CHEIBA Trust
Medical/Dental/Vision Enrollment and Change Form

Anthem

Section 1: Employee information

Last name	First name	M.I.	Gender ☐ Male ☐ Female	Social Security no. (required)	Medical group no.

Home address	City	State	ZIP code

Home phone no.	Date of hire (MMDDYY)	Effective date or date of qualifying event (MMDDYY)

Email address	Name of institution

Section 2: Changes — Complete for changes to existing medical/dental/vision coverage.

Additions

Person(s)
☐ Spouse
☐ Child(ren)

Relationship
☐ Spouse/Statutory Marriage (If Special Enrollment, attach Marriage Certificate)
☐ Common-Law Marriage
☐ Civil Union (If Special Enrollment, attach Civil Union Registration)

Reason
☐ Adoption
☐ Birth
☐ Marriage
☐ Open enrollment
☐ Other: _____

Deletions

Person(s)
☐ Spouse
☐ Child(ren)

Relationship
☐ Spouse/Statutory Marriage (If Special Enrollment, attach Marriage Certificate)
☐ Common-Law Marriage
☐ Civil Union (If Special Enrollment, attach Civil Union Registration)
☐ Other: _____

Reason
☐ Birth
☐ Dependent child ineligible
☐ Open enrollment
☐ Other: _____
☐ Death
☐ Divorce
☐ Medicare/Medicaid

Cancel employee coverage
☐ Medical ☐ Vision
☐ Dental

Name change/correction

Previous name	Corrections

Section 3: Coverage desired

Medical plan coverage

☐ BlueAdvantage Point-of-Service (HMO/POS) ☐ Blue Priority HMO ☐ Prime Blue Priority PPO ☐ High Deductible Health Plan HSA 2500
Medical coverage for: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

Dental plan coverage

☐ Essential Choice
Dental coverage for: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

Vision plan coverage

☐ Blue View Vision (Voluntary Full Service) ☐ Post-Tax ☐ Pre-Tax
Vision coverage for: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Employee + Family

Section 4: List of eligible dependents — List self and all eligible dependents including your spouse you wish to cover. Use a separate sheet if needed. Please check coverage desired for self and dependents. (M)edical — (D)ental — (V)ision

Name (last, first, M.I.)	Relationship	Plan type	Sex	Social Security no. (required)	Date of birth (MM/DD/YY)	Primary Care Provider name and no. (Must complete for Blue Advantage POS, Prime Blue Priority PPO & Blue Priority HMO)	Current patient
	Self	☐ M ☐ D ☐ V	☐ M ☐ F				☐ Yes ☐ No
		☐ M ☐ D ☐ V	☐ M ☐ F				☐ Yes ☐ No
		☐ M ☐ D ☐ V	☐ M ☐ F				☐ Yes ☐ No
		☐ M ☐ D ☐ V	☐ M ☐ F				☐ Yes ☐ No
		☐ M ☐ D ☐ V	☐ M ☐ F				☐ Yes ☐ No

COLORADO HIGHER EDUCATION INSURANCE BENEFIT ALLIANCE TRUST (CHEIBA TRUST)

Other insurance
Have you or any of your dependents had any other health coverage in the last six months, or currently have coverage other than the applied for coverage? ☐ Yes ☐ No
If yes, complete the section below for all members.

Member name	Carrier	Start date (MMDDYY)	End date (MMDDYY)

Section 5: Medicare coverage information — Complete if you, your spouse or any dependent child(ren) are covered under Medicare.

Name (Last, First, M.I.)	Part A effective date (MMDDYY)	Part B effective date (MMDDYY)	If you or other members are under age 65, give reason for disability	Medicare claim no.

Section 6: Signature required

I acknowledge that I have read the front as well as the reverse side of this application and certify that I agree to all matters covered therein.

Employee signature	Date (MMDDYY)
X	

For more information about Anthem, its products and services visit anthem.com.

The following applies to health plans, dental and vision coverage offered through Anthem Blue Cross and Blue Shield and HMO Colorado (collectively called "the Plans"):

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I hereby authorize my employer, until this authorization be revoked by notice in writing, to deduct in advance each month from the earned or accrued wages due me, such amounts as may be necessary to pay the rates which are currently in effect or shall be in effect in the future for coverage for which I am applying.

I certify that I am regularly scheduled to work at least .5 FTE and that I am included on the payroll records of the employer.

I hereby authorize by my signature, any physician, hospital, clinic or other organization or person to release to the Plans, its administrator and its reinsures all medical records which it may require for the purpose of evaluating the information provided in this application. I also authorize by my signature, any physician, hospital, clinic or other organization or person to release, to the Plans, its administrator or its representative, all medical records which the latter may require for the purpose of diagnosis and assessment of quality care and utilization of health care services appropriate to my medical condition. I further agree that the Plans have the right to cancel or rescind my coverage in the event that I fail to cooperate in providing the company with these records with 30 days advance notice. A copy of this authorization shall be as valid as the original.

For individuals applying for Blue Advantage Point-of-Service coverage:
You must indicate the primary care physician (PCP) choice for each enrollee from the Blue Advantage POS network on the first page of this application. If you do not indicate a PCP, we may need to select one for you. You can find a PCP online at anthem.com by selecting Find a Doctor.

For individuals applying for Blue Priority HMO coverage:
You must indicate the primary care physician (PCP) choice for each enrollee from the Blue Priority HMO network on the first page of this application. If you do not indicate a PCP, we may need to select one for you. You can find a PCP online at anthem.com by selecting Find a Doctor.

For individuals applying for Prime Blue Priority PPO coverage:
You must indicate the primary care physician (PCP) choice for each enrollee from the Blue Priority PPO network on the first page of this application. If you do not indicate a PCP, we may need to select one for you. You can find a PCP online at anthem.com by selecting Find a Doctor.

Description of Special Enrollments
If you are declining enrollment for yourself of your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependent's other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. To request special enrollment, submit a completed application to the address below. To obtain more information, contact Anthem Customer Service at 1-800-542-9402; or Anthem Blue Cross and Blue Shield, P.O. Box 5858, Denver, CO 80217-5858.

Please contact your group Benefit Administrator if you need assistance in completing this application.