# Enrollment Application

Anthem. BlueCross BlueShield

**INSTRUCTIONS:**

Please read carefully, complete electronically, or in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer.

**Section 1: Employer Required**

| | | |
|---|---|---|
| **Forklifts of St. Louis, Inc.** | 4720 LaGuardia Drive, St. Louis, MO 63134 | |
| Group No. **00250081** | Request Effective Date ___/___/____ | Branch/Location # 1 2 3 4 |

**Section 2: Reason for Application – Required**

☐ New enrollment ☐ New hire ☐ Add dependent (Fill in Section 3)
☐ Annual open enrollment (N/A to Life) ☐ Rehire – Date: ____
☐ COBRA – Qualifying event: _____ COBRA event date: ____
☐ Waiver (To decline ALL coverage skip to Section 12)

**Section 3: Status Change/Event – Required, if you checked "Add dependent" option in Section 2.**

| | |
|---|---|
| Event date | ☐ Marriage ☐ Birth ☐ Adoption (Attach legal documentation) ☐ Legal guardianship (Attach legal documentation)<br>☐ Loss of coverage (reason): _____ ☐ Terminated employment ☐ Other: _____ |

**Section 4: Plan/Type of Coverage – Required. To decline a plan type, check "No coverage". If you are waiving all coverage, go to Section 12.**

Type of medical coverage: ☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage

Type of dental coverage: ☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage

**Section 5: Employee Information – Required**

| | | | | | | |
|---|---|---|---|---|---|---|
| Last name | | | First name | | M.I. | Social Security no.[2] (required) |
| Date of birth | Age | Sex ☐ Male ☐ Female | Marital status ☐ Single ☐ Married ☐ Divorced | Height | | Weight |
| Home phone no. | | Business phone no. | | Email address | | |
| Street address | | | City | State | ZIP code | County |
| Retired? ☐ Yes ☐ No<br>Disabled? ☐ Yes ☐ No<br>Hospitalized? ☐ Yes ☐ No | Occupation | | Hours working per week | Full-time hire date | | Income reported by:<br>☐ W-2 ☐ 1099<br>☐ Other: _____ |

1 Anthem will facilitate the opening of a Health Savings Account (HSA) in your name, if directed by your employer.
2 Anthem is required by the Internal Revenue Service to collect this information.

In Missouri, (excluding 30 counties in the Kansas City area) Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association.
ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

## Section 6: Family Information — Required. List only dependents you wish to enroll, attach a separate sheet if necessary.

**Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under Section 10, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 6.**

**Spouse/Domestic Partner**

| Last name | First name | M.I. | Social Security no.* (required) |
|---|---|---|---|
| | | | |

| Date of birth | Height | Weight | Sex | Relationship to employee | Currently hospitalized or disabled? |
|---|---|---|---|---|---|
| | | | ☐ M ☐ F | ☐ Spouse ☐ Domestic Partner | ☐ Yes ☐ No If yes, give reason: _____ |

If spouse/DP address is different than employee, please provide full address

**Dependent**

| Last name | First name | M.I. | Social Security no.* (required) | Full-time student? |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |

| Date of birth | Height | Weight | Sex | Relationship to employee | Currently hospitalized or disabled? |
|---|---|---|---|---|---|
| | | | ☐ M ☐ F | ☐ Child ☐ Other: _____ | ☐ Yes ☐ No If yes, give reason: _____ |

| Court ordered health care coverage? | If dependent address is different than employee, please provide full address |
|---|---|
| ☐ Yes ☐ No (If yes,attach legal documentation) | |

**Dependent**

| Last name | First name | M.I. | Social Security no.* (required) | Full-time student? |
|---|---|---|---|---|
| | | | | ☐ Yes ☐ No |

| Date of birth | Height | Weight | Sex | Relationship to employee | Currently hospitalized or disabled? |
|---|---|---|---|---|---|
| | | | ☐ M ☐ F | ☐ Child ☐ Other: _____ | ☐ Yes ☐ No If yes, give reason: _____ |

| Court ordered health care coverage? | If dependent address is different than employee, please provide full address |
|---|---|
| ☐ Yes ☐ No (If yes, attach legal documentation) | |

## Section 8: Other Health Coverage — Required

**Do you and/or your dependents have other health coverage? ☐ Yes ☐ No If yes, complete below.**

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage?

| Provide name, phone number and address of the HMO or insurance company | Policy/certificate no. | Effective date |
|---|---|---|
| | | |

| Policy/certificate holder name | Social Security no.* (required) | Date of birth | Relationship to employee |
|---|---|---|---|
| | | | |

**Are you and/or your dependents enrolled in Medicare or Medicaid? ☐ Yes ☐ No If yes, complete below.**

| Enrollee name | Medicare/Medicaid ID no. | Medicare Part A effective date | Medicare Part B effective date | ESRD onset date |
|---|---|---|---|---|
| | | | | |
| Enrollee name | Medicare/Medicaid ID no. | Medicare Part A effective date | Medicare Part B effective date | ESRD onset date |
| | | | | |

| Medicare Part D ID no. | Medicare Part D carrier | Medicare Part D effective date | Medicare Part D term date |
|---|---|---|---|
| | | | |

Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

*Anthem is required by the Internal Revenue Service to collect this information.

**Have you and/or your dependents had prior health coverage? ☐ Yes ☐ No If yes, complete below.**

| Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No | Policy/certificate no. |
|---|---|
| | |

| Group name/ID no. | Date policy in effect | Date policy termed |
|---|---|---|
| | | |

Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? ☐ Yes ☐ No

| List prior carrier(s) | Date policy in effect | Date policy termed |
|---|---|---|
| | | |

Please check the type of prior coverage

☐ Employee ☐ Employee+Spouse/DP ☐ Employee+Child(ren) ☐ Employee+Spouse/DP+Child(ren)

Termination reason:

☐ Divorce/legal separation ☐ Employment terminated ☐ Employer/group contribution ceased ☐ Other

☐ Death of spouse/DP ☐ COBRA coverage exhausted ☐ Group plan terminated

## Section 9: Significant Terms, Conditions and Authorizations (TERMS) — Please read this section carefully before signing the application.

**Genetic Information Non-discrimination Act (GINA):** When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

**Health Savings Account Notice:** I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem Blue Cross and Blue Shield at any time.

1. I understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. For a period of two (2) years from the earlier of the policy date or the issue date, Anthem may deny benefits, rescind your policy or cancel coverage based on material misrepresentation or significant omission found in this application. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

I certify each Social Security number listed on this application is correct.

**Thank you for choosing Anthem Blue Cross and Blue Shield.**

## Section 10: Signature — Required, if you are applying for coverage. Please review your application for errors or omissions.

**Read Section 10 carefully before signing.**
I have read and understand the language in the TERMS section of this application and agree to all of its terms.

| Employee signature | Date |
|---|---|
| **X** | |

**Section 11: Waiver of coverage** — Complete for yourself and/or any eligible dependents. Check all that apply.

| Type of coverage | Waived for | Name | Reason for waiving (already protected by coverage) | |
|---|---|---|---|---|
| ☐ Medical | ☐ Self<br>☐ Spouse/DP<br>☐ Child(ren) | | ☐ Anthem<br>☐ Other carrier<br>☐ No coverage | Certificate/policy no. or Carrier name and ID no. |
| ☐ Dental | ☐ Self<br>☐ Spouse/DP<br>☐ Child(ren) | | ☐ Anthem<br>☐ Other carrier<br>☐ No coverage | Certificate/policy no. or Carrier name and ID no. |
| ☐ Vision | ☐ Self<br>☐ Spouse/DP<br>☐ Child(ren) | | ☐ Anthem<br>☐ Other carrier<br>☐ No coverage | Certificate/policy no. or Carrier name and ID no. |
| ☐ Life | ☐ Self<br>☐ Spouse/DP<br>☐ Child(ren) | | ☐ Anthem<br>☐ Other carrier<br>☐ No coverage | Certificate/policy no. or Carrier name and ID no. |
| ☐ All | ☐ Self<br>☐ Spouse/DP<br>☐ Child(ren) | | ☐ Anthem<br>☐ Other carrier<br>☐ No coverage | |

Check all that apply:

☐ I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. If I want to apply for such coverage at a later date, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse or domestic partner) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependents or I become eligible for a subsidy (state premium assistance program).

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

☐ I have been given an opportunity to apply for the available group life benefits offered by my employer/group. The benefits have been explained to me, and I and/or my dependent(s) decline to participate. My dependent(s) or I were not induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for coverage in the future, I may be required to provide evidence of insurability at my expense.

**Section 12: Signature — Required, if you want to waive coverage for yourself and your dependents.**

| Employee signature | Date |
|---|---|
| X | |