

State of Maine Member Enrollment/Member Change Form



In Maine, Anthem Blue Cross and Blue Shield is a trade name of Anthem Health Plans of Maine, Inc., an independent licensee of the Blue Cross and Blue Shield Association. © Registered marks of the Blue Cross and Blue Shield Association.

If you have any questions, please contact the State Office of Employee Health and Benefits at **1-800-422-4503 or 287-6780**. All questions need to be completed before this application can be processed.

DO NOT USE RED INK

1. Subscriber/Applicant Information			2. Enrollment Reason		Anthem Use Only	
Current Anthem BCBS Contract Number, if any		Current Group Number	<input type="checkbox"/> New Hire	<input type="checkbox"/> Annual Enrollment	Issued Effective Date	Firm Division Number
Last Name	First Name	M.I.	<input type="checkbox"/> Portability or Qualifying Life Event		/ /	
Home Address Number and Street or P.O. Box		Apt. #	<input type="checkbox"/> Retiree - date of retirement _____		Health Benefit Plan	Waiting Period
City	State	Zip Code	<input type="checkbox"/> COBRA - start date _____			
Home Telephone () ()	Work Telephone () ()		COBRA qualifying event: _____			
Please check one: The applicant is <input type="checkbox"/> Active Employee <input type="checkbox"/> Retired Employee <input type="checkbox"/> COBRA <input type="checkbox"/> Other: _____			<input type="checkbox"/> Other _____			
3. Change Status. Please check the reason(s) for change below and indicate date.						
Type of Change: <input type="checkbox"/> Name Change <input type="checkbox"/> Address Change <input type="checkbox"/> Add Dependent/Spouse/DP <input type="checkbox"/> Delete Dependent/Spouse/DP <input type="checkbox"/> PCP Change						
Reason for Change. Please check all that apply:						
<input type="checkbox"/> Marriage		<input type="checkbox"/> Birth		<input type="checkbox"/> Adoption		<input type="checkbox"/> Death
<input type="checkbox"/> Involuntary Loss of Coverage		<input type="checkbox"/> Involuntary Loss of Medicaid		<input type="checkbox"/> Covered by Medicaid		<input type="checkbox"/> Covered by Other Insurance
<input type="checkbox"/> Annual Enrollment		<input type="checkbox"/> Entrance to the Military		<input type="checkbox"/> Discharge from the Military		<input type="checkbox"/> Court Order changing custody
<input type="checkbox"/> Court Order		<input type="checkbox"/> Other _____				Date of Change or Event

4. Membership Choices		5. Employer Information			
<input type="checkbox"/> HMO Choice (managed care)		Company Name/Department Agency		State of Maine	
<input type="checkbox"/> Comp-Care (available only if you live outside of Maine)		Address		114 State House Station, Augusta, ME 04333	
		Date of Hire	Date of Rehire (if applicable) or Return from Leave	Date Eligible	# Hours worked per week

6. Applicant and Member Information (list only family members you wish to enroll, delete, or change)
 You may apply to cover your legal spouse, Domestic Partner (a completed Affidavit of Domestic Partnership must also be attached to this application) and unmarried children and stepchildren under 19 years of age. You may also apply to cover some children and stepchildren 19 and older if they are unmarried and more than 50% dependent on you.

Sex	Names of Person(s) to be covered			Is anyone covered by other insurance	If disabled, date of disability	Social Security #	Birthdate	Primary Care Physician		Current Patient
	Last Name	First Name	M.I.					Name	PCP Provider Number	
<input type="checkbox"/> M <input type="checkbox"/> F	Self			<input type="checkbox"/> Y <input type="checkbox"/> N				Name	PCP Provider Number	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Legal Spouse or <input type="checkbox"/> Domestic Partner (DP)			<input type="checkbox"/> Y <input type="checkbox"/> N				Name	PCP Provider Number	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent			<input type="checkbox"/> Y <input type="checkbox"/> N				Name	PCP Provider Number	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent			<input type="checkbox"/> Y <input type="checkbox"/> N				Name	PCP Provider Number	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent			<input type="checkbox"/> Y <input type="checkbox"/> N				Name	PCP Provider Number	<input type="checkbox"/> Y <input type="checkbox"/> N

Are you or any family members currently claiming Workers' Comp Medical Benefits? Yes No *If yes, name of claimant: _____*

7. Prior Coverage Information
 If you had prior coverage that is no longer in effect, why did your prior coverage end? Reason: _____
 Was every member listed on this application previously covered by this employer's prior health plan? Yes No
 Have you or any family members had health insurance coverage within 90 days of your date of hire, annual enrollment or qualifying life event? Yes No *If yes, please complete the following:*
 Certificate Number Yours _____ Spouse's/DP _____ Dependent's _____
 Insurance Company _____ Address _____ City _____ State _____ Zip _____
 Phone Number _____ Date Coverage Began _____ Date Coverage Ended _____ **OR** Coverage is still in effect _____

8. Other Information
 Is anyone listed on this application currently eligible for Medicare? Yes No *If yes, please complete the following for each person to be covered who has Medicare.*

Name(s) of Medicare Beneficiaries			Health Insurance Claim Number	Medicare Part A Effective Date	Medicare Part B Effective Date	Check all reasons you qualified for Medicare		
First Name	M.I.	Last Name		/ /	/ /	Age 65	Disability	ESRD
				/ /	/ /			
				/ /	/ /			

9. Applicant Signature
 I am requesting coverage for myself and all dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the group agreement and Certificate of Coverage. I understand that each family member's care must be provided or arranged by his/her Primary Care Physician (PCP) (does not apply to Comp-Care) except as described in my Certificate of Coverage.

_____ / /
 Applicant Signature Print Name Date

10. Election Not To Enroll
 I do not wish to enroll in a plan. Please check one: I have other coverage **OR** I do not have any other coverage.
 I understand that the opportunity to enroll at any future date will be subject to the regulations of Anthem Blue Cross and Blue Shield.

_____/_____/_____
 Signature Date