

Anthem Enrollment/Change Form for Non Affiliated Employees
Manchester School District
(Please print clearly)

Office Use Only

Effective Date: _____

Group Number: _____

Section 1. Member/Applicant Information

Employee Name (First, Middle Initial, Last) _____ Employee SSN (xxx-xx-xxxx) _____ - ____ - _____

Home Address: _____
Address City State Zip

Section 2. New Membership

Open Enrollment New Hire _____ Rehire _____ Other (reason) _____

Section 3. Change to Existing Membership

Type of Change: Plan Change Add Spouse/Dependent Remove Spouse/Dependent Voluntary Cancellation

Date of change: _____

Reason for Change (check all that apply):

Marriage Divorce Birth Open Enrollment Loss of Other Coverage Change in Employment Status

Other (reason) _____

Section 4. Membership Choices

- HMO Access Blue Plan
 POS Blue Choice Plan
 * High Deductible HSA Plan (Regional)
 *High Deductible HSA Plan (National)

* The difference between the High Deductible Regional and National plans: With the Regional plan your coverage is limited in the New England area (emergencies are covered nationally) with lower service costs. Insurance premiums for both plans are identical. The National plan has coverage all over the US but the discounts are lower than they are on the Regional plan, which results in higher service costs under the National plan.

Your Membership Choices

- Single
 Couple
 Parent/Child(ren)
 Family

Section 5. List yourself and members to be added/cancelled

I understand and agree that this Enrollment/Change Request may be transmitted to Anthem or its agent by my employer. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms.

* Please indicate A = Add or D = Delete

	A/D*	Name of Spouse or Dependent (First, Middle Initial, Last)	SSN xxx-xx-xxxx	Birthdate xx/xx/xxxx	Sex M or F	PCP Name (first and last) PCP ID (if available)
Self						
Legal Spouse						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						

Section 6. Employee Signature

I wish to elect coverage under my employer’s benefit plan for the coverage indicated above. I understand that my enrollment will be subject to the terms of the plans’ requirements. I certify that all information is true and correct to the best of my knowledge and that false information will lead to loss of benefits (or termination of employment).

I authorize my employer to make medical and dental pre-tax salary reductions unless I revoke in writing. I understand that if the premium increases or decreases during the Plan Year, my salary reduction will be adjusted. This part of my election will automatically carry over into subsequent plan years unless I revoke it in writing.

SIGNATURE _____

DATE _____

