

Group Size:

2-14 small business 15-50 community 51-99 mid-size Acct. Code: _____ Group Number(s): _____

Is your group also enrolled in Anthem HealthKeepers? Yes No If yes, Anthem HealthKeepers Group Number(s): _____

Company Name ("the Applicant"): _____ Year Operational: _____

Street Address: _____

City: _____ Zip: _____ County: _____

Billing Address: (if different from above) _____

City: _____ Zip: _____

Group Administrator: _____ Title: _____ Phone Number: () _____

E-mail Address: _____ Fax Number: _____

Company Executive: _____ Title: _____

A. BENEFIT SELECTION

Effective Date:

Health Benefits: _____ **Dental Benefits:** _____
Month Day Year Month Day Year

Indicate how often you would like to be billed: once every 1 month 2 months 3 months 6 months 12 months

Health Benefits Available for Groups with 2-50 Employees:

- | | | | |
|-------------------------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> KeyCare 10 5/10/25 | <input type="checkbox"/> KeyCare 30 10/30/50 with \$150 ded | <input type="checkbox"/> KeyCare 1,000 10/20/35 | <input type="checkbox"/> KeyCare 15 Plus 10/20/35 |
| <input type="checkbox"/> KeyCare 10 10/20/35 | <input type="checkbox"/> KeyCare 30/2,000 10/30/50 | <input type="checkbox"/> KeyCare 1,000 10/30/50 with \$150 ded | <input type="checkbox"/> KeyCare 15 Plus 10/20/35 no cap |
| <input type="checkbox"/> KeyCare 15 10/20/35 | <input type="checkbox"/> KeyCare 30/2,000 10/30/50 with \$150 ded | <input type="checkbox"/> KeyCare 2,000 10/30/50 | <input type="checkbox"/> KeyCare 15 Plus 10/30/50 |
| <input type="checkbox"/> KeyCare 15 10/30/50 | <input type="checkbox"/> KeyCare 200 10/20/35 | <input type="checkbox"/> KeyCare 2,000 10/30/50 with \$150 ded | <input type="checkbox"/> KeyCare 20 Plus 10/20/35 no cap |
| <input type="checkbox"/> KeyCare 20 10/20/35 | <input type="checkbox"/> KeyCare 200 10/30/50 | <input type="checkbox"/> KeyCare 10 Plus 10/20/35 | <input type="checkbox"/> KeyCare 20 Plus 10/30/50 |
| <input type="checkbox"/> KeyCare 20 10/30/50 | <input type="checkbox"/> KeyCare 500 10/20/35 | <input type="checkbox"/> KeyCare 10 Plus 10/20/35 no cap | |
| <input type="checkbox"/> KeyCare 25 10/20/35 | <input type="checkbox"/> KeyCare 500 10/30/50 with \$150 ded | <input type="checkbox"/> KeyCare 10 Plus 10/30/50 | |
| <input type="checkbox"/> KeyCare 25 10/30/50 with \$150 ded | | | |
| <input type="checkbox"/> KeyCare 30 10/30/50 | | | |

Cost Awareness (15+ only)

- | | | | |
|--------------------------------------------------------------|--------------------------------------------------------------------|---------------------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> BlueCare 15 10/20/35 | <input type="checkbox"/> BlueCare 30 10/30/50 | <input type="checkbox"/> BlueCare 200 10/20/35 | <input type="checkbox"/> BlueCare 1,000 10/30/50 with \$150 ded |
| <input type="checkbox"/> BlueCare 20 10/20/35 | <input type="checkbox"/> BlueCare 30 10/30/50 with \$150 ded | <input type="checkbox"/> BlueCare 200 10/30/50 | <input type="checkbox"/> BlueCare 2,000 10/30/50 |
| <input type="checkbox"/> BlueCare 20 10/30/50 | <input type="checkbox"/> BlueCare 30/2,000 10/30/50 | <input type="checkbox"/> BlueCare 500 10/20/35 | <input type="checkbox"/> BlueCare 2,000 10/30/50 with \$150 ded |
| <input type="checkbox"/> BlueCare 25 10/20/35 | <input type="checkbox"/> BlueCare 30/2,000 10/30/50 with \$150 ded | <input type="checkbox"/> BlueCare 500 10/30/50 with \$150 ded | |
| <input type="checkbox"/> BlueCare 25 10/30/50 with \$150 ded | <input type="checkbox"/> Standard Benefit Plan | <input type="checkbox"/> BlueCare 1,000 10/20/35 | |
| <input type="checkbox"/> Essential Benefit Plan | <input type="checkbox"/> without Dental | | |
| <input type="checkbox"/> without Dental | | | |

Optional Benefits:

- Contraceptive Rider
- Dependent Maternity
- Well Baby at 100%
- Morbid Obesity
- Other _____
- \$150 Routine Wellness at 100% (available only with BlueCare Deductible Plans)
- Anthem Standard EAP (15+ only)
- Anthem Enhanced EAP (15+ only)
- Value Added Association Name _____

Vision Rider

- Whole Group
- Voluntary
- Premier 12/12
- Premier Plus 12/12
- Designer 12/12
- Premier 12/24 (15+ only)
- Premier Plus 12/24 (15+ only)
- Designer 12/24 (15+ only)

Anthem Dental Benefits:⁵

(Dental benefits may be purchased without health benefits by groups with 6 or more eligible employees.)

- | | | |
|---------------------------------------------------------|-----------------------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Anthem Dental PPO Plan I | <input type="checkbox"/> Anthem Dental PPO Plan II ¹ | <input type="checkbox"/> Anthem Dental PPO Plan III ² |
| <input type="checkbox"/> 100/80 | <input type="checkbox"/> 100/80/50 | <input type="checkbox"/> 100/80/50/50 |
| <input type="checkbox"/> 100/50 (f/k/a Plan 50) | <input type="checkbox"/> 100/90/50 | <input type="checkbox"/> 100/90/50/50 |
| | <input type="checkbox"/> 100/90/60 | <input type="checkbox"/> 100/90/60/50 |
| | <input type="checkbox"/> 100/100/60 | <input type="checkbox"/> 100/100/60/50 |
| <input type="checkbox"/> Anthem Dental Indemnity Plan I | <input type="checkbox"/> Anthem Dental Indemnity Plan II ¹ | <input type="checkbox"/> Anthem Dental Indemnity Plan III ² |
| <input type="checkbox"/> 100/80 | <input type="checkbox"/> 100/80/50 | <input type="checkbox"/> 100/80/50/50 |
| <input type="checkbox"/> 100/50 (f/k/a Plan 50) | <input type="checkbox"/> 100/90/50 | <input type="checkbox"/> 100/90/50/50 |
| | <input type="checkbox"/> 100/90/60 | <input type="checkbox"/> 100/90/60/50 |
| | <input type="checkbox"/> 100/100/60 | <input type="checkbox"/> 100/100/60/50 |

Deductible³: 0 25 50

Anthem Dental – Voluntary⁴ 1 1/80 2 2/80 Dual Option 1 Dual Option 2

Notes:

¹ This alternative is only available to groups enrolling 6 or more employees, 100/80/50 plan has a \$1250 calendar year max.
² This alternative is only available to groups enrolling 21 or more employees, 100/80/50/50 plan has a \$1500 calendar year max.
³ \$50 deductibles only for PPO 100/50 and Indemnity 100/50 and groups with less than 15 employees enrolling.
⁴ Requires at least 50 eligible employees and at least 30% participation.
⁵ Dual option dental available to group enrolling 26 or more employees.

Health Benefits Available for Groups with 51-99 Employees:

- | | | | |
|--------------------------------------|-----------------------------------------------|----------------------------------------|------------------------------------------|
| <input type="checkbox"/> KeyCare 10 | <input type="checkbox"/> KeyCare 25 | <input type="checkbox"/> KeyCare 200 | <input type="checkbox"/> KeyCare 10 Plus |
| <input type="checkbox"/> KeyCare 15 | <input type="checkbox"/> KeyCare 30 | <input type="checkbox"/> KeyCare 500 | <input type="checkbox"/> KeyCare 15 Plus |
| <input type="checkbox"/> KeyCare 20 | <input type="checkbox"/> KeyCare 30/2,000 | <input type="checkbox"/> KeyCare 1,000 | <input type="checkbox"/> KeyCare 20 Plus |
| | | <input type="checkbox"/> KeyCare 2,000 | |
| | <input type="checkbox"/> Cost Awareness _____ | | |
| <input type="checkbox"/> BlueCare 15 | <input type="checkbox"/> BlueCare 30 | <input type="checkbox"/> BlueCare 100 | <input type="checkbox"/> BlueCare 500 |
| <input type="checkbox"/> BlueCare 20 | <input type="checkbox"/> BlueCare 30/2,000 | <input type="checkbox"/> BlueCare 200 | <input type="checkbox"/> BlueCare 1,000 |
| <input type="checkbox"/> BlueCare 25 | | | <input type="checkbox"/> BlueCare 2,000 |

Prescription Drug Options:

For KeyCare Plus

- 5/10/25 with drug cap 10/20/35 with drug cap 10/30/50 10/30/50 with \$150 deductible
- no drug cap no drug cap

For all other Anthem BlueCare and Anthem KeyCare plans

- 5/10/25 10/20/35 10/30/50 10/30/50 with \$150 deductible

The 5/10/25 drug option is not available under the following BlueCare and KeyCare plans: 20, 25, 30, 30/2,000 and 2,000.

The 10/20/35 drug option is not available under the following BlueCare and KeyCare plans: 2,000 and 30/2,000.

The 10/20/35 with drug cap drug option is not available under KeyCare 20 Plus.

Optional Benefits:

- Contraceptive Rider Dependent Maternity Well Baby at 100% Other _____
- \$300 Routine Wellness at 100% Morbid Obesity Value Added Association Name _____
- Anthem Standard EAP Anthem Enhanced EAP
- \$0 inpatient copayment (available on KeyCare 10, KeyCare 10 Plus and KeyCare 15 Plus)
- Specialist = PCP copayment (available on KeyCare 10 Plus only)

Vision Rider

- Whole Group Voluntary Premier 12/12 Premier Plus 12/12
- Designer 12/12 Premier 12/24 Premier Plus 12/24
- Designer 12/24

Anthem Dental Benefits:⁵

- Anthem Dental PPO Plan I Anthem Dental PPO Plan II¹ Anthem Dental PPO Plan III²
- 100/80 100/80/50 100/80/50/50
- 100/50 (f/k/a Plan 50) 100/90/50 100/90/50/50
- 100/90/60 100/90/60/50
- 100/100/60 100/100/60/50
- Anthem Dental Indemnity Plan I Anthem Dental Indemnity Plan II¹ Anthem Dental Indemnity Plan III²
- 100/80 100/80/50 100/80/50/50
- 100/50 (f/k/a Plan 50) 100/90/50 100/90/50/50
- 100/90/60 100/90/60/50
- 100/100/60 100/100/60/50

Deductible³: 0 25 50

Anthem Dental – Voluntary⁴ 1 1/80 2 2/80 Dual Option 1 Dual Option 2

Notes:

¹ This alternative is only available to groups enrolling 6 or more employees, 100/80/50 plan has a \$1250 calendar year max.

² This alternative is only available to groups enrolling 21 or more employees, 100/80/50/50 plan has a \$1500 calendar year max.

³ \$50 deductibles only for PPO 100/50 and Indemnity 100/50 and groups with less than 15 employees enrolling.

⁴ Requires at least 50 eligible employees and at least 30% participation.

⁵ Dual option dental available to group enrolling 26 or more employees.

B. COVERAGE HISTORY

1. Name of present carrier: _____
2. Was your group enrolled with Anthem Blue Cross and Blue Shield within the past 12 months? No Yes
If yes, give group number and cancellation date. _____
3. Are your employees covered by Workers' Compensation? No Yes
If yes, give name of insurer. _____

C. GROUP INFORMATION

1. Type of Organization: Proprietorship Partnership Corporation Other _____
2. SIC Code: _____ (if known, otherwise check the appropriate box below and briefly describe the nature of your business)
- | | | | |
|---------------------------------------------------------|----------------------------------------|-------------------------------------------------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Agriculture, Forestry, Fishing | <input type="checkbox"/> Finance | <input type="checkbox"/> Public Administration | <input type="checkbox"/> Retail Trade |
| <input type="checkbox"/> Construction | <input type="checkbox"/> Mining | <input type="checkbox"/> Transportation, Communications,
Electric, Gas or Sanitation Service | <input type="checkbox"/> Services |
| <input type="checkbox"/> Education | <input type="checkbox"/> Manufacturing | | <input type="checkbox"/> Wholesale Trade |
- Nature of your business: _____ 3. _____

Will this policy cover any subsidiaries or affiliated companies? No

Yes *

If yes, list the name of the subsidiary/affiliate and explain the relationship between the parent company and the subsidiary/affiliate including the name of each owner and percent owned. _____

Is this group a branch, subsidiary, or affiliate of another company? No Yes *

If yes, explain _____

* Note: If yes to either of the above questions, permission to reconfigure group coverage by deleting or combining with the other branches, subsidiaries, affiliates, or parent company at a later date must be obtained from Anthem Blue Cross and Blue Shield.

4. Is Ceridian the COBRA administrator? No Yes

If yes and group size is 15-99, is the premium disbursed to Anthem or to the group? Anthem Group

D. ELIGIBILITY INFORMATION

1. Do any employees work out of state? No Yes If yes, give number of employees working out of state: _____
2. What is the percentage of premium your company contributes toward coverage (must be at least 50% of employee premium)?
Employee Coverage _____% Dependent Coverage _____%
3. What is the waiting period that new employees must serve before becoming eligible to enroll into the group health care plan? _____ (days)

E. ENROLLMENT INFORMATION

1. Please attach an Employee Application for each eligible employee applying for coverage and indicate the number of applications attached: _____ (“Eligible Employee” is defined below)
2. Please attach a copy of your company’s most recent Virginia Employment Commission’s “Employer’s Quarterly Tax Report” (VEC-FC-20 and 21) with the following information noted on the copy. If a VEC form is not filed, contact your Anthem sales representative for alternate documents.
- Write the number of hours normally worked each week beside each employee’s name.
 - List any new employees not printed on the VEC with hours worked.
 - List any other enrolling employee who does not appear on the VEC with hours worked and an explanation as to why he/she does not appear on the VEC.
- For each employee on the VEC form not applying for coverage, write one of the following codes to indicate why he/she is not applying for coverage:

“T”: Terminated

“P”: Not Eligible because they work part-time

“N”: Not Eligible because they are enrolled in Medicare, CHAMPUS/TRICARE, FEP, or COBRA; they have coverage through a spouse’s group program; they are enrolled in an Anthem Personal Health Care plan; or they have not met the employer waiting period

“E”: Eligible, but chooses to waive coverage because they have coverage through an individual program; or they are waiving for another reason not noted above.

F. ELIGIBILITY DEFINITIONS

Eligible Employee:

- An active employee* of the Applicant who works at least 25 hours per week as of the effective date and who works 50 weeks or more per year. Employment must be verifiable from state or federal wage or tax reports.
- An employee, as defined above, who enters into employment* after the policy effective date and who completes the group imposed waiting period for eligibility and applies for coverage within 31 days.
- Any other class of persons represented by the Applicant, provided that written approval of their eligibility is obtained from Anthem Blue Cross and Blue Shield; or
- Employees eligible for continuous coverage under State or Federal laws, e.g. COBRA.

- To become an eligible employee, a director or officer of a corporate Applicant must meet the same requirements as other employees of the Applicant.
- Independent contractors (those whose wages are reported on IRS form 1099) are considered to be self-employed and are not eligible for group coverage.

Eligible Dependent:

- Employee's lawful spouse, or unmarried child who is under the age limit of the group's plan. Child includes a stepchild or other child for whom the employee is legal guardian and for whom the employee provides at least 50% support.
- Dependents eligible for continuous coverage under State or Federal laws, e.g. COBRA.

*Note:

- A partner, proprietor or owner is an eligible employee if he/she actively works for the Applicant a minimum of 25 hours per week, 50 weeks per year for pay or profit, verifiable from wage or tax reports.

G. CERTIFICATION AND GROUP SIGNATURE

Certification:

The Applicant certifies that the information on this form is correct to the best of his or her knowledge. If Anthem Blue Cross and Blue Shield accepts the coverage for which application is hereby made, the Applicant shall:

1. Maintain enrollment at or above 75% of the total number of eligible employees.
2. Provide every eligible employee an opportunity to enroll when he or she becomes eligible (**only eligible employees as defined above may be added**).
3. Acknowledge that the terms and conditions of the coverage will be as described in the group policy, and that such group policy is incorporated herein by reference as if the same were set forth in this document in full.
4. Offer no other type of group health care or dental coverage. (If only the dental program coverage is purchased, no other dental coverage may be offered.)
5. Maintain the minimum employer contribution of 50% of the premium for Employee-Only coverage type.
6. Acknowledge that Anthem Blue Cross and Blue Shield may review necessary documentation to verify the group's eligibility.

The Applicant understands that Anthem Blue Cross and Blue Shield may deny claims and void the policy if Anthem Blue Cross and Blue Shield finds that the Applicant misrepresented information needed to accept this application. When false or misleading information is discovered, Anthem Blue Cross and Blue Shield may void the policy without advance notice and refund premium back to the effective date shown on this application if the discovery is made within 2 years after such effective date. Any claims paid during the period for which the coverage was not in force will be deducted from any premium refund. If the amount of benefits paid by Anthem Blue Cross and Blue Shield on the behalf of the Applicant exceeds the premium paid, the Applicant agrees to refund such excess amount to Anthem Blue Cross and Blue Shield.

The Applicant understands that payment is due the first day of the month following receipt of the statement.

The Applicant understands that Virginia mandated Standard and Essential products are available to groups with 2 to 50 eligible employees.

I certify that I have read the certifications above and have the authority to sign this application on behalf of the group.

Signature: _____ **Title:** _____ **Date:** _____

H. AGENT/BROKER AGREEMENT

The Group authorizes Anthem Blue Cross and Blue Shield to recognize the following agent/broker/agency (if any) to be the Group's Agent of Record:

Agent/Broker Name (print) _____ Agency Name _____
 Address _____
 Agent/Broker/Anthem ID Number A O _____ - _____ Telephone Number _____

I hereby certify that all the information in the Group Application and Employee Applications is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual requesting coverage, except as noted on the health questionnaire, as required. I have complied with Anthem's underwriting rules and regulations and have explained in detail the coverage to the group and its employees.

Agent/Broker Signature: _____ Date: _____

I. SALES REPRESENTATIVE:

I hereby certify that all information has been verified:

Signature: _____ Rep. Code #: _____ Date: _____

SECTION BELOW FOR OFFICE USE ONLY

Submitted By _____ Rep. No. _____ Terr. _____
 Check Number _____ Check Amount _____ Initial Waiver: Ongoing Waiver:
 Group No. _____ Group Effective Date _____ Renewal Date _____
 Assoc. Code _____ Association Name _____ LOB _____
 Parent No. _____ Package No. _____ EAP Standard: EAP Enhanced:
 Blue Advantage:
 Commission _____
 (51-99 only)

	Cov ID	Benefit Index	RTG Type	Effective Date	Single Rate	Sub/Minor Rate	Emp/Children Rate	Emp/Spouse Rate	Family Rate
BC									
BS									
MM									
Vision Rider									
Other Rider(s)									
Other Rider(s)									

