Small Group Employee Change Form

Anthem

Consult the Certificate of Coverage for complete term and conditions. Complete electronically or in black ink and return to your employer.
Please use extra sheets of paper if necessary.

Section A: Employer and Employee Information

Employer name			Employer tax ID no.		
Employee home address — Street or P.O. Box if applicable		City	County	State	ZIP code
Retired? ☐ Yes ☐ No	Primary phone no.	Employee email address			

I am providing my email address because **I, and my enrolled dependents, want to receive information about our benefits electronically**. These communications may include Identification (ID) Cards, Certificates of Coverage or Evidence of Coverage, grievance, appeals, and medical necessity determination notifications, Explanation of Benefits, other required notices, and personalized information to help get the most out of the benefits. I understand I need to register on anthembluecross.com or the Sydney Health mobile app to get the most out of my plan's digital tools, and I will make sure Anthem has my most up-to-date email address. I, and my enrolled dependents, understand that we can update our email addresses, change our communication preferences, and request free copies of any materials at any time by going to anthembluecross.com or calling the Member Services number on my ID Card.

You must fill out the following section: Would you like to be added to the Donate Life Registry?
☐ **YES or** ☐ **SKIP THIS QUESTION**

Reason for change(s) — Select all that apply.

☐ Address change	☐ Cancel Spouse/Domestic Partner or dependent	☐ Enrollment in Medicare (Fill in Section C)
☐ Name change	☐ Change Primary Care Physician (PCP)	☐ Cancel all coverage
☐ Benefit change	☐ Change Primary Care Dentist (PCD)	☐ Cancel product(s)
☐ Add Spouse/Domestic Partner or dependent		☐ Other:

Event reason — Select all that apply.

☐ Open enrollment*	☐ Birth of child	☐ Involuntary loss of coverage	☐ Termination of employment
☐ Marriage	☐ Adoption of child	☐ Other insurance	☐ Termination of other group plan
☐ Divorce	☐ Death	☐ Court ordered coverage	☐ Other[2]:

Event date: ____/____/_____ (MM/DD/YYYY) *Leave Event Date field blank.
Effective date is subject to terms of Certificate of Coverage. See "When Coverage Begins" under "Who is Covered."

Section B: Employee and Dependent Type of Coverage and Coverage Information — Complete this section for you and dependents to be covered. All fields required. Attach a separate sheet if necessary.

Enrollee	Employee/Subscriber	Spouse/Domestic Partner/Dependent* ☐ Add ☐ Change ☐ Cancel
Social Security no.[1]	– –	– –
Birthdate (MM/DD/YYYY)	/ /	/ /
Last name		
First name, Middle initial		
Gender	☐ Male ☐ Female ☐ Gender X	☐ Male ☐ Female ☐ Gender X
Check all that apply:		☐ Spouse ☐ Domestic Partner ☐ Dependent
*Enter dependent's address, if different:		
Medical Coverage		
Medical contract code		
Primary Care Physician (PCP) name[3]		
PCP ID no.		
Existing patient	☐ Yes ☐ No	☐ Yes ☐ No

1 Anthem Blue Cross (Anthem) is required by the Internal Revenue Service to collect this information.
2 See Certificate of Coverage description of "Special Enrollment Periods" under "Who is Covered" for other event reasons.
3 To select a PCP and/or PCD, visit our website at www.anthembluecross.com/find-care. If your Anthem benefit plan requires you to pick a PCP and/or PCD and you do not select one, we will assign one to you. You will be able to change to another PCP and/or PCD by contacting us.

Dental Coverage		
Enrollee	**Employee/Subcriber**	**Spouse/Domestic Partner/Dependent**
Dental contract code		
Primary Care Dentist (PCD) name[3]		
PCD ID no.		
Existing patient	☐ Yes ☐ No	☐ Yes ☐ No
Vision Coverage		
Vision contract code		

Section C: Prior and Other Group Coverage — Attach a separate sheet if necessary.

Is anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name: _____

Medicare ID no.	Part A effective date (MM/DD/YYYY) / /	Part B effective date (MM/DD/YYYY) / /	Medicare eligibility reason (select all that apply) ☐ Age ☐ Disability ☐ End-stage renal disease: Onset date (MM/DD/YYYY) ____/____/_____
Medicare Part D ID no.	Medicare Part D Carrier		Part D effective date (MM/DD/YYYY) / /

Is anyone applying for coverage covered by other health insurance? ☐ Yes ☐ No If yes, please provide the following:

Name of Person covered (Last, First, M.I.)	Type (select one)	Coverage (select all that apply)	Insurer name	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start: ___/___/____ End: ___/___/____
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start: ___/___/____ End: ___/___/____

Section D: Terms, Conditions and Authorizations

In signing this application I represent that: I have read, or have had read to me, the completed application, and I realize any false statement or misrepresentation may result in loss of coverage. I certify each Social Security Number listed on this application is correct.

By providing a phone number, I agree and consent that Anthem and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.

As an eligible employee, I request coverage for myself and eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. I understand all benefits are subject to conditions stated in my employer's Group Contract and my Certificate of Coverage.

INSURANCE FRAUD STATEMENT: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Sign here		
	Applicant signature X	**Today's date (MM/DD/YYYY)** / /
	Company officer signature X	**Today's date (MM/DD/YYYY)** / /
	Printed name	**Group no.**

3 To select a PCP and/or PCD, visit our website at www.anthembluecross.com/find-care. If your Anthem benefit plan requires you to pick a PCP and/or PCD and you do not select one, we will assign one to you. You will be able to change to another PCP and/or PCD by contacting us.

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。ID カードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kannscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kannscht.

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf