



**IF NO DEPENDENTS, PLEASE SKIP TO QUESTION 6 ON PAGE 3**

**5. FAMILY INFORMATION\* (If electing Employee Only coverage, skip to Section 6)**

*\*If applying for HMO or POS coverage, list the PCP name and PCP number. Each family member may select a different PCP. 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 the 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 when obtained.*

Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Child	Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Last name		First name	M.I.

Check all that apply:

- a. Child to be covered by non-custodial parent due to medical child support order?  Yes  No (if yes, attach documentation)
- b. Full-time student?  Yes  No (applicable only to policies with unique student status eligibility requirements)
- c. Disabled/handicapped before age 23?  Yes  No (if yes, attach physician certification)

Anthem PCP Name*	Anthem PCP ID #*
Anthem PCP Address	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Relationship to applicant <input type="checkbox"/> Child	Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Last name		First name	M.I.

Check all that apply:

- a. Child to be covered by non-custodial parent due to medical child support order?  Yes  No (if yes, attach documentation)
- b. Full-time student?  Yes  No (applicable only to policies with unique student status eligibility requirements)
- c. Disabled/handicapped before age 23?  Yes  No (if yes, attach physician certification)

Anthem PCP Name*	Anthem PCP ID #*
Anthem PCP Address	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Relationship to applicant <input type="checkbox"/> Child	Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Last name		First name	M.I.

Check all that apply:

- a. Child to be covered by non-custodial parent due to medical child support order?  Yes  No (if yes, attach documentation)
- b. Full-time student?  Yes  No (applicable only to policies with unique student status eligibility requirements)
- c. Disabled/handicapped before age 23?  Yes  No (if yes, attach physician certification)

Anthem PCP Name*	Anthem PCP ID #*
Anthem PCP Address	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Relationship to applicant <input type="checkbox"/> Child	Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Last name		First name	M.I.

Check all that apply:

- a. Child to be covered by non-custodial parent due to medical child support order?  Yes  No (if yes, attach documentation)
- b. Full-time student?  Yes  No (applicable only to policies with unique student status eligibility requirements)
- c. Disabled/handicapped before age 23?  Yes  No (if yes, attach physician certification)

Anthem PCP Name*	Anthem PCP ID #*
Anthem PCP Address	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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 (MM/DD/YY)	Please indicate whom this coverage applies to (check all that apply): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> All Children <input type="checkbox"/> Child: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Last Name</span> <span>First Name</span> </div>		
Do you intend to continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no</b> , please provide cancellation date of coverage: _____ <b>If yes</b> , 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: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Group Insurance <input type="checkbox"/> Non Group Insurance		

**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 #	Medicare Part A Effective date	Medicare Part B Effective date	Medicare Part D Effective date	65 or over: <input type="checkbox"/> Working <input type="checkbox"/> Retired
Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease (ESRD) <input type="checkbox"/> ESRD & Disability				

**8. EMPLOYEE CERTIFICATION (Please date and sign this certification.)**

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 the policy.

- If the Company checked on page 1 of this application is Anthem Blue Cross and Blue Shield (Anthem), 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.
- If the Company checked on page one of this application is HealthKeepers, Inc., Peninsula Health Care, Inc., or Priority Health Care, Inc., I understand that 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 this application.

The employee, and any person authorized to act on behalf of the employee, is entitled to receive a copy of this form and will be provided with a copy upon their request.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_