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

Please complete in black ink only.

Section A: Application Type			
☐ **New group enrollment**	Requested effective date (MM/DD/YYY)		
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. The open enrollment does not apply to life and disability products.			
Section B: Company Information			
Legal company name			Employer tax ID no. (required)
Doing Business As (DBA)			
Company street address			
City	County	State	ZIP code
Billing address- If different from above			
City		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	Type of business (be specific)	Head of Firm	Date business established
Company contact name		Title	
Primary phone no.	Fax no.	Email address	
Additional company contact name		Title	
Primary phone no.	Fax no.	Email address	

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.

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 complete below.

Legal name	Federal tax ID no.	No. of employees employed

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

Section C: Type of Coverage

1. Medical Coverage – Check all that apply.

PPO Plans	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
Century Preferred	☐ (2V1A) 10/0%/2500	☐ (2V1W)1000/20%/6000 ☐ (2V0Z) 1500/20%/3000 ☐ (2V2C) 2000/0%/4000 ☐ (2V1F) 2500/0%/4500 ☐ (2V36) 1350/10%/3675 w/HSA ☐ (2V3J) 4250/20%/7350 w/HRA ☐ (2V28) Tiered 1500/0%/5000	☐ (2V12) 3500/30%/5500 ☐ (2V2Q) 3750/25%/7350 ☐ (2V2L) 4500/0%/6000 ☐ (2V2G) 5000/25%/7350 ☐ (2V32) 3000/20%/5500 w/HSA ☐ (2V1S) 3000/0%/6500 w/HSA	☐ (2V2U) 5000/30%/6650 w/HSA ☐ (2V1K) 5500/20%/6650 w/HSA ☐ (2V1N) 6650/0%/6650 w/HSA
EPO Plans	**Anthem Platinum**	**Anthem Gold**	**Anthem Silver**	**Anthem Bronze**
Century Preferred	☐ (2V3A) 10/0%/2500	☐ (2V3E)1000/20%/6000		
HMO Plans	**Anthem Platinum**	**Anthem Gold**	**Anthem Silver**	**Anthem Bronze**
BlueCare	☐ (2V2Y) 25/10%/3500 ☐ (2V16) 10/0%/2500	☐ (2V20) Tiered 20/0%/6600		

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 Dental Family and Anthem Dental Family Enhanced plans include certified pediatric dental essential health benefits. All other plans including Anthem Dental Prime and Anthem Dental Complete with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.

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

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

☐ Voluntary Plans

Contract codes – 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

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.

4. Life/AD&D and Disability Coverage – Check all that apply. A minimum of two employees must enroll.

Life products

Select Life/AD&D products and group contribution percentage:

Product choice	Percentage
☐ None	
☐ Basic Life & AD&D	_____%
☐ Basic Dependent Life	_____%
☐ Optional Supplemental/Voluntary Life and AD&D*	_____%
☐ Optional Supplemental/Voluntary Dependent Life*	_____%

*Available for Groups of 10+

Disability products

Select products and group contribution percentage:

Product choice	Percentage
☐ None	
☐ Short Term Disability	_____%
☐ Long Term Disability	_____%
☐ Voluntary Short Term Disability*	_____%
☐ Voluntary Long Term Disability*	_____%

*Available for Groups of 10+

If disability benefits are selected, indicate whether the employee pays disability premiums on a pre or post tax basis.

Short Term Disability	Voluntary Short Term Disability	Long Term Disability	Voluntary Long Term Disability
☐ Pre Tax	☐ Pre Tax	☐ Pre Tax	☐ Pre Tax
☐ Post Tax	☐ Post Tax	☐ Post Tax	☐ Post Tax

Are more than 50% of eligible employees in the group related by marriage or blood? ☐ Yes ☐ No

Life/AD&D and/or Disability Eligibility Probationary Period/Waiting Period

Would you like to waive the eligibility probationary period/waiting period for ALL existing employees at initial group enrollment? ☐ Yes ☐ No

Is the eligibility probationary period/waiting period for new eligible employees enrolling in Life/AD&D and/or Disability plans after the group's coverage effective date the same as the medical policy eligibility period? ☐ Yes ☐ No
If no, enter the Life/AD&D and Disability eligibility probationary period/waiting period below.

Class number	Coverage description (Ex. Life, Short Term Disability, Long Term Disability, etc.)	Description of eligibility probationary period (Ex. Date of hire, First of month following 60 days of continuous employment, etc.)

Will rehired employees be eligible to reinstate their Life/AD&D and/or Disability coverage at the level of coverage they had on their last day worked?
☐ Yes ☐ No

If yes, length of time the group has to rehire an employee under this provision: ☐3 months ☐6 months ☐9 months ☐12 months

Eligible employees must be actively at work, and must satisfy any applicable waiting period. Minimum work hours required for eligible full-time employees is 30 hours per week unless otherwise indicated.

Prior Coverage

Has this group had life/AD&D and/or disability coverage within 12 months of this application's signature date? ☐ Yes ☐ No

Will this plan replace current	Insurance Company Name - Policy/Contract Number	Termination Date (MM/DD/YYYY)
Life/AD&D coverage ☐ Yes ☐ No		
Disability coverage ☐ Yes ☐ No		

Participation Requirements

Basic Life, Basic Accidental Death & Dismemberment, Short Term Disability: 100% participation required on non-contributory plans and 75% participation required on contributory plans.

Long Term Disability: 100% participation required on all non-contributory plans. 100% participation required for contributory plans of two or three eligible employees. 75% participation required on contributory plans with four or more eligible employees.

Basic Dependent Life: 100% participation required on non-contributory plans.

Optional Supplemental/Voluntary Life/Accidental Death & Dismemberment: The greater of five enrolled employees or 20% participation required.

Voluntary Short Term Disability and Voluntary Long Term Disability: The greater of 10 enrolled employees or 20% participation required.

Section D: Eligibility

1. Average number of Full Time Equivalent (FTE) employees during the prior calendar year (including employed owners/officers):_____
2. Number of eligible full-time employees (minimum 30 hours per week - see above for Life/Disability eligibility minimum hours):_____
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:_____

   Life/Disability:_____
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: General Agreement

Please read this section carefully before signing the application.
The following subsection is for Medical/Dental/Vision Applicants:

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.

By signing below, we, the employer, agree that Anthem can deliver plan materials and related items, including but not limited to benefit booklets, summaries, billing statements, notices of nonpayment and cancellation and other notices, via email or other electronic means as permitted by law. We agree that we will provide and update Anthem with a current email address. We understand that at any time we can request a free copy of these materials by mail, by contacting Anthem Enrollment and Billing or via the EmployerAccess system.

The following subsection is for Life, AD&D and/or Disability Applicants:

The undersigned employer and/or authorized representative hereby requests that it be approved for insurance coverage through Anthem Life Insurance Company (Anthem Life). Employer understands and represents to the best of his knowledge and belief the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the (Anthem Life) trust policy(ies), if applicable;
2. To make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed;
3. To maintain records and furnish to Anthem Life or their designated agent(s), any information required in connection with administration of the insurance coverage;
4. To provide notice of applicable conversion rights to eligible employees and eligible dependents;
5. That statements of medical history will be required of employees and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem Life for Life and Disability Insurance;
6. That approval for this insurance may cancel any prior contracts and/or coverage with Anthem Life effective immediately preceding the effective date of the employer's coverage;
7. To pay Anthem Life by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership;
8. That claims filed by or on behalf of members may, at Anthem Life option, be suspended if premiums are not received timely;
9. Employer will receive, on behalf of members, all notices delivered by Company, and immediately forward such notices to persons involved, at their last known address;
10. The advance premium check does not create temporary or interim insurance coverage and that receipt and deposit of that payment does not guarantee issuance of insurance coverage. Rather, issuance of insurance coverage is expressly conditioned on Company's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these Conditions are met, there shall be no liability on the part of Company except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees;

11. That in order for Company to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Company, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Company may be different than the coverage applied for herein. In that event, Company shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued;
12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Company by the employer. Company reserves the right to review such rates upon receipt of all individual applications and modify the rates, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the group's coverage or premium rate as of the effective date of coverage;
13. The entire application for Group Insurance has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief;
14. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work full-time (unless otherwise approved by Company in writing) and meet any other eligibility requirements for coverage;
15. The requested coverage is not in effect unless and until this application is approved by Company, that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Company.
16. I understand that 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 a denial of insurance benefits.

Sign here	Company officer signature **X**	Title	
	Printed name		Date (MM/DD/YYYY)
Accepted by Anthem authorized representative		Printed name	Date (MM/DD/YYYY)

Section G: 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 have fully explained to the Employer that an employee not actively at work on the policy effective date or their eligibility date will not be covered for life, AD&D or disability insurance until such employee returns to active work full-time.
6. 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. I am licensed in the state of Connecticut for the types of insurance solicited.
7. 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)