State of Maine
Member Enrollment/Member Change Form

Anthem

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

Current Anthem BCBS Contract Number, if any | Current Group Number

Last Name | First Name | M.I.

Home Address Number and Street or P.O. Box | Apt. #

City | State | Zip Code

Home Telephone ( ) | Work Telephone ( )

Please check one:

The applicant is ☐ Active Employee ☐ Retired Employee ☐ COBRA ☐ Other:_____

2. Enrollment Reason

☐ New Hire ☐ Annual Enrollment

☐ Portability or Qualifying Life Event

☐ Retiree – date of retirement _____

☐ COBRA – start date _____

COBRA qualifying event: _____

☐ Other _____

Anthem Use Only

Issued Effective Date	Firm Division Number
___/___/___	
Health Benefit Plan	**Waiting Period**

3. Change Status. Please check the reason(s) for change below and indicate date.

Type of Change: ☐ Name Change ☐ Address Change ☐ Add Dependent/Spouse/DP ☐ Delete Dependent/Spouse/DP ☐ PCP Change

Reason for Change. Please check all that apply:

☐ Marriage ☐ Birth ☐ Adoption ☐ Death ☐ Divorce

☐ Involuntary Loss of Coverage ☐ Involuntary Loss of Medicaid ☐ Covered by Medicaid ☐ Covered by Other Insurance

☐ Annual Enrollment ☐ Entrance to the Military ☐ Discharge from the Military ☐ Court Order changing custody

☐ Court Order ☐ Other _____ **Date of Change or Event** _____

4. Membership Choices

☐ HMO Choice (managed care)

☐ Comp-Care (available only if you live outside of Maine)

5. Employer Information

Company Name/Department Agency **State of Maine** | Group Number (if existing group)

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 (Last Name, First Name, M.I.)	Is anyone covered by other insurance	If disabled, date of disability	Social Security #	Birthdate	Primary Care Physician (If applying for Comp-Care **DO NOT COMPLETE THIS SECTION**. If applying for HMO Choice, each member must fill in PCP information. For current listing of valid PCP's go to the HMO Choice network at **www.anthem.com** in the PCP section.)	Current Patient
☐ M ☐ F	Self	☐ Y ☐ N				Name PCP Provider Number	☐ Y ☐ N
☐ M ☐ F	☐ Legal Spouse or ☐ Domestic Partner (DP)	☐ Y ☐ N				Name PCP Provider Number	☐ Y ☐ N
☐ M ☐ F	Dependent	☐ Y ☐ N				Name PCP Provider Number	☐ Y ☐ N
☐ M ☐ F	Dependent	☐ Y ☐ N				Name PCP Provider Number	☐ Y ☐ N
☐ M ☐ F	Dependent	☐ Y ☐ N				Name PCP Provider Number	☐ Y ☐ 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: First Name	M.I.	Last Name	Health Insurance Claim Number	Medicare Part A Effective Date	Medicare Part B Effective Date	Check all reasons you qualified for Medicare: 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