Employer Application
Group size 51+ eligible employees
Indiana

Please complete electronically, or in blue or black ink only.

Group no.

Section 1: Company information

☐ New enrollment ☐ Renewal/Plan amendment	Benefit year ☐ Calendar year ☐ Plan year	Requested effective date (MMDDYYYY)
Applicant (legal name of group)		Tax ID/FEIN (required)
Name of association (if applicable)		
Company street address		
City	County	State / ZIP code
Billing address — If different from above		
City	County	State / ZIP code
Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Limited Liability Company (LLC) ☐ Labor union ☐ Trust ☐ Government unit/agency ☐ Other: _____		
SIC code — Required	Type of business	No. of years in business
Group administrator name		Primary phone no.
Email address		Fax no.
Additional company contact name		
Email address		Primary phone no.
Current group carrier	Current carrier effective date / Type of coverage	Type of funding
Is any part of group subject to bargaining agreement? ☐ Yes ☐ No Will bargaining agreement participants be considered eligible employees? ☐ Yes ☐ No		
Union name (attach copy of agreement)	Union no.	Contract expiration date

Group no.

Section 1: Company information — Continued

List all affiliates/subsidiaries/divisions (list names, locations, no. employed at each location.) Attach a separate page to show any separate billing addresses.

Names of affiliates/subsidiaries/divisions	Location	No. of employees per location

Total no. of employees residing/working outside of home office state	List no. of employees at each office location

Has your group been turned down for coverage in the last 12 months? ☐ Yes ☐ No
If yes, by whom, when, and why? _____

Will any insurance carrier(s), in addition to Anthem, provide medical coverage as part of the group's employee benefit plan? ☐ Yes ☐ No
If yes, list carrier(s) and product(s) offered: _____

In the past 36 months, has the company or any affiliate entity filed for protection or operated under federal/state bankruptcy laws (Chapter 11 or 7) or state receivership? ☐ Yes ☐ No

In the past 36 months, has any creditor filed or threatened to file a petition requesting the company or any affiliated entity to be placed voluntarily into bankruptcy? ☐ Yes ☐ No

Section 2: Type of coverage

Medical coverage

Large Group 51–99 options

☐ Blue Access PPO
☐ Blue Access PPO HRA
☐ Blue Access PPO HSA
☐ HealthSync HMO
☐ HealthSync HMO HSA with Copay
☐ Link Virtual First HealthSync HMO
☐ HealthSync POS
☐ HealthSync POS – 3Tier
☐ HealthSync POS HSA
☐ HealthSync POS – 3Tier HSA

Large Group 100+ options

☐ Anthem Essential PPO (renewal only)
☐ Blue Access PPO
☐ Blue Access PPO HSA
☐ Blue Access PPO HRA
☐ Blue Access PPO HRA with Copay (renewal only)
☐ Blue Access PPO Deductible First HRA
☐ Blue Access PPO HIA Plus
☐ Blue Preferred HMO
☐ HealthSync POS
☐ HealthSync POS – 3Tier
☐ HealthSync POS HSA
☐ HealthSync POS – 3Tier HSA
☐ HealthSync POS – 3Tier HRA (renewal only)
☐ HealthSync POS – 3 Tier HRA with Copay (renewal only)
☐ HealthSync POS HRA (renewal only)
☐ HealthSync POS HRA with Copay (renewal only)

☐ Add HRA Wrap (Administered by Anthem)

For employers providing a Health Savings Account (HSA) option:
Do you want Anthem to disclose your group's data to its banking services provider to establish Health Savings Accounts?
☐ No ☐ Yes — Requires completion of the CDHP questionnaire.

Flexible Spending Account (FSA) coverage — Multiple plans can be selected.

☐ Healthcare FSA (excluded if you have an HSA plan)
☐ Limited-Purpose FSA (for dental and vision services)
☐ Dependent Care FSA
☐ Commuter Parking
☐ Commuter Transit
☐ No FSA coverage at this time

Dental coverage

☐ Prime Essential Choice Quote ID: _____
☐ Prime Consumer Choice Quote ID: _____
☐ Other: _____ Quote ID: _____
☐ Complete Essential Choice Quote ID: _____
☐ Complete Consumer Choice Quote ID: _____

Vision coverage

☐ Vision

Contribution requirements

Choose your group contribution level for each month:

Medical: _____% per employee _____% per dependent (optional)
Dental: _____% per employee _____% per dependent (optional)
Vision: _____% per employee _____% per dependent (optional)

Do any classes have a percentage of group contribution different than above? ☐ Yes ☐ No
If yes, explain: _____

Group no.

Group Accident, Critical Illness, and Hospital Indemnity Insurance

Refer to sold case proposal for plan details.

☐ Accident Insurance — Contract code 1: _____ Contract code 2: _____ Contract code 3: _____

☐ Critical Illness Insurance — Contract code 1: _____ Contract code 2: _____ Contract code 3: _____
☐ Tobacco rated ☐ Uni–Tobacco

☐ Hospital Indemnity Insurance — Contract code 1: _____ Contract code 2: _____ Contract code 3: _____

Medicare Part D coverage

Prescription drug benefits: ☐ Wrap ☐ Waiver ☐ Subsidy

If subsidy (CMS Information needed):

Plan sponsor ID: _____

Application ID: _____

Unique benefit option identifier: _____

Section 3: Eligibility

Eligible full-time employees must work at least 30 hours per week, must be actively at work and must have satisfied any applicable eligibility waiting period. Eligible full-time employees do not include temporary or seasonal employees.

Total number of employees (including part-time): _____

Total number of full-time employees (including those within their waiting period): _____

Total number of full-time employees in employee waiting period: _____

Probationary period/waiting period for eligible enrollees:
☐ None ☐ First of month after hire date ☐ 1 month ☐ 30 days ☐ 2 months ☐ 60 days ☐ 90 days

Do any classes of employees have a different waiting period? ☐ Yes ☐ No
If yes, explain: _____

New eligible enrollees will become effective on:
☐ Day following completion of waiting period/probationary periods **(required for selection of 90 day waiting period)**
☐ First of month following completion of waiting period/probationary period

Do you wish to offer coverage for domestic partners? ☐ Yes ☐ No

Is your group subject to COBRA? ☐ Yes ☐ No
Do you have a COBRA administrator? ☐ Yes ☐ No
Do you want an Anthem affiliate to administer COBRA for your group? ☐ Yes ☐ No If yes, please complete and sign the COBRA agreement.

List employees/dependents on Continuation of Coverage/COBRA	Name of persons in COBRA eligibility period	List all totally disabled employees and dependents

ERISA qualified? ☐ Yes ☐ No

Employee termination effective date: ☐ End of month ☐ End of day

Plan type (check all that apply) ASO plan? ☐ Yes ☐ No Form 5500 no.: ___ ___ ___

ERISA	**Non-ERISA**
☐ For profit entity plan	☐ Religious entity plan
☐ Non-profit entity plan	☐ Government entity plan
☐ Partnership-partners and employees plan	☐ Partnership-partners only
☐ Tribes – employees plan	☐ Tribes – members
	☐ Workers' compensation/unemployment

If you selected Non-ERISA, is your employer plan? ☐ Public ☐ Private

Group no.

Section 4: Open enrollment

Our standard open enrollment period is at least 31 days prior to the group's renewal date and 31 days following, which is held no less frequently than once in any 12 consecutive months. If you want to designate a different open enrollment period, please indicate the following:

Start date: End date: (MMDDYYYY)

Section 5: Read this section carefully before signing. Please review your application for errors or omissions.

The employer and/or authorized representative hereby requests that it be approved for coverage through Anthem Blue Cross and Blue Shield (hereinafter "Anthem" unless otherwise specified) and to be bound by Anthem's rules and regulations pertaining to coverage under the insurance contracts and policies, as adopted and/or revised from time to time. Employer understands and certifies the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable.
2. To make the coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Anthem or their designated agent(s), any information required in connection with administration of the coverage.
4. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.
5. That statements of medical history will be required of employees, and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem.
6. That approval for this coverage may cancel any prior contracts and/or coverage with Anthem effective immediately preceding the effective date of the employer's coverage.
7. To pay Anthem by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and state-mandated continued group coverage and/or conversion process, if applicable.
8. That claims filed by or on behalf of members may, at Anthem's option, be suspended if premiums are not timely received.
9. If applicable, employer will receive on behalf of members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.
10. The advance premium check does not create temporary or interim coverage and that receipt and deposit of that payment does not guarantee issuance of coverage. Rather, issuance of coverage is expressly conditioned on Anthem's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.
11. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem may be different than the coverage applied for herein. In that event, Anthem shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.
12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any misstatements on employees' application or failure to report new medical information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rates as of the effective date of coverage.
13. The entire application for group coverage has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
14. All employees applying for coverage are employees of the employer and receive salary or wages documented on state and/or federal payroll reports. Eligible full-time employees must work at least 30 hours per week, must be actively at work, must have satisfied any applicable eligible waiting period.
15. The requested coverage is not in effect unless and until this application is approved by Anthem, that approval of coverage shall be evidenced by issuing group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem.
16. The employer acknowledges that he has signed the attached benefit proposals indicating the coverages requested.
17. The broker listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.

Section 6: Signature — Please attach a check for the first month's premium. Read section 5 carefully before signing.

Printed name of authorized group representative	Title
Signature of authorized group representative X	Date (MMDDYYYY)

Group no.

Section 7: Agent/producer/broker certification

I certify that:

1. I have reviewed the attached employee and group applications and waivers for completeness and accuracy.
2. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials on the application.
3. I have not signed any of the applications for a group representative or individual applicant.
4. I have advised the group that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the group's premium retroactive to the effective date and that coverage shall not be effective until Anthem approves the application and the group receives a written notice and contract from Anthem.

Are commissions paid to the agent or agency? ☐ Agent ☐ Agency

Writing payable/sub-agent/producer/broker			**Second writing payable/sub-agent/producer/broker**		
Split commission percentages: Medical: _____% Dental: _____%			Split commission percentages: Medical: _____% Dental: _____%		
Agency name	Agency tax ID no.		Agency name	Agency tax ID no.	
Agent/producer/broker name	Agent tax ID no.		Agent/producer/broker name	Agent tax ID no.	
Commissions paid to tax ID (must match designation above)			Commissions paid to tax ID (must match designation above)		
Agent/producer/broker street address			Agent/producer/broker street address		
City	State	ZIP code	City	State	ZIP code
Agent/producer/broker phone no.			Agent/producer/broker phone no.		
Agent/producer/broker email address			Agent/producer/broker email address		
Signature	Date (MMDDYYYY)		Signature	Date (MMDDYYYY)	

For general agent/producer/broker use only			
General agent/producer/broker name	General agent/producer/broker tax ID no.		
Street address	City	State	ZIP code

Sales representative	
Sales representative name	Sales representative ID no.