MEWA Employee Change Form
[For [1-50]Employee Small Groups]
Missouri

Instructions:
If you are cancelling coverage for a dependent or changing a name, please provide a reason in the designated sections. Complete electronically or in black ink and return to your employer. Please use extra sheets of paper if necessary. NOTE: Some changes may be made by accessing anthem.com.

Section A: General Information			
Employer name	Group no.		Employee life class
Employee last name	Employee first name	M.I.	Employee Social Security no.* (required)

Section B: Employee Information — Required

Reason for change –Required. Check all that apply.

☐ Address change ☐ Add spouse/Domestic Partner or dependent ☐ Change life classification ☐ Cancel coverage
☐ Name change ☐ Cancel spouse/domestic partner or dependent ☐ Enrollment in Medicare (Fill in Section E)
☐ Benefit change ☐ Change Primary Care Physician (PCP) ☐ Other:_____
☐ Change Life and/or Disability classification from Class _____ to Class _____

☐ Add ☐ Change ☐ Cancel	**Event reason-Required. Check all that apply**. ☐ Open enrollment (not applicable for Life and Disability products) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage ☐ Other insurance ☐ Death ☐ Divorce ☐ 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 ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)
Primary phone no.	Secondary phone no.	Email address	
Primary Care Physician (PCP) name	PCP ID no.	Existing Patient? ☐ Yes ☐ No	
[Primary Care Dentist (PCD) name]	[PCD ID no.]	[Existing Patient? ☐ Yes ☐ No]	

[Coverage Selected: ☐ Medical [☐ Dental[*]] [☐ Vision[*]] [Other: Explain _____]
[*Primary Applicant must be included for Spouse/Domestic Partner and/or Dependent coverage eligibility.]]

Section C: Family Information — Spouse and dependents to be added/changed/cancelled. Attach a separate sheet if necessary.

☐ Add ☐ Change ☐ Cancel	**Event reason-Required. Check all that apply**. ☐ Open enrollment (not applicable for Life and Disability products) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage ☐ Other insurance ☐ Death ☐ Divorce ☐ Other- please explain: _____ **Event date/Requested effective date- Required** _____/_____/_____ **(MM/DD/YYYY)**

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.*(required)
Sex ☐ Male ☐ Female	Disabled? ☐ Yes ☐ No	Birthdate (MM/DD/YYYY) _____/____/_____	Relationship to applicant ☐ Spouse ☐ Domestic Partner

PCP Name	PCP ID no.	Existing patient? ☐ Yes ☐ No
[PCD Name]	[PCD ID no.]	[Existing patient? ☐ Yes ☐ No]

[Coverage Selected: ☐ Medical [☐ Dental[*]] [☐ Vision[*]] [Other: Explain _____]
[*Primary Applicant must be included for Spouse/Domestic Partner and/or Dependent coverage eligibility.]]

Does the Spouse/Domestic Partner have a different address? ☐ Yes ☐ No
If yes, please enter:

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Section C: Family Information — Continued

☐ Add
☐ Change
☐ Cancel

Event reason-Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability products) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other- please explain: _____

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

Dependent last name	First name	M.I.	Social Security no.*(required)

Sex	Disabled?	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐Male ☐ Female	☐ Yes ☐ No	_____/____/_____	☐ Child ☐ Other If other, what is relationship? _____

PCP Name	PCP ID no.	Existing patient? ☐ Yes ☐ No
[PCD Name]	[PCD ID no.]	[Existing patient? ☐ Yes ☐ No]

[Coverage Selected: ☐ Medical [☐ Dental[*]] [☐ Vision[*]] [Other: Explain _____]
[*Primary Applicant must be included for Spouse/Domestic Partner and/or Dependent coverage eligibility.]]

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter:

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

☐ Add
☐ Change
☐ Cancel

Event reason-Required. Check all that apply.
☐ Open enrollment (not applicable for Life and Disability products) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage
☐ Other insurance ☐ Death ☐ Divorce ☐ Other- please explain: _____

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

Dependent last name	First name	M.I.	Social Security no.*(required)

Sex	Disabled?	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No	_____/____/_____	☐ Child ☐ Other If other, what is relationship? _____

PCP Name	PCP ID no.	Existing patient? ☐ Yes ☐ No
[PCD Name]	[PCD ID no.]	[Existing patient? ☐ Yes ☐ No]

[Coverage Selected: ☐ Medical [☐ Dental[*]] [☐ Vision[*]] [Other: Explain _____]
[*Primary Applicant must be included for Spouse/Domestic Partner and/or Dependent coverage eligibility.]]

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter:

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

☐ Add ☐ Change ☐ Cancel	**Event reason-Required. Check all that apply**. ☐ Open enrollment (not applicable for Life and Disability products) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Involuntary loss of coverage ☐ Other insurance ☐ Death ☐ Divorce ☐ Other- please explain: _____ **Event date/Requested effective date- Required _____/_____/_____ (MM/DD/YYYY)**

Dependent last name	First name	M.I.	Social Security no.*(required)

Sex	Disabled?	Birthdate (MM/DD/YYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No	_____/____/_____	☐ Child ☐ Other If other, what is relationship? _____

PCP Name	**PCP ID no.**	**Existing patient?** ☐ Yes ☐ No
[PCD Name]	**[PCD ID no.]**	**[Existing patient?** ☐ Yes ☐ No]

[Coverage Selected: ☐ Medical [☐ Dental[*]] [☐ Vision[*]] [Other: Explain _____]
[*Primary Applicant must be included for Spouse/Domestic Partner and/or Dependent coverage eligibility.]]

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter:

Has this person used tobacco products 4 or more times per week, on average, in the last 6 months? ☐ Yes ☐ No
Has this person currently enrolled or willing to enroll in a tobacco cessation wellness program? ☐ Yes ☐ No

*Anthem is required by the Internal Revenue Service to collect this information.

Section D: Plan/Type of Coverage

1. Medical Coverage

Enter network name, product plan name and contract code selected:

Network name	Product plan name	Contract code, if known

Note for Health Savings Account (HSA) enrollees:
If you enroll in an HSA plan, Anthem will facilitate the opening of a Health Savings Plan in your name, if directed by your employer.

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

2. Dental Coverage

Product plan name	Contract code, if known

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

3. Vision Coverage

☐ I am enrolling in my Employer's vision plan, if any.	Contract code, if known

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

4. Life and Disability Coverage

☐ I am enrolling in my Employer's Life and/or Disability plan(s), if any

☐ Basic Life and AD&D
☐ Basic Dependent Life
☐ Optional Supplemental/Voluntary Life and AD&D
☐ Optional Supplemental/Voluntary Dependent Life Spouse
☐ Optional Supplemental/Voluntary Dependent Life Child

$ _____ (employee amount)
$ _____ (spouse amount)
$ _____ (child amount)

☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income	Occupation	Life and Disability class 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.

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.

Spouse/Domestic Partner signature	Spouse/Domestic Partner name	Date (MM/DD/YYYY)
X		/ /

[5. Flexible Spending Account (FSA) coverage – please confirm with your employer that FSA is available to you for enrollment.]

[☐ Healthcare FSA (excluded if you have an HSA plan)]
[☐ Limited-Purpose FSA (for dental and vision services)]
[☐ Dependent Care FSA]

Section E: Other Group Coverage

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

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date: _____
Medicare Part D ID no.	Medicare Part D Carrier		Part D effective date

On the day your coverage begins, will you or a family member be covered by Medicare? ☐ Yes ☐ No
On the day your coverage begins, will you or a family member be covered by other health coverage? ☐ Yes ☐ No
On the day your coverage begins, will you or a family member be covered by other dental coverage? ☐ Yes ☐ No
If yes to any of these questions, please provide the following. If any coverage will remain in force once you enroll with Anthem, leave the End date blank.

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable)
	☐ Individual ☐ Group	☐ Health ☐ Dental ☐ Orthodontia				**Start:** ____/_____/______ **End:** ____/_____/______
	☐ Individual ☐ Group	☐ Health ☐ Dental ☐ Orthodontia				**Start:** ____/_____/______ **End:** ____/_____/______
	☐ Individual ☐ Group	☐ Health ☐ Dental ☐ Orthodontia				**Start:** ____/_____/______ **End:** ____/_____/______
	☐ Individual ☐ Group	☐ Health ☐ Dental ☐ 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 Blue Cross and Blue Shield (Anthem) 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 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:

- Employee's spouse, 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 children will end on the last day of the month in which the children reach age 26.
- 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 handicap, 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.

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

For a period of two (2) years from the earlier of the policy date or the issue date, Anthem may deny benefits, rescind your policy or cancel coverage based on material misrepresentation of significant omission found in this application.

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.

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.

Sign here	**Applicant signature** X	Date (MM/DD/YYYY) / /

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

1. I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., to Anthem, its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem. This information will be used for purposes which mean: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS, sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. 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. 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 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.

Employee signature X	Date (MM/DD/YYYY) / /
Spouse/Domestic Partner signature X	Date (MM/DD/YYYY) / /