

**Employee Change Form
For Small Groups
Wisconsin**



Consult the Evidence of Coverage for complete coverage terms and conditions. For more information about Anthem Blue Cross and Blue Shield (Anthem) and Anthem Life Insurance Company (Anthem Life), its products and services, visit anthem.com. Please complete electronically or in black ink only and use extra paper if necessary.

Section A: General Information			
Employer name		Group no.	Employee life class
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.			
<input type="checkbox"/> Address change	<input type="checkbox"/> Add Spouse/Domestic Partner or dependent	<input type="checkbox"/> Cancel coverage	<input type="checkbox"/> Cancel products
<input type="checkbox"/> Name change	<input type="checkbox"/> Cancel Spouse/Domestic Partner or dependent	<input type="checkbox"/> Enrollment in Medicare (Fill in Section E)	
<input type="checkbox"/> Benefit change	<input type="checkbox"/> Change Primary Care Physician (PCP)	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Change Life and/or Disability classification from Class ___ to Class ___			
Event reason — Required. Select all that apply.			
<input type="checkbox"/> Open enrollment (not applicable for Life and Disability)	<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth of child	<input type="checkbox"/> Adoption of child
<input type="checkbox"/> Loss of coverage	<input type="checkbox"/> Other insurance	<input type="checkbox"/> Death	<input type="checkbox"/> Termination
<input type="checkbox"/> Court ordered coverage	<input type="checkbox"/> Other- please explain: _____		
Event date/Requested effective date — Required ____/____/____ (MM/DD/YYYY)			
Home address — street and PO Box if applicable		City	State ZIP code
County	Birthdate (MM/DD/YYYY) / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner
Primary phone no.		Occupation	
Email address: _____			
For myself and any dependents, I'm providing my email address because I agree to receive information about my benefits by email or electronically. This may include my Certificate or Evidence of Coverage, explanation of benefits, Evidence of Insurability underwriting documents, required notices and helpful or personalized information to get the most out of my benefits. I will make sure Anthem and/or Anthem Life has my most up to date email. These electronic communications may include specific details about me and my plan. I also understand that by providing my email address, information about my dependents may also be sent by email or electronically. I know I can change my mind at any time and request a free copy of specific materials by mail. To do either, I (or my enrolled dependent) will update our communication preferences by going to anthem.com or calling Member Services.			

Section C: Family Information — Spouse/Domestic Partner and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.			
Event reason — Required. Select all that apply.			
<input type="checkbox"/> Add	<input type="checkbox"/> Open enrollment (not applicable for Life and Disability)	<input type="checkbox"/> Marriage	<input type="checkbox"/> Birth of child
<input type="checkbox"/> Change	<input type="checkbox"/> Adoption of child	<input type="checkbox"/> Loss of coverage	<input type="checkbox"/> Other insurance
<input type="checkbox"/> Cancel	<input type="checkbox"/> Other- please explain: _____		
Event date/Requested effective date — Required ____/____/____ (MM/DD/YYYY)			
Spouse/Domestic Partner or Dependent Last name		First name	M.I. Social Security no. ¹ (required)
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY) / /	Relationship to applicant: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Child <input type="checkbox"/> Other? If other, what is relationship? _____
Does the Spouse/Domestic Partner or dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please enter:			

1 Anthem is required by the Internal Revenue Service to collect this information.
2 Eligibility subject to Evidence of Coverage.

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin (BCBSWI), CompCare Health Services Insurance Corporation (CompCare) and Wisconsin Collaborative Insurance Company (WCIC). BCBSWI underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by CompCare or WCIC; CompCare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Life and Disability products underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Section D: Plan/Type of Coverage						
1. Medical Coverage						
Medical product plan name:			Contract code, if known:			
Member medical coverage — select one: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family						
2. Dental Coverage						
Dental product plan name:			Contract code, if known:			
Member dental coverage — select one: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family						
3. Vision Coverage						
Vision product plan name:			Contract code, if known:			
Member vision coverage — select one: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family						
4. Life, Accidental Death & Dismemberment (AD&D), and Disability Coverage						
<input type="checkbox"/> I am enrolling in my Employer's Life and/or Disability plan(s), if any						
<input type="checkbox"/> Basic Life and AD&D				<input type="checkbox"/> Short Term Disability		
<input type="checkbox"/> Basic Dependent Life				<input type="checkbox"/> Long Term Disability		
<input type="checkbox"/> Optional Supplemental/Voluntary Life and AD&D		\$ _____ (employee amount)		<input type="checkbox"/> Voluntary Short Term Disability		
<input type="checkbox"/> Optional Supplemental/Voluntary Dependent Life Spouse		\$ _____ (spouse amount)		<input type="checkbox"/> Voluntary Long Term Disability		
<input type="checkbox"/> Optional Supplemental/Voluntary Dependent Life Child		\$ _____ (child amount)				
Current annual income: \$			Life and Disability class no.:			
If selecting Short Term Disability coverage: Do you work in New York? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you work in New Jersey? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Primary Beneficiary – Attach a separate sheet if necessary.						
Last name		First name	M.I.	Relationship	Social Security no.	Percentage
Last name		First name	M.I.	Relationship	Social Security no.	Percentage
Contingent Beneficiary – Attach a separate sheet if necessary.						
Last name		First name	M.I.	Relationship	Social Security no.	Percentage
Last name		First name	M.I.	Relationship	Social Security no.	Percentage
Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above.						
<p>Spousal/Domestic Partner Consent for Community Property States Only (Note: The insurance company is not responsible for the validity of a Spouse's/Domestic Partner's consent for designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your Spouse/Domestic Partner if your Spouse/Domestic Partner will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your Spouse/Domestic Partner read and sign the following. I am aware that my Spouse/Domestic Partner, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior Spousal/Domestic Partner consent or waiver under this plan.</p>						
Spouse/Domestic Partner signature		Spouse/Domestic Partner name		Date (MM/DD/YYYY)		
X				/ /		

Section E: Prior and Other Group Coverage

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) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD: Onset date (MM/DD/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	Insurer phone no.	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: ____/____/____ End: ____/____/____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: ____/____/____ End: ____/____/____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: ____/____/____ End: ____/____/____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: ____/____/____ End: ____/____/____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia				Start: ____/____/____ End: ____/____/____

Section F: Terms, Conditions and Authorizations — 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/or Anthem Life 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 30 days.
- Any other class of persons identified by the Employer, provided that written approval of their eligibility is obtained from the Company(ies); or
- Employees eligible for continuous coverage under state or federal laws.

Eligible dependent (see Evidence of Coverage for complete dependent eligibility terms):

- Employee's Spouse, eligible Domestic Partner, or children age 26 or younger, which includes a newborn, natural child, or a child placed with the employee for adoption, a stepchild 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 life coverage, only employee's Spouse, or children age 26 or younger, legally adopted children, and stepchildren are eligible.
- The age limit of 26 does not apply for the initial enrollment or maintaining enrollment of an unmarried child who cannot support himself or herself because of mental retardation, mental illness, or physical incapacity that began prior to the child reaching the age limit. Coverage may be obtained for the child who is beyond the age limit at the initial enrollment if the employee provides proof of 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.
- For medical coverage only: A child who, prior to age 27, was called to active duty in the National Guard or reserve component of the U.S. armed forces while a full time student and has returned to full time student status upon return from the active duty service.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that:

- I have read, or have had read to me, the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.
- I certify each Social Security number listed on this application is correct.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

Life and/or Disability Authorization Section – Read carefully before signing.

1. I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, including any health or other insurance company affiliated with Anthem Life Insurance Company, consumer reporting agency or employer having information available as to claims, diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me, to give any and all such information to authorized representatives of Anthem Life Insurance Company (Anthem Life), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life, and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Anthem representatives to evaluate and adjudicate my current application for life or disability coverage or any claims under such coverage, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Anthem solely to assist with the evaluation and adjudication of my current life or disability application or claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information as applicable. I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem.
2. Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.
3. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
4. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

This authorization, for purposes of processing this application form, is valid from the date signed for a period of 30 months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. For the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization shall remain valid for the term of coverage of the policy for an accident and sickness insurance benefit and for the duration of the claim if the claim is not for an accident and sickness insurance benefit. A photocopy and/or electronic copy is as valid as the original. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.

I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan, including my Spouse/Domestic Partner unless he/she signs below. I am acting as their agent and representative.

Sign here	Applicant signature X	Date (MM/DD/YYYY) / /
	Spouse/Domestic Partner signature X	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 무료 지원을 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 مجاناً. 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 fòm 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 ਵਿੱਚ ਮੁਫਤ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ 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>