ☐ All Children ☐ Child's Name: _____	☐ Yes ☐ No If No, please provide cancellation date: __/__/____

If you plan to continue other coverage, please provide the following information:

Address of other coverage:	City:	State:	Zip:

Phone number of other carrier/plan: ( )	Policyholder name (Last, First, M.I.):	Policyholder's date of birth:	Type of coverage: ☐ Health ☐ Dental

7. MEDICARE COVERAGE

If you or your dependents are enrolled in Medicare Part A, B & D complete the following. List additional dependents on a separate sheet and attach it to the application.

Last name of covered person: First Name: M.I.

HIC Number:	Medicare Part A Effective date: _____/_____/_____	Medicare Part B Effective date: _____/_____/_____	Medicare Part D Effective date: _____/_____/_____	65 or over: ☐ Working ☐ Retired

Reason for Medicare Entitlement:

☐ Age ☐ Disability ☐ End Stage Renal Disease (ESRD) ☐ ESRD & Disability

I certify that I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage under this policy. I understand that if false or misleading information is discovered within two years after the effective date of my coverage, Anthem may void my coverage without advance notice and refund my premium (less any claims paid) back to the effective date shown on this application, or may adjust the group's premium retroactively to my effective date. If the amount of benefits paid by Anthem exceeds the premiums paid, I agree to refund the excess amount to Anthem.

I authorize any medical professional, medical-care institution, or any other provider of health care services or supplies to furnish to the benefits administrator or medical review departments of Anthem Blue Cross Blue Shield information concerning services or supplies provided to me or persons covered for the purposes of review, investigation or payment of a claim. I understand that a copy of this authorization is available to me or my authorized representative upon request. For medical review claims purposes, this authorization is valid for the duration of coverage. For underwriting purposes this authorization is valid for 30 months from the date signed by me.

_____ _____

Employee Signature Date