MEA Health Plans
Member Enrollment/Member Change Form

Anthem

Section 1: Employer information

School district name			Group no. (if existing group)
Address	City	State	ZIP code
Date of hire (MMDDYYYY)	Date of rehire (if applicable) (MMDDYYYY)	Date eligible (MMDDYYYY)	No. hours worked per week

Date of hire/rehire: The first day the individual performs services for wages or any other form of compensation is the Date of hire/rehire.

Section 2: Member/applicant information

Current Anthem Blue Cross and Blue Shield (Anthem) Member ID, if any	Last name	First name	M.I.
Home address no., street or P.O. Box and apt. no.	City	State	ZIP code
Home phone	Work phone	Email address	Please check one ☐ Other: ☐ Active employee ☐ Retired employee ☐ COBRA

Section 3: Reason for member enrollment — Please check the reason below and date if required.

☐ Annual enrollment ☐ New group (Initial enrollment) ☐ COBRA — start date: ☐ COBRA — event date: ☐ New hire ☐ Portability or qualifying life event ☐ Retiree — date of retirement: ☐ Other: _____

Section 4: Change status — Please check type and date of change below.

☐ Name change ☐ Add dependent ☐ Delete dependent ☐ Address change ☐ PCP change Date of change: (MMDDYY)

Reason for change

☐ Adoption	☐ Annual enrollment	☐ Birth	☐ Court order
☐ Court order changing custody	☐ Covered by Medicaid	☐ Covered by other insurance	☐ Death
☐ Discharge from the military	☐ Divorce	☐ Entrance to the military	☐ Involuntary loss of coverage
☐ Involuntary loss of Medicaid	☐ Marriage	☐ Other: _____	

Section 5: Membership choices

☐ Standard ☐ Choice Plus ☐ Standard $500 Plan ☐ Standard $1,000 Plan

Notice: There are hospitals, health care facilities, physicians or other health care providers who are not included in this plan's network. Your financial responsibilities for payment of covered services may differ if you use a network provider or a non-network provider. Please refer to the online provider directory available at anthem.com to determine if a particular provider is in the network, or contact Customer Service for assistance.

Section 6: Member information — List only dependents you wish to enroll, delete or change.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26).

Children over the age of 26 may be eligible for coverage as a dependent if they are incapable of self-sustaining employment by reason of a physical, mental, intellectual or developmental impairment. List all dependents beginning with the eldest.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 6 of the application, under Section 6, Terms, Conditions, and Authorizations, prior to answering the questions in Section 4.

Name(s) of person(s) (Last name, first name, M.I.)	Sex	Has other insurance?	If disabled, when?	Social Security no.[1] (required)	Date of birth (MM/DD/YYYY)	Primary Care Physician (PCP)[2] (See below for instructions)	Current patient
Self	☐ M ☐ F ☐ Unspecified	☐ Y ☐ N				Name / PCP no.	☐ Y ☐ N
☐ Legal spouse ☐ Domestic partner	☐ M ☐ F ☐ Unspecified	☐ Y ☐ N				Name / PCP no.	☐ Y ☐ N
Dependent	☐ M ☐ F ☐ Unspecified	☐ Y ☐ N				Name / PCP no.	☐ Y ☐ N
Dependent	☐ M ☐ F ☐ Unspecified	☐ Y ☐ N				Name / PCP no.	☐ Y ☐ N
Dependent	☐ M ☐ F ☐ Unspecified	☐ Y ☐ N				Name / PCP no.	☐ Y ☐ N

1 Anthem is required by the Internal Revenue Service to collect this information.
2 If applying for Choice Plus, each member must fill in PCP information. For current listing of valid PCPs, go to the HMO Choice network at anthem.com. If applying for Standard, do not complete this section.

Section 6: Member information (continued) — List only dependents you wish to enroll, delete or change.

Are you or any family members currently claiming Workers' Compensation Medical Benefits? ☐ Yes ☐ No
If yes, name of claimant: _____

Section 7: Prior coverage information — This section must be completed.

Have you or any other family member had health insurance coverage in the 90 days prior to your date of hire or the effective date of your new policy? ☐ Yes ☐ No
If yes, please complete the following:

	Self	Legal spouse/ Domestic partner	Dependents		
			1	2	3
Name of insurance company					
Certificate (policy) no.					
Date coverage began					
Date coverage ended or is coverage still in effect?					

Section 8: Medicare beneficiaries information

Is anyone listed on this application currently eligible for Medicare? ☐ Yes ☐ No
If yes, please complete the following for each person to be covered who is eligible for or covered by Medicare.

Name(s) of Medicare beneficiaries	Medicare no.	Medicare Part A effective date	Medicare Part B effective date	Check all reasons you qualified for Medicare
				☐ Age 65 ☐ Disability ☐ ESRD
				☐ Age 65 ☐ Disability ☐ ESRD
				☐ Age 65 ☐ Disability ☐ ESRD
				☐ Age 65 ☐ Disability ☐ ESRD

Section 9: Terms, Conditions, and Authorizations (TERMS)

Please read this section carefully before signing the application.

I have read and accept the Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

I certify each Social Security number listed on this application is correct.

Fraud notice: 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. All statements by the applicant contained in the application shall be deemed representation and not warranties unless they are fraudulent misrepresentations.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Applicant signature	Print name	Date (MMDDYYYY)
X		

Section 10: No coverage — Complete this section if you do not want coverage.

I do not wish to enroll in a plan. Please check one: ☐ I have other coverage OR ☐ I do not have any other coverage
I understand that the opportunity to enroll at any future date will be subject to the regulations of Anthem.

Applicant signature	Print name	Date (MMDDYYYY)
X		

For questions about MEA Choice Plus or MEA Standard, please call 833-990-3607
All questions need to be completed before this application can be processed.

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