Employee Enrollment Application

Group Critical Illness Insurance

Kentucky

Anthem

INSTRUCTIONS

Read and complete all of this form. If you need more space, attach a separate sheet of paper and sign and date. Please use 4 digits for years.

Internal Use Only - Applicant Should Not Complete

Group No.	Member ID	Class	Change Effective Date (MM/DD/YYYY)
		1	

Section 1: Reason for application

Event Date (MM/DD/YYYY) ☐ New Enrollment ☐ Change of Existing Coverage ☐ Add or Remove Dependents

Section 2: Applicant Information

Last Name	First Name	M.I.	Date of Birth (MM/DD/YYYY)

Social Security No.	Phone No.	Email Address

Street Address	City	State	Zip Code

Employer/Association/Union Name	Are You Actively At Work?	Hours Worked Per Week	Date of Full Time Hire (MM/DD/YYYY)
Roman Catholic Diocese of Owensboro	☐ Yes ☐ No		

Section 3: Insurance Coverage - Check All That You Are Applying for and complete applicable questions

Accept	Decline	
☐	☐	**Voluntary Critical Illness Insurance** Coverage Option: ☐ Employee Only ☐ Employee + Spouse ☐ Employee + Children ☐ Family

If change, state reason: ☐ Marriage/Domestic Partner ☐ Divorce ☐ Death of covered person ☐ Birth/Adoption ☐ Other: _____

If any person to be covered by a Critical Illness plan is a resident of CA, GA, NY or CO, please answer the following question:

Will all applicants who reside in CA, GA, NY, or CO , when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy, an employer sponsored health plan, or an HMO that provides essential health benefits? **(Please note that if the response is No, such applicants are not eligible for coverage)** ☐ Yes ☐ No

Section 4: Beneficiary Designation (percentages should add up to 100%)

Type	Name of beneficiary	Percentage	Social Security Number	Relationship to applicant	Age
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

Section 5: Dependent Information - Complete all details for dependents applying for coverage

Last Name, First Name, Middle Initial	Sex	Date of birth (MM/DD/YYYY)	SSN	Relationship
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			

Section 6: Authorization - read carefully before signing

1. I understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield (Anthem) program, unless allowable by law.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. 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.
4. 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.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I certify each Social Security number listed on this application is correct.

I have read and accept the Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

Anthem Blue Cross and Blue Shield is the trade name of **Anthem Health Plans of Kentucky, Inc.** Thank you for choosing **Anthem Blue Cross and Blue Shield.**

Employee Signature	Date (MM/DD/YYYY)
X	

IMPORTANT CRITICAL ILLNESS INSURANCE ELIGIBILITY INFORMATION:

The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:

CRITICAL ILLNESS INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.