Indiana Dental Association –
ANTHEM ENROLLMENT APPLICATION

Anthem

It is essential that you read this application carefully and complete all the necessary sections.

If you are a new enrollee applying for health coverage, please complete the following sections:
2-Reason for Application
4-Type of Coverage/Plan
5-Employee Information
6-Family Information
7-Other Health Coverage (if you will have active health coverage in addition to this coverage) must answer yes or no. If yes, complete additional information.
8-Prior Health Coverage, must answer yes or no. If yes, complete additional information.
9-Medical Information
10-Signature and Date
11-Waiver of Coverage (sign the waiver of coverage for any eligible dependents not enrolling)

If you are waiving coverage, please complete the following sections:
2-Reason for Application (Waiver)
5-Employee Information
11-Waiver of Coverage (sign the waiver of coverage for yourself and/or any eligible dependents not enrolling)

If you are adding a dependent(s), please complete all the above sections <u>AND</u> section 3- Status Change/Event.

It is important that you read and understand the Significant Terms, Conditions and Authorizations on the last page.

Your signature and date is required on the last page.

Note: You may be required to supply additional information.

Send completed Application to: IDA Insurance Services
1319 E. Stop 10 Road
Indianapolis, IN 46227
or Fax to: 317-687-3682

Thanks for choosing the Indiana Dental Association and Anthem Blue Cross and Blue Shield.

www.anthem.com
www.IDAinsurance.com

Enrollment Application

Use form for new enrollments, additions, changes or terminations.

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer.

1. **Employer/Group Use:** Dental Office Name, Address, Phone & Fax #			
Group # (ex:00XXXXX)	Client Code ID ----	Plan Type	Requested Effective Date ☐ Employer Contribution
		☐ Group ☐ Member Dentist	___ ___ / ___ ___ / ___ ___ ___ ___
Anthem Use: Plan	Health Effective Date	COB	Pre-ex (date)
	____ / ____ / ____	☐ YES ☐ NO	___ ___ / ___ ___ / ___ ___ ___ ___

2. Reason for Application

- ☐ New Enrollment
- ☐ Waiver
- ☐ Annual Open Enrollment
- ☐ COBRA/Conversion
- ☐ Cancel Dependent
- ☐ Special Enrollment
- ☐ New Hire
- ☐ Rehire (date) ___/___/_____
- ☐ Add Dependent (see Section 3)
- ☐ Change of Employer
- ☐ Termination of Coverage
- ☐ Address or name changes

3. Status Change/Event (include legal documentation)

Event Date_____/_____/_____

- ☐ Marriage
- ☐ Birth
- ☐ Adoption
- ☐ Legal Guardianship
- ☐ Other

4. Type of Coverage/Plan

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family
- ☐ No Coverage

Deductible Option:

Traditional
- ☐ 500

PPO
- ☐ 500
- ☐ 1000
- ☐ 2500

HSA
Individual Coverage:
- ☐ 1100
- ☐ 2000
- ☐ 2650

Family Coverage:
- ☐ 2200
- ☐ 4000
- ☐ 5250

5. Employee Information

Last Name	First Name, M.I.	Date of Birth	Age	Sex ☐ M ☐ F	Social Security #	☐ Single ☐ Divorced ☐ Married	Height	Weight

Home Address	City	State	ZIP Code	County

Home Telephone	Business Telephone	Email Address

Are You:	Retired?	Disabled?	Hospitalized?	Occupation	Full Time Date of Hire	Hours working per week	Income reported by:
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		____/____/_____		☐ W2 ☐ 1099 ☐ Other:

6. Family Information *Spouse and dependents to be covered or deleted (Attach a separate sheet if necessary.)*

1. Last Name	First Name, M.I.	Relationship to Applicant	Full Time Student?
		☐ Spouse ☐ Son ☐ Daughter ☐ Other _____	☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (if yes, provide full address)

Date of Birth	Sex	Social Security #	Height	Weight	Eligible for federal income tax exemption? / Court ordered health care coverage? / Currently hospitalized or disabled?
	☐ M ☐ F				☐ Yes ☐ No / ☐ Yes ☐ No (if yes, include legal documentation) / ☐ Yes ☐ No (if yes, give reason)

2. Last Name	First Name, M.I.	Relationship to Applicant	Full Time Student?
		☐ Spouse ☐ Son ☐ Daughter ☐ Other _____	☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (if yes, provide full address)

Date of Birth	Sex	Social Security #	Height	Weight	Eligible for federal income tax exemption? / Court ordered health care coverage? / Currently hospitalized or disabled?
	☐ M ☐ F				☐ Yes ☐ No / ☐ Yes ☐ No (if yes, include legal documentation) / ☐ Yes ☐ No (if yes, give reason)

3. Last Name	First Name, M.I.	Relationship to Applicant	Full Time Student?
		☐ Spouse ☐ Son ☐ Daughter ☐ Other _____	☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (if yes, provide full address)

Date of Birth	Sex	Social Security #	Height	Weight	Eligible for federal income tax exemption? / Court ordered health care coverage? / Currently hospitalized or disabled?
	☐ M ☐ F				☐ Yes ☐ No / ☐ Yes ☐ No (if yes, include legal documentation) / ☐ Yes ☐ No (if yes, give reason)

4. Last Name	First Name, M.I.	Relationship to Applicant	Full Time Student?
		☐ Spouse ☐ Son ☐ Daughter ☐ Other _____	☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (if yes, provide full address)

Date of Birth	Sex	Social Security #	Height	Weight	Eligible for federal income tax exemption? / Court ordered health care coverage? / Currently hospitalized or disabled?
	☐ M ☐ F				☐ Yes ☐ No / ☐ Yes ☐ No (if yes, include legal documentation) / ☐ Yes ☐ No (if yes, give reason)

7. Other Health Coverage **Please Check One:** ☐ YES (complete below.) ☐ NO

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 number	Effective Date
			_____/_____/_____
Policy / Certificate holder's name	**Social Security Number**	**Date of Birth**	**Relationship to Applicant**
		_____/_____/_____	

If you and / or your dependents are enrolled in Medicare Part A or Medicaid, complete the following.

Enrollee's Name(s)	Medicare/Medicaid ID#	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
		_____/_____/_____	_____/_____/_____	____/____/_____
		_____/_____/_____	_____/_____/_____	____/____/_____

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

8. Prior Health Coverage **Please Check One:** ☐ YES (complete below.) ☐ NO

Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No Policy/Certificate #	Group name / ID#	Dates policy in effect: _____/_____/_____ - _____/_____/_____
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)	Dates policy in effect: _____/_____/_____ - _____/_____/_____

Please check the type of prior coverage:
☐ Employee ☐ Employee / Spouse ☐ Employee / Child(ren) ☐ Employee / Spouse / Child(ren)

Termination reason: ☐ Divorce / legal separation ☐ Death of spouse ☐ COBRA coverage exhausted ☐ Employment terminated
☐ Group plan terminated ☐ Employer/group contribution ceased ☐ Other:

9. Medical Information

Please note that no person will be denied health coverage on an individual basis due to the answers provided below.

(if yes, circle condition and provide detail below)

1. Do you or your dependents regularly take medication? . . . ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future?. . . . . ☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant? If yes, Name _____ Due Date _____ ☐ Yes ☐ No
4. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor; disorder of the blood or immune system; stroke, aneurysm, diabetes (list age of onset below); mental/nervous disorder; depression, alcohol or drug abuse/dependency; kidney, liver or pancreas disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; or muscular dystrophy? . . . . . ☐ Yes ☐ No
5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? . . . . . ☐ Yes ☐ No
6. Have you or any of your dependents visited the emergency room on 2 or more occurrences for the same condition in the last 12 months? . . . . . ☐ Yes ☐ No
7. Have you or your dependents used tobacco products in the last 12 months? . . . . . ☐ Yes ☐ No

(If yes, circle condition)

8. To the best of your knowledge, have you or any of your dependents, within the last 5 years, had a diagnosis of or treatment for the following:
   a. Ulcer, hernia, diverticulitis, irritable bowel or other intestinal disorder? . . . . . ☐ Yes ☐ No
   b. Thyroid, goiter or gallbladder disorder? . . . . . ☐ Yes ☐ No
   c. High blood pressure, cholesterol or triglycerides? . . ☐ Yes ☐ No
   d. Anemia, chest pain, heart murmur or disorder of the veins/circulatory system? . . . . . ☐ Yes ☐ No
   e. Rheumatic fever, carpal tunnel syndrome or disorder of the muscles or joints?. . . . . ☐ Yes ☐ No
   f. Epilepsy, convulsions, paralysis or disorder of the brain or nervous system?
   g. Asthma, allergies, sinus, or disorder of the respiratory system?. . . . . ☐ Yes ☐ No
   h. Any STD or disorder of the prostate, genital, reproductive or urinary system? . . . . . ☐ Yes ☐ No
   i. Any disorder of the skin, ears, or eyes?. . . . . ☐ Yes ☐ No
9. Have you or any of your dependents, within the last 2 years engaged in skydiving, hang gliding, underwater diving, racing (any type), rodeo, mountaineering, professional sports, piloting a plane or are any such activities contemplated? . . . . . ☐ Yes ☐ No
10. Are you or any of your dependents presently disabled or had a condition not identified above during the past 5 years? . . . ☐ Yes ☐ No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest #	Name of Individual	Diagnosis	Treatment	Medication	Date(s) of Treatment	Hospitalized? (Y/N)	Surgery (Y/N)	Recovered? (Y/N)	Physician's name
					/ /				
					/ /				
					/ /				
					/ /				
					/ /				
					/ /				
					/ /				

Please read the TERMS on the reverse side of this page. Your signature is required on the reverse side of this to submit this application.

Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield Program.
2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
3. I am applying for the coverage selected on this application. If I select a coverage, or combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
6. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or recission or cancellation of my coverage(s).

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health coverage will be provided by one of the following companies based upon the state in which your employer, trust or association is located:

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.

Thank you for choosing Anthem Blue Cross and Blue Shield

10. Read the TERMS section above carefully before signing. Please review your application for errors or omissions.

By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Application Signature	Date ____/____/________

11. Waiver of coverage for employee and / or any eligible dependent not enrolling

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer Name	Carrier: ☐ Anthem (give certificate / policy #) ☐ Other Carrier (give name, ID#)	
Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer Name	Carrier: ☐ Anthem (give certificate / policy #) ☐ Other Carrier (give name, ID#)	
Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer Name	Carrier: ☐ Anthem (give certificate / policy #) ☐ Other Carrier (give name, ID#)	
Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer Name	Carrier: ☐ Anthem (give certificate / policy #) ☐ Other Carrier (give name, ID#)	

I certify that 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. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures.

If I am declining enrollment for myself or my dependents (including my spouse) 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. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. 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.

Applicant Signature	Date ____/____/________