



# HEALTH Insurance Benefit Feb. 2018 - Jan. 2019

THIS FORM MUST BE COMPLETED BY EVERY EMPLOYEE

Employee NAME	Social Security #	Birth Date	Hire Date	Phone Number (    )
Home ADDRESS	City, State	Zip Code	E-mail	

Please check the YES or NO box below indicating your decision regarding HEALTH INSURANCE COVERAGE.

**YES**, I want to participate on a pre-tax basis for HEALTH insurance premiums and I will need to complete the attached application.

I cannot change this election during the plan year unless I have a "Life Event", such as termination, change in employment status, marriage, divorce, death of family member, birth or adoption of a child, or change in benefits by my employer or my spouse's/child's employer. This election replaces any previous election.

If you elect to also pay for dependent coverage and have deductions made from your paycheck, you may elect to have those deductions made "pre-tax", which will reduce your federal, state and social security taxes. The only drawback to this plan is that your earnings reported to social security will be less, and when you retire, your social security benefits may be affected by your earnings record. Everyone chooses this Salary Reduction Plan. (Place a check here  if you do NOT want to participate in the Salary Reduction Plan for dependent premiums deducted from your paycheck.)

I authorize my employer to make the following salary deductions – CIRCLE ELECTION:

### Monthly HEALTH INSURANCE PREMIUMS

	ANTHEM <sup>®</sup> HEALTHKEEPERS POS 30/1000	ANTHEM <sup>®</sup> KEYCARE PPO 30/1000
Employee ONLY	\$0.00 (paid by Waco)	\$0.00 (paid by Waco)
Employee & CHILD/CHILDREN	\$356.50	\$395.15
Employee & SPOUSE	\$528.14	\$585.42
Employee & FAMILY	\$1,038.65	\$1,151.27

----- OR -----

**NO**, I do NOT want to participate in my employer's HEALTH insurance plan. By WAIVING participation, I realize I will not become eligible to participate until next plan anniversary date (Feb 2019) or occurrence of a life event. This waiver will continue in effect until I notify the company in writing.

YOU MUST STATE A VALID REASON FOR WAIVING COVERAGE.

REASON for Waiver: Spousal Coverage  Individual Policy  Other (specify reason) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

RETURN COMPLETED FORM TO:

Waco, Inc. Attention: Bonnie Ballsrud  
P.O. Box 829 Sandston, VA 23150

Any questions? Contact:

[bballsrud@wacoinc.net](mailto:bballsrud@wacoinc.net) phone: (804) 226-3206/ fax (804) 226-3218

# EMPLOYEE HEALTH ENROLLMENT APPLICATION

(Group Size 15+)

Please PRINT in ink and return to your employer. Use extra sheets of paper if necessary. The Primary Care Physician (PCP) listings of Anthem and its affiliated HMO company can be obtained through [www.anthem.com](http://www.anthem.com).

**APP**

## EMPLOYER/GROUP USE ONLY

Group Name		Group Number		Effective Date M D Y	
Date of hire	Full time hire date	# Hours working per week	Date of eligibility for coverage		
Position/Title			Employee's Social Security #:		

## 1. CHECK COMPANY(S) AND WRITE IN PRODUCT THAT APPLIES. APPLICATION COMPLETED FOR:

- Anthem Blue Cross and Blue Shield  
 HealthKeepers, Inc. \_\_\_\_\_ (HMO)

### Note for Lumenos Health Savings Account (HSA) enrollees:

If you enroll in an Anthem Lumenos HSA plan, Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

### Coverage Option

If your employer/group offers HMO coverage which does not permit you to receive the full range of covered services from the provider of your choice, you will also have the option at the time of your initial enrollment and at each renewal to choose a health care plan allowing you to access care from the provider of your choice ("point-of-service" plan). This point-of-service plan may be offered by the HMO, Anthem Blue Cross and Blue Shield or by another carrier.

## 2. REASON FOR APPLICATION (Check as many as apply)

<input type="checkbox"/> Initial enrollment	<input type="checkbox"/> Marriage Date of marriage: _____
<input type="checkbox"/> Annual open enrollment	<input type="checkbox"/> Loss of eligibility for other coverage Date previous coverage ended: _____
<input type="checkbox"/> New hire	<input type="checkbox"/> Birth of child
<input type="checkbox"/> Rehire – Date of rehire: _____	<input type="checkbox"/> Add Dependent* Date of adoption/placement for adoption, court order or legal appointment: _____
<input type="checkbox"/> COBRA – Qualifying Event: _____ Event Date: _____	

\*If adding a dependent due to adoption, placement for adoption, medical child support order, legal appointment (such as guardianship), legal documentation must be attached to the enrollment application.

## 3. TYPE OF COVERAGE/PLAN

<b>Health Coverage</b>	<input type="checkbox"/> Employee and One Child	<b>Vision Coverage</b>
<input type="checkbox"/> Employee Only	<input type="checkbox"/> Employee and Children	<input type="checkbox"/> <del>Voluntary</del> Vision Vision is included
<input type="checkbox"/> Employee and Spouse	<input type="checkbox"/> Employee and Family	(type of coverage must match health coverage)

## 4. EMPLOYEE INFORMATION\* (Please refer to Definitions of Eligibility, Section 9)

\*If applying for coverage that requires a Primary Care Physician (PCP), list the PCP name, PCP number and address.

Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Last name	First name	M.I.
Street address (Please include Apt. #)		
City	State	Zip
Daytime phone (with area code) ( ) -	Evening phone (with area code) ( ) -	
Email address		
Anthem PCP name* (please provide first and last name)		Anthem PCP ID number*
PCP Address		Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia. Anthem Blue Cross and Blue Shield and its affiliated HMO, HealthKeepers, Inc., are independent licensees of the Blue Cross and Blue Shield Association. ©ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

**5. FAMILY INFORMATION\* (If electing Employee Only coverage, skip to Section 6)**

*\*If applying for HMO or POS coverage, list the PCP name and PCP number. Each family member may select a different PCP. List all family members applying for coverage. List additional dependents on a separate sheet and attach it to the application. Please indicate the relationship between you and each dependent and provide the social security number and date of birth for each covered dependent. In the event of adding a newborn for which their social security number is not available, please complete this application at this time and forward to Anthem their social security number when obtained.*

Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Last name	First name	M.I.
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Anthem PCP Name*	Anthem PCP ID #*
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Email address
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Anthem PCP Address	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship to applicant <input type="checkbox"/> Child	Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Last name	First name	M.I.
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Check all that apply: <input type="checkbox"/> Child is covered by non-custodial parent due to medical child support order (attach documentation) <input type="checkbox"/> Child is over age 25 and disabled/handicapped prior to age 26 (attach physician certification)
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Anthem PCP Name*	Anthem PCP ID #*
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Email address (optional – dependent must be age 18 or older)
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Anthem PCP Address	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Relationship to applicant <input type="checkbox"/> Child	Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
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Last name	First name	M.I.
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Check all that apply: <input type="checkbox"/> Child is covered by non-custodial parent due to medical child support order (attach documentation) <input type="checkbox"/> Child is over age 25 and disabled/handicapped prior to age 26 (attach physician certification)
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Anthem PCP Name*	Anthem PCP ID #*
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Email address (optional – dependent must be age 18 or older)
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Anthem PCP Address	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**IF NO DEPENDENTS, PLEASE SKIP TO QUESTION 6 ON PAGE 3**

Relationship to applicant <input type="checkbox"/> Child	Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Last name		First name	M.I.
Check all that apply: <input type="checkbox"/> Child is covered by non-custodial parent due to medical child support order (attach documentation) <input type="checkbox"/> Child is over age 25 and disabled/handicapped prior to age 26 (attach physician certification)			
Anthem PCP Name*		Anthem PCP ID #*	
Email address (optional – dependent must be age 18 or older)			
Anthem PCP Address		Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Relationship to applicant <input type="checkbox"/> Child	Social security #	Date of birth (MM/DD/YYYY)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Last name		First name	M.I.
Check all that apply: <input type="checkbox"/> Child is covered by non-custodial parent due to medical child support order (attach documentation) <input type="checkbox"/> Child is over age 25 and disabled/handicapped prior to age 26 (attach physician certification)			
Anthem PCP Name*		Anthem PCP ID #*	
Email address (optional – dependent must be age 18 or older)			
Anthem PCP Address		Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**6. TELL US ABOUT YOUR OTHER INSURANCE**

*Please list any health care plan/HMO that you or your family members have been covered by within the past 24 months including Anthem. List additional information on a separate sheet and attach it to the application.*

Other carrier/plan name	Policy/ID number
Effective date (MM/DD/YY)	Please indicate whom this coverage applies to (check all that apply): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> All Children <input type="checkbox"/> Child: _____ <div style="display: flex; justify-content: space-between; width: 100%;"> <span>Last Name</span> <span>First Name</span> </div>
Do you intend to continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If no</b> , please provide cancellation date of coverage: _____ <b>If yes</b> , please provide the following information:	
Address of other coverage	
City	State    Zip
Phone number of other carrier/plan ( ) -	Policyholder name (Last, First, M.I.)
Policyholder's date of birth	Type of coverage: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Group Insurance <input type="checkbox"/> Non Group Insurance

**7. MEDICARE COVERAGE**

If you or your dependents are enrolled in Medicare Part A, B & D complete the following. List additional dependents on a separate sheet and attach it to the application.

Last name of covered person		First name		M.I.
HIC #	Medicare Part A Effective date	Medicare Part B Effective date	Medicare Part D Effective date	65 or over: <input type="checkbox"/> Working <input type="checkbox"/> Retired

Reason for Medicare Entitlement:

Age    Disability    End Stage Renal Disease (ESRD)    ESRD & Disability

**8. DEFINITIONS**

Eligible employee:

- An active employee of the Group Policyholder 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 31 days.
- Any other class of persons identified by the Group Policyholder, provided that written approval of their eligibility is obtained from the HMO or Anthem Blue Cross and Blue Shield; or
- Employees eligible for continuous coverage under state or federal laws, e.g. COBRA.
- To become an eligible employee, a director or officer of a corporate Group must meet the same requirements as other employees of the Group Policyholder.
- Independent contractors (those whose wages are reported on IRS Form 1099) are considered to be self-employed and are not eligible for group coverage.

Eligible dependent:

- Employee's spouse, 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 children will end on the last day of the month in which the children reach 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 mental retardation, mental illness, or physical incapacity 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 handicap 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, e.g. COBRA.

**9. EMPLOYEE CERTIFICATION (Please date and sign this certification.)**

I certify that I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage under the policy.

- For Lumenos Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.
- If the Company checked on page 1 of this application is Anthem Blue Cross and Blue Shield (Anthem), I understand that if false or misleading information is discovered within two years after the effective date of my coverage, Anthem may void my coverage without advance notice and refund my premium (less any claims paid) back to the effective date shown on this application, or may adjust the group's premium retroactively to my effective date. If the amount of benefits paid by Anthem exceeds the premiums paid, I agree to refund the excess amount to Anthem.
- If the Company checked on page one of this application is HealthKeepers, Inc., I understand that the health maintenance organization (HMO) may cancel my coverage with 31 days advance written notice of termination if it finds, within two years of the effective date of my coverage, that I misrepresented information on this application.

The employee, and any person authorized to act on behalf of the employee, is entitled to receive a copy of this form and will be provided with a copy upon their request.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_