Employer Enrollment Application
For 2–50 Employee Small Groups
Colorado

Anthem BlueCross BlueShield

Please complete in blue or black ink only.

Section A: Company Information

Company name	Head of firm	Employer tax ID no. (required)

Company street address	City	County	State	ZIP code
Billing address – If different from above	City	County	State	ZIP code

Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Government unit/agency ☐ Limited Liability Company (LLC)
☐ Organization exempt from Income Tax ☐ Labor union trust ☐ Other _____

SIC code – Required only if applying for Life and Disability coverage	Type of business (be specific)	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

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 give the legal names, federal tax ID no. and number of employees employed by each.

_____

_____

_____

Section B: Application Type

☐ New enrollment ☐ Change(s) Group No. _____	Requested effective date (MM/DD/YYYY)

Employer tax ID no. (required)

Section C: Type of Coverage

1. Medical Coverage – I choose to offer:

☐ **Designated Plan** **1 – 3 enrolling employees (choose one plan)**

☐ **Designated Plan(s)** **4+ enrolling employee (choose a single plan or mix of plans)**

Elements	☐ Core DirectAccess Plus grdf ○ PPO $5,900 Deductible (OUP1) ☐ Core DirectAccess Plus gtpa ○ PPO $4,000 Deductible (OUP2)	☐ Essential DirectAccess Plus gjpa ○ PPO $3,000 Deductible (OUP4) ☐ Essential DirectAccess Plus ggqa ○ PPO $2,000 Deductible (OUP7)	☐ Essential DirectAccess Plus gcqa ○ PPO $1,500 Deductible (OUP6) ☐ Essential DirectAccess Plus w/ Dental ggqa ○ PPO $2,000 Deductible (OUSK)
Classic Solutions	☐ Essential DirectAccess gyia ○ PPO $2,000 Deductible (OUPZ) ☐ Preferred DirectAccess gjha ○ PPO $2,000 Deductible (OUPX) ☐ Preferred DirectAccess Plus gzpa ○ PPO $500 Deductible (OUP5)	☐ Preferred DirectAccess gfha ○ PPO $1,500 Deductible (OUPW) ☐ Preferred DirectAccess Plus w/ Dental gzpa ○ PPO $500 Deductible (OUSH) ☐ Preferred DirectAccess ghla ○ PPO $750 Deductible (OUPQ)	☐ Preferred DirectAccess gfga ○ PPO $1,000 Deductible (OUPV) ☐ Preferred DirectAccess gpka ○ PPO $500 Deductible (OUPN)
Consumer-Driven	☐ Core DirectAccess Plus ghhb ○ HSA $4,500 Deductible (OUPA) ☐ Core DirectAccess Plus gpdb ○ HSA $2,500 Deductible (OUP9) ☐ Core DirectAccess gmua ○ HSA $5,500 Deductible (OUQ0)	☐ Essential DirectAccess gpsa ○ HSA $2,500 Deductible (OUQ4) ☐ Essential DirectAccess gdsa ○ HSA $3,500 Deductible (OUQ6)	
High Performance	☐ Core Guided Access Plus gjqa ○ HMO $5,000 Deductible (OUNG) ☐ Core Guided Access Plus w/ Dental gjqa ○ HMO $5,000 Deductible (OUSF)	☐ Essential Guided Access gpja ○ HMO $1,750 Deductible (OUNH) ☐ Essential Guided Access gcda ○ HMO $2,500 Deductible (OUNE)	☐ Essential DirectAccess Plus gnea ○ PPO $2,500 Deductible (OUNP) ☐ Preferred Guided Access Plus gmca ○ HMO $1,000 Deductible (OUNF)
Focused	☐ Essential DirectAccess Plus ghpa ○ HMO $4,000 Deductible (OUNU) ☐ Essential DirectAccess Plus gzca ○ HMO $3,000 Deductible (OUNQ)	☐ Essential DirectAccess gzia ○ HMO $4,000 Deductible (OUNY) ☐ Essential DirectAccess ggja ○ HMO $2,500 Deductible (OUNZ)	☐ Preferred DirectAccess Plus gfda ○ HMO $1,500 Deductible (OUNR) ☐ Preferred DirectAccess Plus gmpa ○ HMO $500 Deductible (OUN9)

Choose your medical contribution for each month – only **one** choice is allowed.

Contribution option 1: Traditional option – We will contribute (50% to 100%): _____% per employee _____% per dependent (optional).

Contribution option 2: Flat dollar amount option $_____ ($125 or more)

For Consumer-Directed Health plans:

☐ Group will establish Health Savings Account (HSA) with Anthem facilitating with a banking services provider.

☐ Group will establish Health Savings Account (HSA) but does not want Anthem to facilitate in the creation of the account.

HSA administrator name	Phone no.	Email address

2. Dental Coverage – check all that apply

☐ Anthem Dental Pediatric
☐ Anthem Dental Pediatric Enhanced
☐ None
☐ Anthem Adult Dental
☐ Anthem Adult Dental Enhanced
☐ Anthem Dental Family
☐ Anthem Dental Family Enhanced

Choose your dental contribution for each month

_____% per employee _____% per dependent (optional).

NOTE: A separate Dental Application is required to enroll in the Dental Prime and Complete products. Please contact your broker to obtain the necessary forms.

Employer tax ID no. (required)

3. Vision Coverage — select one plan option

Full Service			Materials Only Plans
☐ Anthem Blue View Vision A1	☐ Anthem Blue View Vision B1	☐ Anthem Blue View Vision C1	☐ Anthem Blue View Vision MO1
☐ Anthem Blue View Vision A2	☐ Anthem Blue View Vision B2	☐ Anthem Blue View Vision C2	☐ Anthem Blue View Vision MO2
☐ Anthem Blue View Vision A3	☐ Anthem Blue View Vision B3	☐ Anthem Blue View Vision C3	☐ None
☐ Anthem Blue View Vision A4	☐ Anthem Blue View Vision B4	☐ Anthem Blue View Vision C4	
☐ Anthem Blue View Vision A5			

Choose your vision contribution for each month
_____% per employee _____% per dependent (optional).

Riders/Optional Benefits — select additional optional benefits

All medical plans listed above are Calendar Year. If you want your Medical plan to be based on Plan Year, then you can select from the list provided below.
NOTE: These plans can not be combined with Calendar Year plans.

☐ Core Bronze DirectAccess Plus gtpa • PPO $4,000D (0UQH) ☐ Core Bronze Guided Access Plus gjqa • HMO $5,000D (0UQC)	☐ Essential Silver DirectAccess Plus gnea • PPO $2,500D (0UQE) ☐ Essential Silver DirectAcess ggja • HMO $2,500D (0UQB)	☐ Preferred Gold DirectAccess Plus gfda • HMO $1,500D (0UQA)

Employer tax ID no. (required)

4. Life and Disability Coverage – check all that apply.

Life Products

Basic Life & Accidental Death & Dismemberment (AD&D)

☐ **Option A** – Flat benefit amount for all employees
- ☐ 2 – 9 enrolled employees
  - ☐ $25,000 ☐ $30,000 ☐ $50,000
- ☐ 10 – 19 enrolled employees
  - ☐ $25,000 ☐ $30,000 ☐ $50,000 ☐ $100,000
- ☐ 20+ enrolled employees $_____ (specify amount of $25,000 up to $300,000 maximum. in $1,000 increments)

☐ **Option B** – Benefit is a percentage of salary; check one of the following for all employees
- ☐ 2 – 9 enrolled employees ($25,000 up to $100,000 max.)
  - ☐ 1 x annual salary up to $_____
- ☐ 10 – 19 enrolled employees ($25,000 up to $250,000 max.)
  - ☐ 1 x annual salary up to $_____
  - ☐ 2 x annual salary up to $_____
- ☐ 20+ enrolled employees ($25,000 up to $300,000 max.)
  - ☐ 1 x annual salary up to $_____
  - ☐ 2 x annual salary up to $_____

Please provide list of employees and base salaries

Employer Contribution - _____%

Basic Dependent Life

2 – 19 Lives
- ☐ $10,000 Spouse/$5,000 Child ☐ $5,000 Spouse/$2,500 Child

20 – 50 Lives
- ☐ $20,000 Spouse / $10,000 Child ☐ $5,000 Spouse / $2,500 Child
- ☐ $15,000 Spouse / $7,500 Child ☐ $2,000 Spouse / $1,000 Child
- ☐ $10,000 Spouse / $5,000 Child

Employer Contribution - _____%

Optional Supplemental Life (must be sold with Basic Life)

20 – 50 Lives Only
- ☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ $100,000

Disability Products

Short Term Disability (STD)

☐ $250
or
☐ 67% of Salary to a Maximum Benefit of:
- ☐ $1,000
- ☐ $1,350

STD Elimination Period Options:

☐ 1/8/13	☐ 1/8/26
☐ 8/8/13	☐ 8/8/26
☐ 15/15/13	☐ 15/15/26
☐ 30/30/13 [20+ Lives Only]	☐ 30/30/26 [20+ Lives Only]

Employer Contribution - _____%

Long Term Disability (LTD)

- ☐ Gold - 60% of Salary
- ☐ Silver - 60% of Salary
- ☐ Bronze - 60% of Salary

Maximum Benefit: ☐ $3,000 or ☐ $6,000

LTD Elimination Period Options: ☐ 90 Days or ☐ 180 Days

Employer Contribution - _____%

Prior Coverage

Has this group had coverage within 12 months of this application's signature date? ☐ Yes ☐ No

Will this plan replace current	If yes, carrier name	Termination date
Life coverage ☐ Yes ☐ No		
Disability coverage ☐ Yes ☐ No		

Not Actively At Work Requirements for Life & Disability Products

The employees listed below are not presently actively-at-work and/or are not expected to be actively-at-work on the requested group effective date. Anthem Life may make an exception and assume liability, subject to Underwriting approval, for certain employees. Unless this exception is applied for and granted as indicated below, they will not be covered until they return to active work. To qualify for this exception, the following conditions must all be satisfied. 1) The employee's absence must be due to illness or injury. 2) The employee must be covered by the prior carrier on the day immediately prior to Anthem Life's effective date of coverage for your group. 3) The employee must not be eligible to have coverage continued or extended by the prior carrier after that policy/contract terminates. In no event will the actively-at work requirement be waived for coverage which provides benefits due to total disability, such as short term disability, waiver of premium or extension of benefits. In no event will any increase in coverage or any additional coverage become effective until the employee returns to work. Coverage approved below will end when your group's coverage under Anthem Life's policy ends or at the end of any time period shown below, whichever occurs first. (Attach additional sheet if necessary.)

Employee name	Amount of insurance	Date of birth	Last date worked	Reason not working	Date expected to return	Insured by prior carrier	Request actively at work waiver	Waiver request approved	Underwriter approval
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

Employer tax ID no. (required)

Section D: Eligibility

1. Total number of employees (including employed owners/officers): _____
2. Number of eligible full-time employees (minimum 30 hours per week): _____
3. Are part-time employees to be covered? ☐ Yes ☐ No
4. Number of employees enrolling in:
   Medical: _____ Pediatric Dental: _____
   Vision: _____ Life/Disability: _____
5. Number of eligible DECLINING employees: _____
6. Number of INELIGIBLE employees: _____
7. Number of employees working outside of Colorado _____
8. Will coverage be restricted to a certain classification of employees or employees working a certain number of hours per week? ☐ Yes ☐ No

   If yes, please explain what class(es) or number of work hours are required (must be at least 30 hours)

   _____
9. Probationary period/waiting period for **new employees/rehires**:
   ☐ First of month after hire date
   ☐ 30 days ☐ 60 days

   The standard effective date is first of the month following the waiting period/probationary period.
10. Under the Medicare Secondary Payer rules, which one applies for your group?
    ☐ Medicare is primary (less than 20 employees)
    ☐ Anthem Blue Cross and Blue Shield is primary (20 or more employees)

    Anthem Blue Cross and Blue Shield 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.
11. 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
12. Has this group had prior Medical coverage within 12 months of this application? ☐ Yes ☐ No

    If yes, list carrier name_____

    Termination Date_____

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: Certificates

The Employer has the option to either access electronic copies or receive printed copies of the employee Certificates. Choose one.

☐ Yes – Employer will access electronic copies of the employee Certificates. By marking this option, employer understands that no printed copies of the Certificates will be mailed to its offices and agrees to comply with all applicable provisions of the Employee Retirement Income Security Act (ERISA). Employer shall also make printed copies available to its employees upon request.

☐ No – Employer will not access electronic copies of the Certificates. Employer would like to receive printed copies of the Certificates.

Employer tax ID no. (required)

Section G: General Agreement

Please read this section carefully before signing the application.

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 Life and/or HMO Colorado may rely on this application in deciding whether to provide coverage. If the application is not complete, Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado 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 Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado, 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 Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado. 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 Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado 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 Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado.

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 Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado 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 Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado will refund these premiums after 45 days from the premium deposit date.

Fraudulent Insurance Acts

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Sign here	Company officer signature X	Printed name	Title	Date (MM/DD/YYYY)
Accepted by Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado authorized representative		Printed name		Date (MM/DD/YYYY)

Employer tax ID no. (required)

Section H: Agent/Producer/Broker 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 Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado 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 Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado reviews and approved the application and the employer receives a written notice from Anthem Blue Cross and Blue Shield Anthem Life and/or HMO Colorado.
5. 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 Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado.
6. I have advised the client not to terminate any existing coverage until receiving written notification from Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado that the coverage being applied for by this application is accepted.

Writing payable/sub-agent/producer/broker		**%**	**Second writing payable/sub-agent/producer/broker (Second writing agent not applicable in Maine)**		**%**
Agency name	Agency ID no.		Agency name	Agency ID no.	
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.		
Centerstone dba BenefitMall, Inc.	MDPHQKNKRY		
Street address	City	State	ZIP code

Sales Representative

Sales representative name	Sales representative ID no.		
Street address	City	State	ZIP code

ANTHEM USE ONLY	Group no.	Tracking no.	Effective date (MM/DD/YYYY)