Nye County PPO Enrollment Application and Change Form

Anthem BlueCross BlueShield

Check all coverage that applies: ☑ Medical

Social Security no.[1] (Required) _____ (must be completed by **employee**)

Member no. _____ (must be completed by **employee**)

Employer case no. _____ (must be completed by **employer**)

Dental group /subgroup no. _____ (must be completed by **employer**)

Life group no. _____ (must be completed by **employer**)

Section 1: Reason for completing application

☐ New enrollment ☐ Beneficiary change ☐ Reinstatement of coverage ☐ Personal information change ☐ Coverage change
☐ Canceling coverage ☐ Other: _____
Qualifying event (See section 8 for requirements on qualifying events/special enrollments.): _____
Change effective date: ____ (MM/DD/YY)

Section 2: Benefits and coverage desired

Ask your employer for the medical, dental and vision coverage options available. For life and disability insurance coverage option, see page 4. Ask your employer if coverage for domestic partner (DP)[2] is offered.

Medical benefit plan: ☐ PPO $500
☐ PPO $2,500
☐ PPO HSA $3,300

Medical coverage: ☐ Employee (Emp) ☐ Emp and spouse/DP ☐ Emp and child(ren) ☐ Family ☐ Decline and complete waiver (section 6)

Dental coverage plan: ☐ Dental Prime (select one) ☐ Option 1 ☐ Option 2
☐ Dental Complete (select one) ☐ Option 1 ☐ Option 2
☐ Essential Choice: _____
☐ Consumer Choice: _____
☐ Other: _____

Dental coverage: ☐ Employee (Emp ☐ Emp and spouse/DP ☐ Emp and child(ren) ☐ Family ☐ Decline and complete waiver (section 6)

This section does not apply.

Vision coverage plan: ☐ Blue View Visio
☐ Other: _____

Vision coverage: ☐ Employee (Emp) ☐ Emp and spouse/DP ☐ Emp and child(ren) ☐ Family ☐ Decline and complete waiver (section 6)

FSA coverage plans: ☐ Healthcare Flexible Spending Account ☐ Limited Purpose Flexible Spending Account ☐ Dependent Care Flexible Spending Account
☐ Commuter Transit ☐ Commuter Parking

FSA coverage: ☐ Employee (Emp) ☐ Emp and spouse/DP ☐ Emp and child(ren) ☐ Family ☐ Decline and complete waiver (section 6)

1 Anthem is required by the Internal Revenue Service to collect this information.
2 A person named as Domestic Partner (DP) under a Certificate of Registered Domestic Partnership where required by Nevada law.
3 Confirm with your employer which HSA custodian was selected.

Required: Employee Social Security/member no.: ___ ___ ___ ___ ___ ___ ___ ___ ___

Section 3: Employee and family information

List yourself and all eligible family members who are applying for or waiving coverage. Include domestic partner information only if coverage for domestic partner is offered by your employer. Use a separate sheet, if needed.

☐ Add ☐ Change ☐ Cancel ☐ Waive

Employee last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YY)	Relationship **Self**
Mailing street address for member correspondence	City		State	ZIP code	Home phone no.
Email address	Hire date	Employment date	☐ Hourly ☐ Salaried	Hours worked/ week	Earnings: $_____ Per: _____
Full company name			Position title		
Primary Care Physician (PCP)			PCP ID no.		Current patient ☐ Yes ☐ No
Primary Care Dentist (PCD)			PCD ID no.		Current patient ☐ Yes ☐ No

☐ Add ☐ Change ☐ Cancel ☐ Waive

Spouse/Domestic partner last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YY)	Relationship (required) ☐ Spouse ☐ Domestic partner
Social Security no.[1] (Required)	If you and your spouse/domestic partner have different last names, check the applicable box: ☐ Spouse/DP retaining name				
Primary Care Physician (PCP)			PCP ID no.		Current patient ☐ Yes ☐ No
Primary Care Dentist (PCD)			PCD ID no.		Current patient ☐ Yes ☐ No

☐ Add ☐ Change ☐ Cancel ☐ Waive

Dependent last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YY)	Relationship
Social Security no.[1] (Required)	☐ Over-age Mentally/Physically Disabled Dependent (**Initial Over-age Dependent Affidavit in section 7**, and attach *Mentally/Physically Disabled Dependent Form.*) ☐ Court-ordered Health Care Coverage (Attach copy of court order.)				
Primary Care Physician (PCP)			PCP ID no.		Current patient ☐ Yes ☐ No
Primary Care Dentist (PCD)			PCD ID no.		Current patient ☐ Yes ☐ No

☐ Add ☐ Change ☐ Cancel ☐ Waive

Dependent last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YY)	Relationship
Social Security no.[1] (Required)	☐ Over-age Mentally/Physically Disabled Dependent (**Initial Over-age Dependent Affidavit in section 7**, and attach *Mentally/Physically Disabled Dependent Form.*) ☐ Court-ordered Health Care Coverage (Attach copy of court order.)				
Primary Care Physician (PCP)			PCP ID no.		Current patient ☐ Yes ☐ No
Primary Care Dentist (PCD)			PCD ID no.		Current patient ☐ Yes ☐ No

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

Required: Employee Social Security/member no.:

Section 3: Employee and family information (continued)

☐ Add ☐ Change ☐ Cancel ☐ Waive					
Dependent last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YY)	Relationship
Social Security no.[1] (Required)	☐ Over-age Mentally/Physically Disabled Dependent (**Initial Over-age Dependent Affidavit in section 7**, and attach *Mentally/Physically Disabled Dependent Form.*) ☐ Court-ordered Health Care Coverage (Attach copy of court order.)				
Primary Care Physician (PCP)			PCP ID no.		Current patient ☐ Yes ☐ No
Primary Care Dentist (PCD)			PCD ID no.		Current patient ☐ Yes ☐ No

Section 4: Prior and other insurance

Have you or any of your dependents had any other coverage in the last 12 months or currently have coverage other than the applied-for coverage?
☐ Yes ☐ No If yes, please complete the section below for all covered members. If coverage remains in force, do not complete the end date section of the form below. Use a separate sheet for additional entries, if needed.

Member name (first, middle initial, last)	**Type**	**Carrier** (name, phone no., and policy ID)	**(MM/DD/YY)**
	☐ Medical ☐ Dental ☐ Vision ☐ Orthodontia ☐ Prescription	Name: Phone no.: Policy ID:	Start: End:
	☐ Medical ☐ Dental ☐ Vision ☐ Orthodontia ☐ Prescription	Name: Phone no.: Policy ID:	Start: End:
	☐ Medical ☐ Dental ☐ Vision ☐ Orthodontia ☐ Prescription	Name: Phone no.: Policy ID:	Start: End:
	☐ Medical ☐ Dental ☐ Vision ☐ Orthodontia ☐ Prescription	Name: Phone no.: Policy ID:	Start: End:

Section 5: Medicare coverage — Complete if you, your spouse/domestic partner or dependent child(ren) have Medicare coverage. Use a separate sheet if needed.

Member name (first, middle initial, last)	**Part A effective date (MM/DD/YY)**	**Part B effective date (MM/DD/YY)**	**Reason for disability if under age 65**	**Medicare claim no.**

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

Required: Employee Social Security/member no.: ___

Section 6: Waiver of insurance — Complete only if you intend to waive insurance.

I hereby certify that I have been given the opportunity to participate in my employer's group insurance plan(s) underwritten by the company(ies) indicated on this enrollment application.

The plan has been explained to me, and I decline to participate.

☐ **I do not want to participate in the group insurance plan at this time for the following reason(s):** (Check all that apply.)

- ☐ I have other group health insurance.
- ☐ I have other group dental insurance.
- ☐ I have other group vision insurance.
- ☐ I have other individual health insurance.
- ☐ I have no other insurance coverage, and I am not interested at this time.
- ☐ I have religious objections (non-contributory life insurance).
- ☐ I am a dependent of an active or retired military service member.
- ☐ I am retired from military service.
- ☐ I do not wish to participate (contributory life insurance).
- ☐ I and/or my dependent(s) have coverage under a state child health insurance program or a state Medicaid plan.

Section 7: Over-age Dependent Affidavit

By initialing below, I verify and attest that my dependent(s) age 26 and over is/are unmarried and financially or otherwise dependent on me due to mental and/or physical disability and therefore eligible for coverage under the policy for which I am applying. I understand that I am responsible for notifying Anthem within 31 days of any changes to the status of my dependent(s). I understand that coverage is dictated by the actual situation at the time services are rendered, and if my dependent does not qualify as a dependent when services are provided, the charges for those services are not reimbursable by Anthem and may become my sole responsibility. I also understand that over-age dependent eligibility must be renewed each year, as specified by the *Certificate*. I understand that Anthem reserves the right to request, at any time, proof of over-age dependency. Initials: _____

Section 8: Signature required

I understand that the coverage I am applying for is subject to eligibility requirements. I acknowledge that I have read all sections of this application, including the information on the back page, and certify that I agree to all matters covered herein. I also acknowledge that all information provided on this application is complete and accurate to the best of my knowledge. I understand and agree that this application shall become part of the contract between Anthem and me.

I understand that by signing the field below labeled "Employee signature" I'm also consenting to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Nevada Division of Insurance within the Department of Business and Industry.

Description of Special Enrollments

If you decline enrollment for yourself or your dependents (including your spouse/domestic partner) because of other health insurance or group health plan coverage except coverage under a state child health insurance program or a state Medicaid plan, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you decline enrollment for yourself or your dependents (including your spouse/domestic partner) because of coverage under a state child health insurance program or a state Medicaid plan, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility under the state child health insurance program or state Medicaid plan. However, you must request enrollment within 60 days: (1) after the date the coverage under a state child health insurance program or a state Medicaid plan ends; or (2) after the date you become eligible for state premium assistance for group coverage.

In addition, if you have a new dependent as a result of marriage/registered domestic partnership, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage/registered domestic partnership, birth, adoption or placement for adoption.

To request special enrollment submit a completed application to the address below. To obtain more information, contact Anthem Customer Service at 1-877-811-3106; or Anthem Blue Cross and Blue Shield, P.O. Box 5858, Denver, CO 80217-5858.

Employee signature	Date (MM/DD/YY)
X	