Anthem Vision/Dental Enrollment Application / Change Form

Reason for Application

___ New Application
___ Address / Phone Change ___ Dental
___ Change of Coverage

Qualifying Event________________________________
Date of Event ________________________________
☐ Add Family Member ☐ Delete Family Member

Employer Information

Employer/Company Name	Group Number	Location Code	Effective Date

Employee Information

Last Name	First Name	MI	Date of Birth	Social Security Number

Home Address	City	Zip	Home Phone: Work Phone:

Date of Hire	Hours Worked per Week	Gender: Male Female

Prior Coverage–if this coverage is replacing another dental policy, please provide the following:

	Insurance Company	Certificate Number	Termination Date	6/12*	12/24*
Employee	____________________	____________________	___________________	_____/_____	_____/_____
Dependent	____________________	____________________	___________________	_____/_____	_____/_____
Dependent(s)	____________________	____________________	___________________	_____/_____	_____/_____

*Please list the number of consecutive months of dental coverage in the past 6 months and in the past 12 months and the number of consecutive months of dental coverage with orthodontic benefits in the past 12 months and in the past 24 months.

I represent that the below-named individuals are dependent on me or dependent because of a court order. (Attach a copy of court order.)

Family Information (Only those eligible may be enrolled.) **LIST SELF AND ALL ELIGIBLE DEPENDENTS INCLUDING LEGAL SPOUSE YOU WISH TO COVER** (If additional space is required, attach separate sheet.)

Gender	Relationship	Last Name	First Name	M.I.	Date of Birth	Social Security Number	Vision	Dental
M F								
M F								
M F								
M F								
M F								
M F								

I am requesting coverage for myself and all 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 Agreement and Coverage Document.
In signing this application I represent that:
I have read and understand all the information on this form.

Applicant Signature: ______________________________---------______________ Date__________________

Election not to Enroll

I do not wish to enroll in a plan and understand that the opportunity to enroll at any future date will be subject to the regulations of Anthem Blue Cross and Blue Shield.

Applicant Signature: ____ Date__________________

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