Empire BlueCross
Anthem Life & Disability Insurance Company
Large Group Member Enrollment/Change Form

Empire BlueCross BlueShield — An Anthem Company

Anthem Life

Anthem Life & Disability Insurance Company underwrites Life and Disability products. Empire HealthChoice HMO, Inc. and/or Empire HealthChoice Assurance, Inc. underwrite medical, dental, vision, group accident, specified di ease and hospital indemnity insurance products.

Thank you for choosing Empire BlueCross BlueShield (Empire) and Anthem Life & Disability Insurance Company (Anthem Life).
So that we may quickly and accurately process your enrollment, please complete in full and sign in section 8.

Section 1: Reason for enrollment/change – Please complete section A, B or C.

A. New enrollment/addition – Choose only one reason in bold.

☐ **New hire** – Must indicate start date of full-time employment in section 9. Leave ***Date of change*** fi ld blank. **Date of change:** _____ (MMDDYY)
☐ **Open enrollment** – Leave ***Date of change*** fi ld blank.
☐ **Status change** – Select only one.
☐ Marriage ☐ Newborn ☐ Adoption ☐ Retirement ☐ Medicare eligible For ***Medicare eligible*** only, answer the following questions:
Eligibility criteria – Select only one ..... ☐ Age 65+ ☐ Disability ☐ ESRD: Onset date: _____
Active employee? ..... ☐ Yes ☐ No
Electing company coverage as primary coverage? ..... ☐ Yes ☐ No
Electing Medicare-related coverage as primary coverage? ... ☐ Yes ☐ No
(If company size is under 20 employees and end-stage renal disease does not apply, you must choose this option)
☐ **Age 29 Adult Dependent Election** – Must complete section 4.
☐ **Original COBRA/NYS Continuation of coverage:** _____ (MMDDYY)
Nature of COBRA/NYS event: _____
☐ **Loss of Coverage** – Must indicate last day covered in section 6.
☐ **Waive Life coverage**
☐ **Other:** _____

B. Change – Check all that apply. For all checked boxes below, please supply new information in sections 4 and 5.

☐ Name ☐ Primary Care Physician (PCP) (POS plans only) **Date of change:** _____ (MMDDYY)
☐ Address ☐ Managed Dental Primary Care Dentist (PCD) (If your company offers an Empire Dental plan)
☐ Change Life and/or Disability insurance classific tion from Class _____ to Class _____

C. Cancel coverage – Select only one.

Note: If you are canceling your own coverage, please have your employer fill ut an *Employee Termination Form*. For other cancellations, please check the appropriate box below and enter the name in the Applicant and Family portion in section 5.

Spouse/Dependent ☐ Death ☐ Divorce ☐ Dependent no longer eligible **Date of event:** _____ (MMDDYY)
☐ Other: _____

Section 2: Benefits election

Medical insurance – Select only one plan type.

Large group plans (101+ eligibles)

☐ Empire EPO – (Copay/Deductible/Coinsurance)
☐ Empire EPO – (Copay)
☐ Empire PPO – (Copay/Deductible/Coinsurance)
☐ Empire PPO – (Copay)
☐ Empire PPO with HSA
☐ Empire PPO with HRA
☐ Empire EPO with HSA
☐ Empire EPO with HRA
☐ Empire EPO with HSA – (Copay)
☐ Empire EPO with HRA – (Copay)
☐ Empire EPO – (Deductible/Coinsurance)
☐ Empire PPO – (Deductible/Coinsurance)
☐ Empire EPO with HRA – (Deductible/Coinsurance)
☐ Empire PPO with HRA – (Deductible/Coinsurance)
☐ Empire Blue Access EPO – (Copay Plan)
☐ Empire Blue Access EPO – (Copay Design for 0% Coins Plans)
☐ Empire Blue Access EPO – (Copay w/Deductible)
☐ Empire Blue Access EPO – (Prism/Direct Connect/Deluxe)
☐ Empire Blue Access EPO with HRA – (Ded/Coins)
☐ Empire Blue Access EPO with HRA – (Ded/Coins w/Copays)
☐ Empire Blue Access EPO with HSA – (Ded/Coins)
Other: _____

☐ Empire Blue Access GEPO – (Copay Design)
☐ Empire Blue Access GEPO – (Copay Design for 0% Coins Plans)
☐ Empire Blue Access GEPO – (Copay w/Deductible)
☐ Empire Blue Access GEPO – (Prism/Direct Connect/Deluxe)
☐ Empire Blue Access GEPO with HRA – (Ded/Coins)
☐ Empire Blue Access GEPO with HRA – (Ded/Coins w/Copays)
☐ Empire Blue Access GEPO with HSA – (Ded/Coins)
☐ Empire Blue Access PPO – (Copay)
☐ Empire Blue Access PPO – (Copay Design for 0% Coins Plans)
☐ Empire Blue Access PPO – (Copay w/Deductible)
☐ Empire Blue Access PPO – (Copay/Deductible/Coinsurance)
☐ Empire Blue Access PPO – (Prism/Direct Connect/Deluxe)
☐ Empire Blue Access PPO with HRA – (Deductible/Coinsurance)
☐ Empire Blue Access PPO with HSA – (Deductible/Coinsurance)
☐ Empire Connection EPO – (Prism/Direct Connect/Deluxe)
☐ Empire Connection EPO – (Copay Design for 0% Coins Plans)
☐ Empire Connection EPO – (Copay Design)
☐ Empire Connection EPO – (Copay w/Deductible)
☐ Empire Connection GEPO – (Prism/Direct Connect/Deluxe)
☐ Empire Connection GEPO – (Copay Design for 0% Coins Plans)
☐ Empire Connection GEPO – (Copay)
☐ Empire Connection GEPO – (Copay w/Deductible)

Select only one medical coverage type: ☐ Individual ☐ Employee/Spouse/Domestic Partner ☐ Parent/Child(ren) ☐ Family

Section 4: Applicant information

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

Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Marital status ☐ Single ☐ Married	Marriage date (MMDDYY)	Primary phone no.

Street address	Apt. no.

City	State	ZIP code

Occupation	Primary language

Email address[2]

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

Section 5: Family information – Please list yourself and all eligible family members to be enrolled. Attach additional sheets, if necessary.

To select a PCP and/or PCD, visit our website at empireblue.com/find-doctor. If your Empire 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.

Applicant

Primary care physician (PCP) last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

Primary care dentist (PCD) last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

☐ Spouse ☐ Domestic partner

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

Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

1 Empire is required by the Internal Revenue Service to collect this information.
2 Email address is required for the applicant.
3 Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
4 Please submit *Request for Disabled Child* form (HAC506) with this form; child age must exceed contractual dependent age.

Section 5: Family information — Continued.

Dependent 1

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

Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

Dependent 2

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

Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

1 Empire is required by the Internal Revenue Service to collect this information.
2 Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
3 Please submit *Request for Disabled Child* form (HAC506) with this form; child age must exceed contractual dependent age.

Section 5: Family information — Continued.

Dependent 3

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

Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

Dependent 4

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

Sex ☐ Male ☐ Female	Date of birth (MMDDYY)	Primary language, if different

PCP last name	PCP first name	PCP no.

Current patient of PCP? ☐ Yes ☐ No

PCD last name	PCD first name	PCD no.

Current patient of PCD? ☐ Yes ☐ No

Email address (requested for ages 18 and over): _____

Relationship: ☐ Child of applicant/spouse/domestic partner ☐ Full-time student[2] ☐ Disabled child[3] ☐ Make available age 29 adult dependent child
☐ Other If other, what relationship? _____

Please provide a copy of the Medicare (HIB) card.	Medicare ID no.	Part A coverage start date	Part B coverage start date

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

1 Empire is required by the Internal Revenue Service to collect this information.
2 Child must exceed contractual dependent age and attend accredited college or university. Submit proof with this form. Proof is required annually.
3 Please submit *Request for Disabled Child* form (HAC506) with this form; child age must exceed contractual dependent age.

Section 6: Other medical coverage information — This section must be completed.

The questions in this section are for informational purposes only. The answers provided will have no bearing on eligibility.

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

Name(s) of person(s) (fi st, M.I. last)	Insurance company name	Coverage dates	Provided by employer?	Employment status	Contract type
Self	Carrier name Policyholder name Phone Certific te (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
☐ Spouse ☐ Domestic Partner	Carrier name Policyholder name Phone Certific te (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 1	Carrier name Policyholder name Phone Certific te (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 2	Carrier name Policyholder name Phone Certific te (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)
Dependent 3	Carrier name Policyholder name Phone Certific te (policy no.)	First day covered Last day covered	☐ Yes ☐ No	☐ COBRA/NYS Continuation of coverage ☐ Active ☐ Retiree	☐ Individual ☐ Family ☐ Employee/Spouse ☐ Parent/Child(ren)

Prior and other dental coverage information

Has any person applying for coverage had prior or other dental insuranc verage? ☐ Yes ☐ No

If yes, applicant/family member name(s): _____

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____

Carrier name: _____ Carr hone no.: _____ Member ID: _____

Date coverage began: | | | | | | Date ended: | | | | | | (MMDDYY)

Included orthodontia? ☐ Yes ☐ No

Section 7: Electronic Notice — This section is optional.

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

Applicant signature	Date (MMDDYY)
X	