

# CHEIBA Trust Medical/Dental Enrollment and Change Form



A. EMPLOYEE INFORMATION				
Employee last name	Employee first name	M.I.	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN - -
Home address		City	State	ZIP code
Home phone no.		Name of institution		
Medical group no.	Date of hire (MM-DD-YYYY) - -		Effective date or date of qualifying event - -	

B. CHANGES (COMPLETE FOR CHANGES TO EXISTING MEDICAL/DENTAL COVERAGE.)					
Additions		Deletions		Cancel employee	Name change/Correction
Person(s)	Reason	Person(s)	Reason	Coverage	
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Adoption <input type="checkbox"/> Birth <input type="checkbox"/> Marriage <input type="checkbox"/> Open enrollment <input type="checkbox"/> Other _____	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Birth <input type="checkbox"/> Death <input type="checkbox"/> Dependent child ineligible <input type="checkbox"/> Divorce <input type="checkbox"/> Medicare/Medicaid <input type="checkbox"/> Open enrollment <input type="checkbox"/> Other _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Previous name _____  Corrections _____

C. COVERAGE DESIRED			
Medical plan coverage		Dental plan coverage	
<input type="checkbox"/> BlueAdvantage Point-of-Service (HMO/POS) <input type="checkbox"/> Anthem Blue Cross and Blue Shield PRIME (PPO) <input type="checkbox"/> Anthem Blue Cross and Blue Shield Custom Plus	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Family	<input type="checkbox"/> Anthem Blue Dental PPO Plus (formerly BlueClassic) <input type="checkbox"/> Anthem Blue Dental PPO (formerly BluePreferred)	<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee + Family

**D. LIST OF ELIGIBLE DEPENDENTS (LIST SELF AND ALL ELIGIBLE DEPENDENTS INCLUDING YOUR SPOUSE YOU WISH TO COVER. USE A SEPARATE SHEET IF NEEDED.)**

I the undersigned verify and attest to the fact that my child(ren) is/are unmarried and financially dependent on me or dependent on me because of a court order and is/are therefore eligible for coverage under this policy. (Attach a copy of court order and/or an Overage Dependent Request form.)

Name (Last, First, M.I.)	Relationship	Sex	SSN	Date of birth	Primary Care Provider Name (Must complete for Blue Advantage POS)	Provider no.	Current Patient
	<b>SELF</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Male <input type="checkbox"/> Female					<input type="checkbox"/> Yes <input type="checkbox"/> No

**If you and your spouse are using different last names check applicable box**  
 Common law marriage (Attach copy of Affidavit of Common-law Marriage)       Spouse retaining name

**Other insurance**  
 Have you or any of your dependents had any other health coverage in the last six months, or currently have coverage other than the applied for coverage?  
 Yes  No. If yes, complete the section below for all members.

Member name	Carrier	Start date	End date
		- -	- -
		- -	- -
		- -	- -
		- -	- -

**E. MEDICARE COVERAGE INFORMATION (COMPLETE IF YOU, YOUR SPOUSE OR ANY DEPENDENT CHILD(REN) ARE COVERED UNDER MEDICARE.)**

Name (Last, First, M.I.)	Part A Effective date	Part B Effective date	If you or other members are under age 65, give reason for disability	Medicare claim no.
	- -	- -		
	- -	- -		

**I acknowledge that I have read the front as well as the reverse side of this application and certify that I agree to all matters covered therein.**

Employee signature	Date
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For more information about Anthem, its products and services visit [anthem.com](http://anthem.com).

The following applies to health plans and dental coverage offered through Anthem Blue Cross and Blue Shield and HMO Colorado (collectively called "the Plans"):

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.

I hereby authorize my employer, until this authorization be revoked by notice in writing, to deduct in advance each month from the earned or accrued wages due me, such amounts as may be necessary to pay the rates which are currently in effect or shall be in effect in the future for coverage for which I am applying.

I certify that I am regularly scheduled to work at least .5 FTE and that I am included on the payroll records of the employer.

I hereby authorize by my signature, any physician, hospital, clinic or other organization or person to release to the Plans, its administrator and its reinsures all medical records which it may require for the purpose of evaluating the information provided in this application. I also authorize by my signature, any physician, hospital, clinic or other organization or person to release, to the Plans, its administrator or its representative, all medical records which the latter may require for the purpose of diagnosis and assessment of quality care and utilization of health care services appropriate to my medical condition. I further agree that the Plans have the right to cancel or rescind my coverage in the event that I fail to cooperate in providing the company with these records with 30 days advance notice. A copy of this authorization shall be as valid as the original.

**For individuals applying for BlueAdvantage Point-of-Service coverage:**

I have indicated the Primary Care Provider of my choice, on the front of this application. I understand that the services for which I and my dependents will be eligible, as described in the Certificate, must be obtained from the HMO Colorado Primary Care Provider I have selected.

Pre-existing waiting period for Anthem Blue Cross and Blue Shield PRIME or Custom Plus coverage: We will not pay for services related to a pre-existing condition for six consecutive months (18 months if a Late Entrant) after the member's original effective date, or if earlier, the first day of the waiting period.

NOTE: The pre-existing condition waiting period will be waived for anyone meeting the state-mandated definition of "creditable coverage" within the last 90 days prior to the effective date or our coverage. The period of continuous coverage shall not include any waiting period for the effective date of new coverage.

**General notice of pre-existing condition exclusion**

If your plan is a PPO plan, it imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 6 months (18 months if you are a late enrollee) from your first day of coverage, or if you were in a waiting period, from the first day of your waiting period. However, you can have this exclusion period waived if you have had prior "creditable coverage." Most prior health coverage is creditable coverage and can be used to waive the pre-existing condition exclusion if you have not experienced a break in coverage of at least 90 days in Colorado, or 63 days in Nevada. To have the six-month (or 18-month) exclusion period waived based on your prior creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Anthem at 1-800-542-9402, or mailed to Anthem Blue Cross and Blue Shield, PO Box 5858, Denver CO, 80217-5858.

There are no pre-existing condition waiting periods for BlueAdvantage Point-of-Service (HMO/POS) coverage.

**Description of Special Enrollments**

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependent's other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. To request special enrollment, submit a completed application to the address below. To obtain more information, contact Anthem Customer Service at 1-800-542-9402; or Anthem Blue Cross and Blue Shield, P.O. Box 5858, Denver, CO 80217-5858.

NOTE: A copy of the prior carriers billing will normally suffice to grant a waiver of the pre-existing condition clause for new Anthem BCBS groups. In addition, the employee can obtain proof of prior coverage from the Creditable Coverage form required by Federal (HIPAA) law. Please contact your group Benefit Administrator if you need assistance in completing this application.

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