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## THANK YOU FOR CHOOSING OUR PLAN.

### How to Fill Out This Form -

Please read these instructions before filling out the attached Enrollment and Membership Change Form

#### 1. Tell Us About You

Please complete all information in this section

#### 2. New Membership

Please check the appropriate box. If you are enrolling as a COBRA or C.G.S. 38a-538 extension of coverage member, please indicate the date of the Qualifying Event, and also the Reason Code.

REASON CODE	QUALIFYING EVENT	REASON CODE	QUALIFYING EVENT
01	Divorce	04	Dependent child no longer eligible under terms of employer's contract
02	Termination of employment	05	Reduction in hours/no longer meet group eligibility requirements
03	Spouse of deceased employee		

#### 3. Change Membership

Please check the appropriate box if you are changing membership. Please indicate the reason and date. Some examples include:

ADDRESS	MARRIED	DEPENDENT	LEGALLY SEPARATED	BIRTH	NAME	DIVORCED	ADOPTION
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When adding or cancelling members, please complete all information in Section 6.

#### 4. Your Membership Choices

There is only one plan choice for type of coverage.

Please check the box for individual, two person or family coverage on each line.

#### 5. Where You Work

Please complete all information in this section.

#### 6. List Members To Be Added/Cancelled

A. Please be sure to complete all information in this section including social security numbers and birth dates. This information is required for all members in order to process your application.

B. Indicate last name if different

C. For domestic partnerships, please include the appropriate certification forms. See [http://www.gme.uchc.edu/health\\_consortium/pdfs/bluedomestic.pdf](http://www.gme.uchc.edu/health_consortium/pdfs/bluedomestic.pdf) for application

#### 7. Tell Us About Your Other Insurance

Please be sure to note any other insurance information in this section.

#### 8. Medicare/Medicaid

Please complete all information in this section if you or an enrolled member is covered by Medicare or Medicaid, or have applied for Medicare or Medicaid disability.

#### 9. Employee Signature

Please print, sign and scan or fax the completed application. To e-mail, scan and send securely using your uchc.edu e-mail address to CAHCGroup@UCHC.edu. **THIS WILL ENSURE PROTECTION OF YOUR PERSONAL INFORMATION.** To fax, send to 860-676-1303.

<b>1. Tell Us About You</b> Last Name _____ First Name _____ M.I. _____ Home Address: Number and Street or P.O. Box _____ Apt. # _____ City _____ State _____ Zip Code _____ Home Telephone _____ Work Telephone _____ MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED	<b>2. New Membership</b> <input type="checkbox"/> NEW HIRE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> COBRA/C G.S. 38a-538 DATE OF QUALIFYING EVENT MM / DD / YR REASON _____ SEE INSTRUCTION SHEET	<b>To Be Completed By Employer</b> Requested Effective Date MM / DD / YR Firm Division No. <b>068965-015</b> For Office Use On
<b>3. Change Membership</b> CHANGE <input type="checkbox"/> ADDRESS <input type="checkbox"/> NAME INDICATE FORMER NAME <input type="checkbox"/> OTHER REASON DATE OF QUALIFYING EVENT MM / DD / YR		

<b>4. Your Membership Choices</b> <input type="checkbox"/> CENTURY PREFERRED/PPO <input type="checkbox"/> <small>Individual</small> <input type="checkbox"/> <small>Two Person</small> <input type="checkbox"/> <small>Family</small> <input type="checkbox"/> DENTAL <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Are you or any other eligible dependent listed on this form currently confined to a hospital or other healthcare facility, totally disabled or physically impaired? <input type="checkbox"/> YES <input type="checkbox"/> NO <b>5. Where You Work</b> Capital Area Health Consortium 270 Farmington Avenue Suite 352 Farmington CT 06032-1994 ARE YOU ACTIVELY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO / (IF NO ) REASON <input type="checkbox"/> SICK <input type="checkbox"/> INJURED <input type="checkbox"/> OTHER ARE YOU CURRENTLY CLAIMING WORKERS COMP. MEDICAL BENEFITS? <input type="checkbox"/> YES <input type="checkbox"/> NO DO YOU WORK 30 OR MORE HOURS PER WEEK? <input type="checkbox"/> YES <input type="checkbox"/> NO DATE OF FULL TIME HIRE    DATE OF REHIRE MM / DD / YR    MM / DD / YR
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6. List Members To Be Added/Cancelled					
SEX	NAME (LAST NAME/FIRST/M.I.)	Add	Cancel	Social Security Number	Date of Birth (MM/DD/YYYY)
<input type="checkbox"/> M <input type="checkbox"/> F	Self			_____	MM / DD / YR
<input type="checkbox"/> M <input type="checkbox"/> F	Spouse			_____	MM / DD / YR

DEPENDENTS: Children over 19 may be eligible if disabled, or unmarried full-time students. Please circle disabled dependent.

<input type="checkbox"/> M <input type="checkbox"/> F	Dependent			_____	MM / DD / YR
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent			_____	MM / DD / YR
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent			_____	MM / DD / YR

<b>7. Tell Us About Your Other Insurance</b>	Do you or any other member of your family have any other medical, dental or Anthem BCBS coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, please fill in the information below <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children			
Name of Company	Name of Subscriber (Policyholder)	Policy or ID No.	Reason for Termination	First and Last Date of Coverage

<b>8. Medicare/Medicaid</b>	Do you or any other covered member have Medicare/Medicaid coverage? <input type="checkbox"/> YES <input type="checkbox"/> NO Have you or any covered member applied for Medicare/Medicaid disability? <input type="checkbox"/> YES <input type="checkbox"/> NO					
Name(s) of Medicare Beneficiaries	Are you actively at work?	Retirement date (MM/DD/YY)	Health insurance claim no.	Medicare Part A effective date	Medicare Part B effective date	Medicare Part D effective date
	<input type="checkbox"/> YES <input type="checkbox"/> NO	MM / DD / YR				
	<input type="checkbox"/> YES <input type="checkbox"/> NO	MM / DD / YR				
	<input type="checkbox"/> YES <input type="checkbox"/> NO	MM / DD / YR				

I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or non-payment of claims for myself or my eligible dependents. I understand a copy of this application is provided to me as part of my Subscriber Agreement or health benefit plan document as applicable and is incorporated by reference therein. I certify that my statements in this form are true and complete to the best of my knowledge and belief.

<b>9. Employee Signature</b>	Date MM / DD / YR
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