Employee Enrollment Application For Small Groups Nevada

Anthem

Consult the Booklet or Certificate of Coverage for complete coverage terms and conditions. For more information about Anthem Blue Cross and Blue Shield (Anthem), its products and services, visit anthem.com. Please complete electronically or in black ink only and use extra paper if necessary. The employee who completes this application is solely responsible for its accuracy and completeness. Be sure to answer all questions and to sign and date your application.

Section A: Application Type

Select one:

☐ New enrollment ☐ Open enrollment ☐ COBRA ☐ Rehire date: (MM/DD/YYYY) ____/____/_____

Select qualifying event

☐ Birth, adoption or placement for adoption (for birth and legal adoption)
☐ Loss of dependent child status
☐ Reduction in hours
☐ Covered employee's Medicare entitlement
☐ Loss of CHIP
☐ Marriage/Domestic Partnership
☐ Other _____
☐ Death
☐ Loss of coverage
☐ Medical subsidy
☐ Left employment
☐ Medicare

Qualifying event date: (MM/DD/YYYY) ____/____/_____

Section B: Employee Information

Last name	First name	M.I.	Social Security no.[1] (required) – –
Home address — Street or P.O. Box if applicable	City	State	ZIP code
County	Primary phone no.	Marital Status ☐ Single ☐ Married ☐ Domestic Partner	
Employer name			Group no. (if known)
Employer street address	City	State	ZIP code
Employment Status: ☐ Full-time ☐ Disabled		Occupation	
Date of hire (MM/DD/YYYY) / /	Date of full-time employment (MM/DD/YYYY) / /	Date waiting period begins (MM/DD/YYYY) / /	No. of hours worked per week

Email address: _____

By initialing, I consent for my email address to be used to receive information about our benefits electronically:_____

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 determination notifications, Explanations of Benefits, other required notices, and personalized information to help get the most out of the benefits. I understand I need to register on anthem.com or the Sydney Health℠ mobile app to get the most out of my plan's digital tools, and I will make sure Anthem and HealthKeepers have 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 anthem.com or calling the Member Services number on my ID card.

Section C: Type of Coverage

1. Medical Coverage — Indicate the contract code for the medical plan selected. Your employer will advise you of your plan options and contract codes.

Medical product plan name:	Contract code, if known:

Member medical coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

2. Dental Coverage — Indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.

Standalone Dental plans do not include Essential Health Benefits.

Dental product plan name:	Contract code, if known:

Member dental coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

3. Vision Coverage — Indicate the contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.

Vision product plan name:	Contract code, if known:

Member vision coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

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

Section D: Family Information —

All fields required. Attach a separate sheet if necessary. Complete this section for yourself and all dependents.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your Spouse/Domestic Partner, your children, or your Spouse's/Domestic Partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Employee Last name	First name	M.I.

Sex	Disabled	Birthdate (MM/DD/YYYY)
☐ Male ☐ Female	☐ Yes ☐ No	/ /

Primary Care Physician (PCP) name	PCP ID no.	Existing patient
		☐ Yes ☐ No

Spouse/Domestic Partner Last name	First name	M.I.	Social Security no.[1] (required)
			– –

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No	/ /	☐ Spouse ☐ Domestic Partner

PCP name	PCP ID no.	Existing patient
		☐ Yes ☐ No

Dependent Child Last name	First name	M.I.	Social Security no.[1] (required)
			– –

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No	/ /	☐ Child ☐ Other[2] If other, what is relationship? _____

PCP name	PCP ID no.	Existing patient
		☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter: _____

Dependent Child Last name	First name	M.I.	Social Security no.[1] (required)
			– –

Sex	Disabled	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No	/ /	☐ Child ☐ Other[2] If other, what is relationship? _____

PCP name	PCP ID no.	Existing patient
		☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter: _____

1 Anthem is required by the Internal Revenue Service to collect this information.
2 Eligibility subject to Booklet or Certificate of Coverage.

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

Is anyone applying for coverage currently enrolled in 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:** ___/___/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			**Start:** ___/___/______ **End:** ___/___/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			**Start:** ___/___/______ **End:** ___/___/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			**Start:** ___/___/______ **End:** ___/___/______

Section F: Waiver/Declining Coverage

Type of coverage/Declined for — Select all that apply.		**Reason for declining/refusing coverage:** Select all that apply.
☐ Employee	☐ Medical ☐ Dental ☐ Vision	☐ No coverage ☐ Covered by Spouse's/Domestic Partner's group coverage ☐ Spouse/Domestic Partner covered by their employer's group coverage ☐ Enrolled in individual coverage ☐ Medicare/Medicaid/VA ☐ Enrolled in other Insurance — Please provide company name and plan: ______________________ ☐ Other — please explain: ______________________
☐ Spouse/Domestic Partner	☐ Medical ☐ Dental ☐ Vision	
☐ Dependent(s)	☐ Medical ☐ Dental ☐ Vision List name of dependents to be waived: ______________________	

Sign here only if you are declining coverage. DO NOT SIGN HERE IF YOU ARE APPLYING FOR COVERAGE.

Sign here to decline	**Applicant signature** X	**Applicant name** (print)	**Today's date (MM/DD/YYYY)** / /

Section G: Terms and Conditions — Please read this section carefully before signing the application.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem 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 30 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible dependent (see Booklet or Certificate of Coverage for complete dependent eligibility terms):

- Employee's Spouse/Domestic Partner 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 a child will end on the last day of the month in which the child reaches age 26.
- 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 a mental or physical impairment 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 such mental or physical impairment 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.

Special Enrollment Rights for Medical Coverage Only (see Booklet or Certificate of Coverage for complete enrollment rights):
If you declined enrollment for yourself or your dependent(s) (including a Spouse/Domestic Partner) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- Either your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

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

Section H: Authorizations — Please read this section carefully and then sign below.

In signing this application I represent that:

- I have read, or have had read to me, the completed application. All statements and answers I have given are true and complete, and I realize any materially false statement or misrepresentation in the application may result in loss of coverage.
- I am an eligible employee and I am requesting coverage for myself and all eligible dependents listed on this application.
- 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.
- I understand that I may not assign any payment under my Anthem program.
- I authorize my employer to deduct any required contributions for this insurance from my wages.
- I am asking for the coverage I chose on this application. 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.
- I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for coverage, and that no right is created by my application for coverage.
- 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.
- I authorize the Health Savings Account (HSA) financial custodian (provided I am enrolling in an HSA) to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA and that I may provide Anthem with a written request to revoke my authorization at any time.
- By initialing this application, I agree to the taping or monitoring of any phone calls between Anthem and me.

  Initial: _____

I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company; penalties may include imprisonment, fines or denial of insurance benefits. I also understand all benefits are subject to conditions stated in the Group Contract and the Booklet or Certificate of Coverage.

I give this authorization for myself and on behalf of my eligible dependents, including my Spouse/Domestic Partner, if covered by Anthem, and I am acting as their agent and representative. If my Spouse/Domestic Partner signs this application, he/she is giving this authorization on his/her own behalf.

Sign here to enroll	**Applicant signature** (or custodial parent's or guardian's signature if applicant is under 18) X	**Today's date (MM/DD/YYYY)** / /
	Spouse/Domestic Partner signature X	**Today's date (MM/DD/YYYY)** / /

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