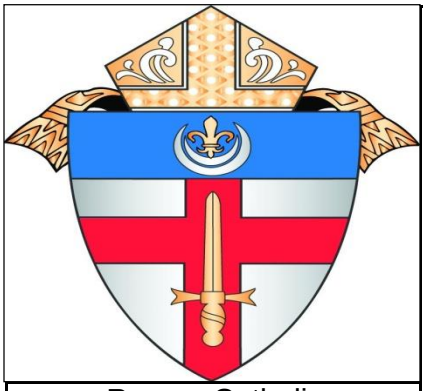
Employee Enrollment Application

Anthem
Anthem Health Plans of Kentucky, Inc.



Roman Catholic
Diocese of Covington

Your Anthem enrollment application is attached. It is essential that you read it carefully and complete all necessary sections.

If you are a new enrollee:

a) Applying for health coverage, please complete sections 2, 4, 5, 6, 7, 8, and 9. Your signature is required in section 9.

b) Waiving your health coverage benefit, please complete sections 2, 5, and 10. Your signature is required in section 10.

c) Complete all appropriate sections, print, sign and mail, fax or email to:

Ms. Elaine Schaser
Diocesan Benefits Office
1125 Madison Avenue
Covington, KY 41011-3115
Phone: (859) 392-1554
Fax: (859) 392-1589
Email: ESchaser@CovDio.org

If you are adding a dependent(s):

Complete section 3 in addition to the above.

NOTE: You may be required to supply additional information.

www.anthem.com

It is important that you read and understand the Significant Terms, Conditions and Authorizations on Page 4.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Anthem Health Plans of Kentucky, Inc: 13550 Triton Park Blvd, Louisville, KY 40223

Diocese of Covington
Employee Medical Plan Enrollment Application

Anthem
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1. Employer/Group Use:	Roman Catholic Diocese of Covington											
Employer Name and Address:	1125 Madison Avenue; Covington, KY 41011-3115											
Group #	Sub-group #				Request Effective Date				Department Name			
W32182					/ /							
Anthem Use: Plan	Health Effective	PCP			COB				Pre-ex (date)			
	/ /		Yes		No		Yes		No	/ /		

2. Reason for Application				3. Status Change / Event			
	New Enrollment		Waiver	Event Date: / /			
	Annual Open Enrollment		New Hire		Marriage		Adoption *
	COBRA		Rehire (date):		Birth		Legal Guardianship *
	Qualifying Event:		/ /		Other:		
			Add dependent				
	Event Date: / /		(See § 3)		* - Include legal documentation		

4. Type of Coverage / Plan									
X	PPO		Employee only		Employee + spouse		Employee + child(ren)		Family coverage
	No coverage (MUST complete and sign Section 10)								

5. Employee Information								
Last Name	First name, M.I.	Date of Birth	Age	Gender		Social Security #		
		/ /			M			
					F			
Home Address	City		State	Zip Code		Single		
						Married		
						Divorced		
Home telephone	Work telephone	eMail address (required)						
Retired	Disabled	Hospitalized	Occupation	Full-time hire date		Hours working/week		
Yes	Yes	Yes		/ /				
No	No	No						

6. Family Information **Spouse and dependents to be covered*									
* Please read the Genetic Information Non-discrimination Act (GINA) information on Pg 3, prior to answering the below questions.									
Dependent #1: Last Name	First name, M.I.	Relationship to Applicant:		Spouse		Son	FT Student?		
				Other:		Daughter		Yes	
								No	
Is dependent's address different than applicant's address?			Yes		No	(If Yes, provide full address below)			
Date of Birth	Gender	Social Security #	Eligible for federal income tax exemption?		Yes		No		
/ /	M		Court ordered health care coverage?		Yes *		No		
	F		Currently hospitalized/disabled?		Yes *		No		
If child, is child married?		Yes		No	(If Yes, to either, include legal documentation and reason)				
Does child have other medical insurance available?		Yes		No					
Dependent #2: Last Name	First name, M.I.	Relationship to Applicant:		Spouse		Son	FT Student?		
				Other:		Daughter		Yes	
								No	
Is dependent's address different than applicant's address?			Yes		No	(If Yes, provide full address below)			
Date of Birth	Gender	Social Security #	Eligible for federal income tax exemption?		Yes		No		
/ /	M		Court ordered health care coverage?		Yes *		No		
	F		Currently hospitalized/disabled?		Yes *		No		
If child, is child married?		Yes		No	(If Yes, to either, include legal documentation and reason)				
Does child have other medical insurance available?		Yes		No					

Name: _____ SSN: _____

Dependent #3: Last Name	First name, M.I.	Relationship to Applicant: ☐ Spouse ☐ Son ☐ Other: ☐ Daughter	FT Student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address below)

Date of Birth	Gender	Social Security #			
/ /	☐ M ☐ F		Eligible for federal income tax exemption?	☐ Yes	☐ No
			Court ordered health care coverage?	☐ Yes *	☐ No
			Currently hospitalized/disabled?	☐ Yes *	☐ No

If child, is child married? ☐ Yes ☐ No (If Yes, to either, include legal documentation and reason)

Does child have other medical insurance available? ☐ Yes ☐ No

For additional dependents, submit on a separate sheet of paper.

7. Other Health Coverage

Please check one: ☐ Yes - must complete this section ☐ No

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage:

Provide name, phone number and address of the HMO or insurance company	Policy/Certificate #	Effective date
		/ /

Policy/certificate holder's name	Social Security #	Date of birth	Relationship to applicant
		/ /	

If you and/or your dependents are enrolled in Medicare or Medicaid, complete the following:

Enrollee's name(s)	Medicare / Medicaid ID number	Medicare Part A effective Date	Medicare Part B effective Date	ESRD onset date
		/ /	/ /	/ /
		/ /	/ /	/ /

Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective Date	Medicare Part B term date	
		/ /	/ /	

Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD/Disability ☐ End Stage Renal Disease

8. Prior Health Coverage

Please check one: ☐ Yes - must complete this section ☐ No

Type of coverage: ☐ Single ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family coverage

Termination reason: ☐ Divorce/legal separation ☐ Death of spouse ☐ COBRA exhausted
☐ Group plan terminated ☐ Employer/group contribution ceased ☐ Employment terminated
☐ Other:

Significant Terms, Conditions and Authorizations (TERMS) *Please read this section carefully before signing*

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Continue to Page 4 for signature page and remaining Terms, Conditions and Authorizations (TERMS)

Name: ______________________________ SSN: ______________

Significant Terms, Conditions and Authorizations (TERMS) *Please read this section carefully before signing*

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless allowed by law.
2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
3. I am applying for the coverage selected on this application. If I select a coverage, or combination of coverages, not available to me and / or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
6. By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material mis-representation or significant ommission found in this application may result in denial of benefits, recission or cancellation of coverage.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health coverage will be provided by one of the following companies based upon the state in which your employer, trust or association is located: **Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.**

9. Read the TERMS section above carefully before signing. Please review your application for errors.

By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Applicant Signature for Electing Health Coverage	Date
	/ /

10. Waiver of health coverage for employee and/or any eligible dependent not enrolling.

Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer Name Carrier: ☐ Anthem (list policy #)	☐ Other (list Carrier name/policy #)
Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer Name Carrier: ☐ Anthem (list policy #)	☐ Other (list Carrier name/policy #)
Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer Name Carrier: ☐ Anthem (list policy #)	☐ Other (list Carrier name/policy #)
Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None
Employer Name Carrier: ☐ Anthem (list policy #)	☐ Other (list Carrier name/policy #)

X I certify that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. If I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependent or I become eligible for a subsidy (state premium assistance program).

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

Applicant Signature for Waiving of Health Coverage	Date
	/ /