Anthem Enrollment/Change Form for School Food & Nutrition 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** ____________________