



**Spotsylvania County
Health/Dental/Vision/Prescription
Enrollment/Change Form**



A. Employer Information (to be completed by employer)

Effective Date		Date of Hire:	
Date of Qualifying Event:			

B. Subscriber Information (to be completed by employee)

Last Name	First Name	MI	Social Security #

Address (street, city, state and zip code)

Phone Number		DOB		SEX		M	F
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Select Anthem Plan (check one):

<input type="checkbox"/>	Key Care 30 Basic Plan 045041-M003 (active employee)	<input type="checkbox"/>	Key Care 20 Optional Plan 045041-M001 (active employee)	<input type="checkbox"/>	Key Care 30 Basic Plan 045041-MC03 (COBRA)
<input type="checkbox"/>	Key Care 30 Basic Plan 045041-MR04 (retired-non Medicare)	<input type="checkbox"/>	Key Care 20 Optional Plan 045041-MR02 (retired non-Medicare)	<input type="checkbox"/>	Key Care 20 Optional Plan 045041-MC01 (COBRA)
<input type="checkbox"/>	Key Care 30 Basic Plan 045041-MR03 (retired-Medicare)	<input type="checkbox"/>	Key Care 20 Optional Plan 045041-MR01 (retired-Medicare)	<input type="checkbox"/>	High Ded Health Plan/HSA 045041-M005 (active employee)

Select Coverage Level (check one):

<input type="checkbox"/>	Employee Only	<input type="checkbox"/>	Employee + Child	<input type="checkbox"/>	Retiree Only (or retirees spouse)
<input type="checkbox"/>	Employee + Spouse	<input type="checkbox"/>	Employee + Family	<input type="checkbox"/>	Retiree + Spouse

Enrollment Types (check appropriate boxes):

Enroll	Change	Marital Status
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Open Enrollment	Add Dependent	Single
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
New Hire	Remove Dependent	Married
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COBRA	Name Change	Divorced
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retired	Address Change	Widowed

Qualifying Event *(circle one)* Qualifying Event: Must attach documentation to support a qualifying event, such as birth letter, marriage certificate, death certificate, Medicare card, divorce decree etc. **This change must be made within 31 days of the qualifying event.**

C. Dependent Information (to be completed by employee, all fields required)

Enroll or Delete	Full Name (First, MI, Last)	Sex	DOB	Relation	Social Security #
E D		M F			
E D		M F			
E D		M F			
E D		M F			
E D		M F			
E D		M F			
E D		M F			
E D		M F			

D. Other Insurance

Do you or your dependents have other coverage? No Yes

Do you intend to continue this coverage? No Yes

If no, please provide cancellation date: _____

If yes, please complete below & attach a copy of your insurance card:

Policy Holder's Full Name: _____

Policy Holder's DOB: _____

Policy Holder's Social Security Number: _____

Insurance Company: _____

Policy ID Number: _____ Policy Effective Date: _____

List Individuals Covered: _____

Do you or your covered dependents have Medicare coverage?

No Yes *If yes, please complete below & attach copy of your Medicare card*

Name	Medicare ID #	Part A Effective	Part B Effective

Are any of your dependents disabled/handicapped before age 23?

No Yes *If yes, attach physician certification*

Name(s) of disabled dependent(s): _____

I hereby apply for membership or request a change in membership with my Health Insurance Plan administered by Anthem Blue Cross and Blue Shield. I understand my Health Insurance premiums will be deducted from my check on a pre-taxed basis. I certify that the dependents I have listed are eligible to be on my plan. I understand that any false statement or misrepresentation in this application may result in loss of coverage under the policy.

Employee Signature: _____ **Date:** _____

Human Resources Use Only

Date	Staff	
		Enrolled online (health and dental)
		H T E
		Dependent documentation reviewed