Employer Enrollment Application
For 1–50 Employee Small Groups[1]
Connecticut

Anthem BlueCross BlueShield

Please complete in black ink only.

Section A: Company Information

Company name			Employer tax ID no. (required)
Company street address			
City	County	State	ZIP code
Billing address – If different from above			
City	County	State	ZIP code

Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Government unit/agency ☐ Limited Liability Company (LLC) ☐ Labor union trust ☐ Other: _____

Will bargaining agreement participants be considered eligible employees? ☐ Yes ☐ No Is any part of group subject to bargaining agreement? ☐ Yes ☐ No

Union name – Attach a copy of the agreement	Union no.	Contract expiration date

SIC code – Required	Head of firm	Date business established
Type of business (be specific)	Company contact name	

Title	Primary phone no.	Fax no.
Email address		
Additional company contact name	Title	
Primary phone no.	Fax no.	
Email address		

Does group have a cafeteria plan under IRS Section 125? ☐ Yes ☐ No

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal revenue Code Section 414? ☐ Yes ☐ No
If yes, please give the legal names, federal tax ID no. and number of employees employed by each.

_____

_____

Will any insurance carrier(s), in addition to Anthem Blue Cross and Blue Shield (Anthem), provide health 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

Open Enrollment

Our standard open enrollment period is at least 31 days before the Group's renewal date and 31 days after, which is held no more often than once in any 12 consecutive months.

Section B: Application Type

☐ New enrollment Requested effective date: ____ ____ ____ ____ (MM/DD/YYYY)

1 A small group must have at least one eligible employee, in addition to the business owner. A spouse cannot be the only eligible employee.

Section C: Type of Coverage

1. Medical Coverage — check all that apply.

PPO Plans	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
Century Preferred	☐ (2H8G) 30/0%/3000	☐ (2H9N) 1000/20%/5500 ☐ (2HAN) 1500/0%/3550 ☐ (2H7K) 1500/20%/3000 ☐ (2HBR) 2000/0%/3050 ☐ (2HAE) 2000/0%/3500 ☐ (2HAJ) 2000/0%/4900 ☐ (2H8J) 2500/0%/5000 ☐ (2HBZ) 2500/20%/4600 ☐ (2HAA) Tiered 2000/0%/5500	☐ (2H7S) 2500/20%/6500 ☐ (2HBC) 2500/50%/6850 ☐ (2HB4) 3000/20%/6750 ☐ (2HB0) 3000/25%/7150 ☐ (2H7V) 3500/30%/5500 ☐ (2H9J) 3550/20%/7150 ☐ (2HBV) 3750/25%/7150 ☐ (2HB8) 4000/50%/7150 ☐ (2HAW) 4500/0%/6000 ☐ (2HAS) 5000/25%/7150 ☐ (2H99) 2700/25%/5000 w/HSA ☐ (2HBG) 2800/20%/4000 w/HSA ☐ (2H9E) 3000/0%/5000 w/HSA ☐ (2HA2) Tiered 2750/0%/6000 w/HSA	☐ (2HBM) 5000/50%/6550 w/HSA ☐ (2H8V) 5500/20%/6550 w/HSA ☐ (2H8P) 6000/0%/6550 w/HSA ☐ (2H8R) 6000/30%/6550 w/HSA ☐ (2H92) 6500/0%/6500 w/HSA
HMO Plans	**Anthem Platinum**	**Anthem Gold**	**Anthem Silver**	**Anthem Bronze**
BlueCare	☐ (2H8C) 30/0%/3000 ☐ (2H9S) Tiered 20/0%/7150	☐ (2H80) 2750/0%/4000 ☐ (2HA6) Tiered 2000/0%/5500	☐ (2H94) 6000/0%/6550 w/HSA	

Choose your medical contribution for each month — The minimum employer contribution is 25% of the lowest eligible employee rate.
We will contribute (25% to 100%) _____% per employee _____% per dependent (optional).

Participation Requirements – If Employees contribute to the premium, then at least 75% of net eligible employees must enroll. If Employer pays 100% of premium, then 100% of net eligible employees must enroll. Participation requirements do not apply to Small Group Employer applications from November 15 – December 15.

For Health Savings Account (HSA) plans — Do you want Anthem to facilitate the HSA banking services? ☐ Yes ☐ No

HSA administrator name	Phone no.	Email address

2. Dental Coverage

Anthem Family Dental and Anthem Family Dental Enhanced plans include certified pediatric dental essential health benefits. All other plans including Anthem Dental Prime and Complete with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits. Please list below the contract code for the dental plan(s) you select.

Contract codes — Indicate the contract code(s) for the dental plan(s) selected. The codes can be found on the proposal/quote output.
Contract code 1: _____ Contract code 2: _____ ☐ No dental coverage selected

Choose your dental contribution for each month:
_____% per employee _____% per dependent (optional)

Select premium level: (Subject to underwriting approval)
☐ Base premium ☐ Bundled premium ☐ Medical Lock premium ☐ Medical Lock and Bundled premium

Is this plan intended to replace any existing group dental coverage? ☐ Yes ☐ No
If yes, please complete the information below for each group dental insurance plan you now have.

Insurer	Type of plan (DHMO, PPO)	Effective date	Proposed termination date

Participation Requirements

Voluntary participation
5-50 Eligible Employees: A minimum of five employees must enroll (there is no participation-percentage requirement for our voluntary plans). Dual Option is not available for voluntary plans.

Value, Classic and Enhanced participation
2-4 Eligible Employees: 100% of eligible employees not covered by another dental plan minimum of two must enroll.
5-50 Eligible Employees: A minimum of 50% of employees not covered by another dental plan are required to enroll. A minimum of two must enroll. For orthodontia, a minimum of 10 employees must enroll. Dual Option (employer can select two plans to offer to employees) is available for groups with at least 15 net eligible employees. A minimum of five employees must enroll in each of the two plans and the two plans offered must have a 20% premium differential.
Medical Lock (Packaged Enrollment): Enrollment and tiering must be identical on both the Anthem medical and Anthem dental plans. Example: enrollees with Single medical coverage must also have Single dental coverage; enrollees with Family medical coverage must also have Family dental coverage.

3. Vision Coverage — Select one plan option.

☐ No vision coverage at this time.
☐ Employer-Sponsored Plans (available for groups with 2-50 employees, minimum of two subscribers must enroll).
☐ Voluntary Plans (available for groups with 5-50 employees, minimum of five subscribers must enroll).

Contract code — Indicate the contract code for the vision plan selected. The codes can be found on the proposal/quote output.
Contract code: _____

Choose your vision contribution for each month.
Employer-sponsored plans require employers to contribute between 50% and 100%.
For Voluntary plans employers may contribute between 0% and 49%.
We will contribute: _____% per employee _____% per dependent (optional)

Select premium level: (Subject to underwriting approval)
☐ Base premium ☐ Bundled premium ☐ Medical Lock premium ☐ Medical Lock and Bundled premium

Participation Requirements

Medical Lock (Packaged Enrollment): All members enrolled in an Anthem medical plan must enroll in Anthem vision. Tiering must be identical on the medical and vision plans. Example: enrollees with Single medical coverage must also have Single vision coverage; enrollees with Family medical coverage must also have Family vision coverage.

Section D: Eligibility

1. Average total number of employees in prior calendar year (including employed owners/officers): ___
2. Number of eligible full-time employees (minimum 30 hours per week): ___
3. Are part-time employees to be covered (working 20 or more hours per week)? ☐ Yes ☐ No
4. Number of employees enrolling in:
   Medical: ___ Dental: ___
   Vision: ___
5. Number of eligible DECLINING employees: ___
6. Number of employees working outside of CT: ___
7. Total number of part-time employees based on the above small employer definition: Total calendar year hours worked by all part-time employees divided by 12 (the months in a calendar year) divided by 120 (the number of full-time hours in a typical month): ___
8. Probationary period/waiting period for **new employees**:
   ☐ None ☐ First of month after hire date ☐ 1 month
   ☐ 30 days ☐ 2 months ☐ 60 days ☐ 90 days
9. New eligible enrollees will become effective on:
   ☐ First of month following completion of waiting period/ probationary period
   ☐ Day following completion of waiting period/probationary periods (required for 90 day waiting period)
   The standard effective date is first of the month following the waiting period/probationary period.
10. Probationary period/waiting period for **rehire employees**:
    ☐ None ☐ First of month after hire date ☐ 1 month
    ☐ 30 days ☐ 2 months ☐ 60 days ☐ 90 days
11. Do you wish to offer coverage for domestic partners? ☐ Yes ☐ No
12. Under the Medicare Secondary Payer rules, which one applies for your group for Medicare due to age?
    ☐ Medicare is primary (less than 20 employees)
    ☐ Anthem is primary (20 or more employees)
    Anthem is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.
13. Is your company currently subject to COBRA (employed 20 or more total employees on at least 50% of the working days in the previous calendar year)? ☐ Yes ☐ No
14. Do you have a COBRA administrator? ☐ Yes ☐ No
15. Do you want an Anthem affiliate to administer COBRA for your group? ☐ Yes ☐ No
    If yes, please complete and sign the COBRA agreement.

Section E: Ownership

Please account for 100% of the ownership, regardless of eligibility. Insert an additional sheet if necessary.

Last name	First name	M.I.	Percentage of ownership	Eligible
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No

Section F: Certificates/EOCs

The Employer has the option to either access electronic copies or receive printed copies of the employee Certificates or Combined Evidence of Coverage and Disclosure Forms (EOCs). Choose one.

☐ Yes – Employer will access electronic copies of the employee Certificates and/or Combined Evidence of Coverage and Disclosure Forms (EOCs). Information on how to access electronic EOCs are included in your Group Benefit Agreement. By marking this option, employer understands that no printed copies of the Certificates/EOCs will be mailed to its offices and agrees to comply with all applicable provisions of the Employee Retirement Income Security Act (ERISA). Employer shall also make printed copies available to its employees upon request.

☐ No – Employer will not access electronic copies of the Certificates and/or Combined Evidence of Coverage and Disclosure Forms (EOCs). Employer would like to receive printed copies of the Certificates and/or Combined Evidence of Coverage and Disclosure Forms (EOCs)

Section G: General Agreement

Please read this section carefully before signing the application.

Please check the box that applies:

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employee Retirement Income Security Act of 1974), apply to obtain the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employee Retirement Income Security Act of 1974) and therefore not subject to ERISA, apply to obtain the coverage indicated.

To the best of our knowledge and belief, all information on this application is true and complete, and Anthem Blue Cross and Blue Shield (Anthem) may rely on this application in deciding whether to provide coverage. If the application is not complete, Anthem reserve(s) the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Anthem, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We understand that the premium rates calculated for the employer are contingent on the accuracy of eligibility data submitted on employees and covered dependents to Anthem. Any misstatements on the employees' applications or failure to report new medical information prior to the employee's effective dates may result in a material change to the group's coverage or premium rates as of the effective date of the group coverage. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing by Anthem and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Anthem. We understand that this small group off-exchange product is not eligible for a premium tax credit.

If we decide to cancel our group coverage after coverage has been issued, we understand that the cancellation will become effective on the last day of the month in which Anthem received the written notification of cancellation, and that no premiums will be refunded for any period between Anthem's receipt of the notification and the last day of the month when the cancellation takes effect. If there are any premiums after the cancellation date, we understand that Anthem will refund these premiums after 45 days from the premium deposit date.

For employers offering a Health Savings Account (HSA) compatible EPO plan: We, the employer, understand that the High Deductible EPO plan is designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. We understand that having this coverage does not establish an HSA.

The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits. The IRS has not yet issued HSA or high deductible health plan regulations or determined that Anthem high deductible plans are qualifying high deductible health plans. Consultation with a tax advisor is recommended.

Sign here	Company officer signature X		Date (MM/DD/YYYY)
	Printed name	Title	

Accepted by Anthem authorized representative	Printed name	Date (MM/DD/YYYY)

Section H: Agent Certification

1. I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.
2. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
3. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Anthem to attribute such additions or changes to me.
4. I have advised the employer 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 employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Anthem reviews and approves the application and the employer receives a written notice from Anthem.
5. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Anthem shall be paid to an agent/broker/producer not appointed/approved by Anthem.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Anthem that the coverage being applied for by this application is accepted.

Writing payable/sub-agent/producer/broker			**%**	**Second writing payable/sub-agent/producer/broker**			**%**
Agency name		Agency ID or TIN		Agency name		Agency ID or TIN	
Agent/producer/broker name				Agent/producer/broker name			
Agent/producer/broker ID no.				Agent/producer/broker ID no.			
Payable/sub-agent/producer/broker ID no. if different				Payable/sub-agent/producer/broker ID no. if different			
Street address				Street address			
City	State	ZIP code		City	State	ZIP code	
Phone no.	Fax no.			Phone no.	Fax no.		
Email address				Email address			
Signature		Date (MM/DD/YYYY)		Signature		Date (MM/DD/YYYY)	

For General Agent/Producer/Broker use only			
General agent/producer/broker name		Agent/producer/broker ID no.	
Street address		City	State / ZIP code

Sales Representative and Account Manager			
Sales representative name		Sales representative ID no.	
Street address		City	State / ZIP code
Account manager name		Account manager ID no.	

ANTHEM USE ONLY	Group no.	Tracking no.	Effective date (MM/DD/YYYY)


Anthem
BlueCross BlueShield

Get help in your language

Language Assistance Services

Anthem BlueCross BlueShield

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-738-6644). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-738-6644). (TTY/TDD: 711)

Albanian
Nëse ju nevojitet ndihmë për ta kuptuar këtë dokument në një gjuhë tjetër, mund ta kërkoni pa kosto shtesë duke telefonuar në numrin e shërbimeve për anëtarët (855-738-6644). (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-738-6644). (TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-738-6644)請求免費協助。(TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-738-6644. (TTY/TDD: 711)

Greek
Αν χρειαστείτε βοήθεια για να κατανοήσετε το παρόν έγγραφο σε άλλη γλώσσα, μπορείτε να τη ζητήσετε χωρίς πρόσθετο κόστος καλώντας τον αριθμό του Τμήματος Υπηρεσιών Μέλους (855-738-6644). (TTY/TDD: 711)

Haitian
Si ou bezwen èd pou konprann dokiman sa a nan yon lòt lang, ou kapab rele nimewo Manm Sèvis la pou mande asistans gratis nan nimewo (855-738-6644). (TTY/TDD: 711)

Hindi
अगर आपको यह दस्तावेज़ वैकल्पिक भाषा में समझने के लिए सहायता की ज़रूरत है, तो आप सदस्य सेवाएँ नंबर (855-738-6644) पर कॉल करके अतिरिक्त लागत के बिना इसके लिए अनुरोध कर सकते हैं। (TTY/TDD: 711)

Italian
Se ha bisogno di assistenza per la comprensione del presente documento in un'altra lingua, può richiederla senza alcun costo aggiuntivo chiamando il numero dedicato ai Servizi per i membri (855-738-6644). (TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-738-6644)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Polish
Jeśli potrzebujesz pomocy w zrozumieniu niniejszego dokumentu w innym języku, możesz ją uzyskać bez ponoszenia dodatkowych kosztów, dzwoniąc do Działu Obsługi Klienta pod numer (855-738-6644). (TTY/TDD: 711)

Portuguese-Europe
Se necessitar de ajuda para compreender este documento noutro idioma, poderá solicitá-la gratuitamente ligando para o número dos Serviços para Membros (855-738-6644). (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-738-6644). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-738-6644). (TTY/TDD: 711)

Vietnamese
Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-738-6644). (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with 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 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.