

EMPLOYEE HEALTH ENROLLMENT APPLICATION

(Group Size 15+)

Please PRINT in ink and return to your employer. Use extra sheets of paper if necessary. The Primary Care Physician (PCP) listings of Anthem and its affiliated HMO company can be obtained through www.anthem.com.

APP

EMPLOYER/GROUP USE ONLY

| | | | | | | |
|----------------|---------------------|--------------------------|----------------------------------|-------------------------|--|--|
| Group Name | | Group Number | | Effective Date M D Y | | |
| Date of hire | Full time hire date | # Hours working per week | Date of eligibility for coverage | | | |
| Position/Title | | | Employee's Social Security #: | | | |

1. CHECK COMPANY(S) AND WRITE IN PRODUCT THAT APPLIES. APPLICATION COMPLETED FOR:

Anthem Blue Cross and Blue Shield

HealthKeepers, Inc. _____ (HMO)

Note for Lumenos Health Savings Account (HSA) enrollees:

If you enroll in an Anthem Lumenos HSA plan, Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

Coverage Option

If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, Anthem Blue Cross and Blue Shield or by another carrier.

Limited Mandate PPO Plan Disclosures

In addition to offering health benefit plans that include all mandated benefits, Anthem Blue Cross and Blue Shield offers Limited Mandate PPO plans.

The Limited Mandate PPO plans, which are now authorized by Virginia law, are not required to provide all state-mandated health benefits. The Limited Mandate PPO plans are not available to groups of more than 50 employees. These plans specifically exclude the following state mandated benefits: coverage for supplies and services related to cancer clinical trials for treatment studies on cancer, prescription contraceptives, hospitalization and anesthesia for dental procedures, diabetes education and training, early intervention, hemophilia, lymphedema except in the connection of breast reconstruction, mental health and substance abuse and TMJ. Obstetrical supplies and services are also excluded in Limited Mandate PPO plans offered in the 2-14 market only. **It is the group's responsibility to ensure it meets the federal requirement to have maternity coverage if it employs 15 or more employees.** Further, all Limited Mandate PPO plans include a limitation on one state-mandated benefit. There is a limit of one glucometer per member per calendar year or plan year, as applicable.

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

| | |
|---|--|
| <input type="checkbox"/> Initial enrollment | <input type="checkbox"/> Marriage Date of marriage: _____ |
| <input type="checkbox"/> Annual open enrollment | <input type="checkbox"/> Loss of eligibility for other coverage Date previous coverage ended: _____ |
| <input type="checkbox"/> New hire | <input type="checkbox"/> Birth of child |
| <input type="checkbox"/> Rehire – Date of rehire: _____ | <input type="checkbox"/> Add Dependent* Date of adoption/placement for adoption, court order or legal appointment: _____ |
| <input type="checkbox"/> COBRA – Qualifying Event: _____ Event Date: _____ | |

*If adding a dependent due to adoption, placement for adoption, medical child support order, legal appointment (such as guardianship), legal documentation must be attached to the enrollment application.

3. TYPE OF COVERAGE/PLAN

| | | |
|--|---|--|
| Health Coverage | <input type="checkbox"/> Employee and One Child | Vision Coverage |
| <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee and Children | <input type="checkbox"/> Voluntary Vision |
| <input type="checkbox"/> Employee and Spouse | <input type="checkbox"/> Employee and Family | <i>(type of coverage must match health coverage)</i> |

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia. Anthem Blue Cross and Blue Shield and its affiliated HMO, HealthKeepers, Inc., are 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.

4. EMPLOYEE INFORMATION* (Please refer to Definitions of Eligibility, Section 9)

**If applying for coverage that requires a Primary Care Physician (PCP), list the PCP name, PCP number and address.*

| | | |
|---|--|---|
| Social security # | Date of birth (MM/DD/YYYY) | Sex: <input type="checkbox"/> M <input type="checkbox"/> F |
| Last name | First name | M.I. |
| Street address (Please include Apt.#) | | |
| City | State | Zip |
| Daytime phone (with area code) () - | Evening phone (with area code) () - | |
| Anthem PCP name* (please provide first and last name) | Anthem PCP ID number* | |
| PCP Address | Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

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? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach documentation) b. Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No (applicable only to policies with unique student status eligibility requirements) c. Disabled prior to age 26/handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes, attach documentation) b. Full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No (applicable only to policies with unique student status eligibility requirements) c. Disabled prior to age 26/handicapped? <input type="checkbox"/> Yes <input type="checkbox"/> 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"/> 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 prior to age 26/handicapped? 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? 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%;"> Last Name First Name </div> |
|---------------------------|---|

Do you intend to continue this coverage? Yes No

If no, please provide cancellation date of coverage: _____

If yes, 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. DEFINITIONS

Eligible employee:

- An active employee of the Group Policyholder who works at least 25 hours per week and 50 weeks per year as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 31 days.
- Any other class of persons identified by the Group Policyholder, provided that written approval of their eligibility is obtained from the HMO or Anthem Blue Cross and Blue Shield; or
- Employees eligible for continuous coverage under state or federal laws, e.g. COBRA.
- To become an eligible employee, a director or officer of a corporate Group must meet the same requirements as other employees of the Group Policyholder.
- Independent contractors (those whose wages are reported on IRS Form 1099) are considered to be self-employed and are not eligible for group coverage.

Eligible dependent:

- Employee's spouse, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for children will end on the last day of the month in which the children reach age 26. *(The new dependent age limit of 26 applies at the group's first renewal after September 23, 2010.)*
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition.)
- Dependents eligible for continuous coverage under State or Federal laws, e.g. COBRA.

9. 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.

- For Lumenos Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.
- 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., I understand that the health maintenance organization (HMO) may cancel my coverage with 31 days advance written notice of termination 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 _____