Employee Change Form
For Small Groups
Virginia

Anthem
And Its Affiliate HealthKeepers, Inc.

PPO health care plans, including dental and vision coverage, are preferred provider organization insurance products offered by Anthem Blue Cross and Blue Shield, the trade name of Anthem Health Plans of Virginia, Inc. (Anthem); HMO health care plans are health maintenance organization products offered by HealthKeepers, Inc. (HealthKeepers).

Consult the Booklet or Certificate of Coverage for complete coverage terms and conditions. For more information about Anthem and HealthKeepers, their products and services, visit anthem.com. Please complete electronically or in black ink only and use extra paper if necessary.

Application completed for (select the company that applies):

☐ **Anthem Health Plans of Virginia, Inc.**
2015 Staples Mill Road
Richmond, VA 23279

☐ **HealthKeepers, Inc.**
2015 Staples Mill Road
Richmond, VA 23279

Section A: General Information			
Employer name	Group no.		
Employee last name	Employee first name	M.I.	Employee Social Security no.[1] (required) - -

Section B: Employee Information — Required

Reason for change — Required. Select all that apply.

☐ Address change ☐ Add Spouse or Domestic Partner or dependent ☐ Enrollment in Medicare (Fill in Section E)
☐ Name change ☐ Cancel Spouse or Domestic Partner or dependent ☐ Cancel all coverage
☐ Benefit change ☐ Change Primary Care Physician (PCP) ☐ Cancel product(s)
☐ Other: _____

Event reason — Required. Select all that apply.

☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child/child placed for adoption
☐ Foster Child ☐ Step Child ☐ Loss of coverage ☐ Other insurance ☐ Death ☐ Termination ☐ Court ordered coverage
☐ Other — please explain: _____

Event date/Requested effective date — Required _____/_____/_____ **(MM/DD/YYYY)**

Home address — Street or P.O. Box if applicable	City	State	ZIP Code

Birthdate (MM/DD/YYYY): / /	Sex: ☐ Male ☐ Female	Marital status: ☐ Single ☐ Married ☐ Domestic Partner

Primary phone no.[2]	Occupation	
PCP name	PCP ID no.	Existing patient ☐ Yes ☐ No

Email address: _____

I'm providing my email address because **I, and my enrolled dependents, want to receive information about our benefits electronically.** These communications may include Identification (ID) Cards, Certificates of Coverage, billing invoices, Explanations of Benefits, Evidences of Insurability underwriting documents, required notices including cancellations and renewals, and helpful or specific personalized information to help get the most out of the benefits. I understand I need to register on anthem.com or the Sydney Health℠ mobile app to get the most out of my plan's digital tools, and I will make sure Anthem and HealthKeepers have my most up to date email address. I, and my enrolled dependents, understand that we can update our email addresses, change our communication preferences, and request free copies of any materials at any time by going to anthem.com or calling the Member Services number on my ID card.

1 Anthem and/or HealthKeepers is required by the Internal Revenue Service to collect this information.
2 By providing your phone number in section B, this information is also relevant to the authorization in section G.

Employee name: _____ Social Security no.: _____-_____-_____

Section C: Family Information — Dependents (includes Spouse or Domestic Partner and child(ren)) to be added/changed/cancelled. Attach a separate sheet if necessary.

☐ Add
☐ Change
☐ Cancel

Event reason — Required. Select all that apply.
☐ Open enrollment ☐ Marriage ☐ Birth of child ☐ Adoption of child/child placed for adoption ☐ Foster Child
☐ Step Child ☐ Loss of coverage ☐ Other insurance ☐ Death
☐ Other — please explain: _____
Event date/Requested effective date — Required _____/_____/_____ **(MM/DD/YYYY)**

Dependent Last name	First name	M.I.	Social Security no.[1] (required) - -

Sex ☐ Male ☐ Female	Disabled? ☐ Yes ☐ No	Birthdate (MM/DD/YYYY) / /	Relationship to applicant: ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Other[3] If other, what is the relationship? _____

PCP name	PCP ID no.	Existing patient ☐ Yes ☐ No

Does the Dependent(s) have a different address? ☐ Yes ☐ No
If yes, please enter: _____

Section D: Plan/Type of Coverage

1. Medical Coverage

Medical product plan name:	Contract code, if known:

Member medical coverage — select one: ☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + Child(ren) ☐ Family

2. Dental Coverage

Dental product plan name:	Contract code, if known:

Member dental coverage — select one: ☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + Child(ren) ☐ Family

3. Vision Coverage

Vision product plan name:	Contract code, if known:

Member vision coverage — select one: ☐ Employee only ☐ Employee + Spouse or Domestic Partner ☐ Employee + Child(ren) ☐ Family

Section E: Prior and Other Group Coverage — Attach a separate sheet if necessary.

Is anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name: _____

Medicare ID no.	Part A effective date (MM/DD/YYYY) / /	Part B effective date (MM/DD/YYYY) / /	Medicare eligibility reason (select all that apply) ☐ Age ☐ Disability ☐ End-stage renal disease (ESRD): Onset date (MM/D/YYYY) _____/_____/_____

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date (MM/DD/YYYY) / /

Is anyone applying for coverage covered by other health insurance? ☐ Yes ☐ No If yes, please provide the following:

Name of person covered (Last, First, M.I.)	Type (select one)	Coverage (select all that apply)	Insurer name	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			**Start:** ____/_____/____ **End:** ____/_____/____
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			**Start:** ____/_____/____ **End:** ____/_____/____

1 Anthem and/or HealthKeepers is required by the Internal Revenue Service to collect this information.
3 Please refer to Section F: Terms and Conditions for definition. Eligibility subject to Booklet or Certificate of Coverage.

Section F: Terms and Conditions — Please read this section carefully before signing the application.

Eligible employee:

- An active employee of the Employer who works the number of hours per week to be eligible for benefits as defined by the Employer and approved by Anthem and HealthKeepers as of the effective date. Employment must be verifiable from state or federal wage tax reports.
- An employee, as defined above, who enters into employment after the coverage effective date and who completes the group imposed waiting period for eligibility (if any) and applies for coverage within 31 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from Anthem and HealthKeepers; or
- Employees eligible for continuous coverage under state or federal laws.

Eligible employee does not include independent contractors (whose compensation is reported on IRS Form 1099) and directors and officers of the Group Policyholder if they do not work the required number of hours per week described above.

Eligible dependent (for plans offered by Anthem and HealthKeepers) (see Booklet or Certificate of Coverage for complete dependent eligibility terms):

- Employee's Spouse or Domestic Partner or children age 26 or younger, which includes a newborn, natural child, adopted child, or a child placed with the employee for adoption, a stepchild, Domestic Partner's child, foster child, or any other child for whom the employee has legal guardianship or court ordered custody. The age limit for enrolling a child is age 26. Coverage for a child will end on the last day of the month in which the child reaches age 26.
- For all plans, you may enroll your children (as defined in the group policy) if they are less than 26 years old and may continue to be enrolled until they reach age 26. The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of a child who cannot support himself or herself because of an intellectual or physical handicap that began prior to the child reaching age 26. Coverage may be obtained for the child who is age 26 or older at the initial enrollment if the employee provides proof of such intellectual or physical handicap and dependence at the time of enrollment. (The employee may be asked to provide a physician's certification of the dependent's condition).
- Dependents eligible for continuous coverage under state or federal laws.

Section G: Authorizations — Please read this section carefully and then sign below.

In signing this application I represent that:

- I certify that I have read, or have had read to me, the completed application. All statements and answers I have given are true and complete, and I realize any false statement or misrepresentation in the application may result in loss of coverage.
- I am an eligible employee and I am requesting coverage for myself and all eligible dependents listed on this application.
- I certify each Social Security number listed on this application is correct.
- By providing a phone number, I agree and consent that Anthem and its affiliates including HealthKeepers and CarelonRx Inc. (pharmacy benefits manager) may call me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.
- I authorize my employer to deduct any required contributions for this insurance from my wages.
- I authorize the Health Savings Account (HSA) financial custodian (provided I am enrolling in an HSA) to provide Anthem and/or HealthKeepers with information about my HSA, including account number, account balance and information regarding account activity. I understand that my authorization is required before the financial custodian may provide Anthem and/or HealthKeepers with information regarding my HSA and that I may provide Anthem and/or HealthKeepers with a written request to revoke my authorization at any time.

I give this authorization for myself and on behalf of my eligible dependents, including my Spouse or Domestic Partner, if covered by Anthem, and/or HealthKeepers, and I am acting as their agent and representative. If my Spouse or Domestic Partner signs this application, he/she is giving this authorization on his/her own behalf.

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

If the application is incomplete, we will reach out to you for additional information. This may delay the effective date of your coverage.

Sign here	**Applicant signature** (or custodial parent's or guardian's signature if applicant is under 18) X	**Today's date (MM/DD/YYYY)** / /
	Spouse or Domestic Partner signature X	**Today's date (MM/DD/YYYY)** / /

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ iਵੱਚ ਮੁਫ਼ਤ iਵੱਚ ਮਦਦ ਹਾiਸਲ ਕਰਨ ਦਾ ਿਅਧਕਾਰ ਹੈ। ਬਸ ਆਪਣy ਆਈਡੀ ਕਾਰਡ ਤੇ iਦੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf