Employee Change Form Application

Anthem Health Plans of Kentucky, Inc.

Anthem Life Insurance Co.

Please complete this form ONLY when making changes to your existing coverage. If you are APPLYING for coverage or ADDING a dependent(s), complete the "Anthem Enrollment Application" instead of this form. When completing section 2, be sure to include the date of the event causing the change(s). If you are cancelling coverage for a dependent, changing a PCP, or changing a name, please provide a reason in the designated sections. Complete in ink and return to your employer, using extra sheets of paper if necessary.
NOTE: Some changes may be made by accessing www.anthem.com. Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through www.anthem.com.

1. Employer/Group Use:
Employer Name and Address: City of Harrodsburg
208 South Main Street Harrodsburg, KY 40330

Group #	Sub-group #/Life Division #	Request Effective Date	Life Classification	Applicant #/Dept. name
44187				

Anthem use: Plan	Health Effective Date	Life Effective Date	Dental Effective Date	Vision Effective Date	PCP	COB	Pre-ex (date)
	/ /	/ /	/ /	/ /	☐ Yes ☐ No	☐ Yes ☐ No	/ /

2. Reason for Change
Event date / / ☐Address ☐ Change Life Beneficiary ☐Cancel/Waiving Coverage (Refer to section 9) ☐PCP change ☐ Name change
☐Change Life Classification ☐ Enrollment in Medicare (see section 7) ☐Conversion ☐ Benefit change ☐ Cancel dependent ☐Other _____

3. Type of Coverage/Plan

Health Coverage
☐HMO*1 ☐ POS* ☐PPO _____ ☐ Blue Traditional®
☐Anthem Essential℠ PPO
☐Blue Access℠ Hospital Surgical PPO
☐Lumenos® Health Savings Account
☐Lumenos® Health Reimbursement Account
☐Lumenos® Health Incentive Account
☐Lumenos® Health Incentive Account Plus
☐Employee only ☐ Employee+spouse ☐ Employee+child(ren)
☐Family coverage ☐ No coverage

Dental Coverage
☐PPO
☐Dental Blue® 100
☐Dental Blue® 100/200/300
☐Employee only ☐ Employee+spouse
☐Employee + child(ren)
☐Family coverage ☐ No coverage

Vision Coverage
☐ Vision
☐ Employee only
☐ Employee+spouse
☐ Employee+child(ren)
☐ Family coverage
☐ No coverage

Life Coverage
☐Life (see section 6)

Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.
Health Savings Account Notice: 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 Blue Cross Blue Shield with information regarding my HSA. I hereby authorize *the financial custodian* to provide Anthem Blue Cross Blue Shield with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem Blue Cross Blue Shield with a written request to revoke my authorization at any time.

4. Employee Information **Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.* (SS# required)

Last name	First name, M.I.	Date of birth	Sex	Social Security #		Height	Weight
		/ /	☐M ☐F	- -	☐Single ☐Divorced ☐Married		

Home address	City	State	Zip code	County (KY residents include Municipality)

Hours worked per week	Anthem PCP name and address*	Anthem PCP ID number*	New patient? ☐Yes ☐No

If PCP is a change, please indicate the reason for the change.

5. Family Information *Spouse and dependents to be changed/cancelled. (Attach a separate sheet if necessary.)* Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.* (SS# required for spouse/domestic partner)

1 ☐Change ☐ Cancel | Last name | First name, M.I.

Date of birth	Sex	Social Security #	Relationship to insured	Reason for change
/ /	☐M ☐F	- -	☐Spouse ☐Daughter ☐Son ☐Other ____	

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Anthem PCP name and address*	Anthem PCP ID number*	New patient? ☐Yes ☐No

2 ☐Change ☐ Cancel | Last name | First name, M.I.

Date of birth	Sex	Social Security #	Relationship to insured	Reason for change
/ /	☐M ☐F	- -	☐Spouse ☐Daughter ☐Son ☐Other ____	

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Anthem PCP name and address*	Anthem PCP ID number*	New patient? ☐Yes ☐No

3 ☐Change ☐ Cancel | Last name | First name, M.I.

Date of birth	Sex	Social Security #	Relationship to insured	Reason for change
/ /	☐M ☐F	- -	☐Spouse ☐Daughter ☐Son ☐Other ____	

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Anthem PCP name and address*	Anthem PCP ID number*	New patient? ☐Yes ☐No