Anthem BlueCross BlueShield
And Its Affiliate HealthKeepers, Inc.

Enrollment/Change Form - Henrico County General Government and Public Schools

A. SUBSCRIBER INFORMATION (To be completed by Employee) Complete Sections A through D

I ELECT THE FOLLOWING PLAN FOR MYSELF AND MY DEPENDENTS

(Choose One of the four plans)

☐ Standard POS ☐ Premier POS ☐ HDHP HSA ☐ Out-of-Area PPO

☐ **Decline Coverage**. I elect to decline coverage with the Henrico County General Government and Public Schools. I will not be eligible to enroll until the next open enrollment period or a qualifying event.

PLEASE MAKE THE FOLLOWING CHANGES: **Please include supporting documentation for the change.**

ENROLL
- ☐ Open Enrollment
- ☐ New Hire (date of hire)_____
- ☐ COBRA (date of eligibility)_____
- ☐ Qualifying Event (description/date) _____

TERMINATE COVERAGE
- ☐ Cancel Coverage

CHANGE
- ☐ Add Dependent
- ☐ Drop Dependent
- ☐ Name Change (previous name) _____
- ☐ Plan Change
- ☐ Address Change

EMPLOYMENT STATUS
Please check one:
- ☐ ACTIVE
- ☐ RETIRED
- ☐ RESIGNED

Please check one:
- ☐ GENERAL GOVERNMENT
- ☐ SCHOOLS

MARITAL STATUS
Please check one:
- ☐ SINGLE
- ☐ WIDOWED
- ☐ MARRIED
- ☐ DIVORCED

LAST NAME	FIRST NAME	MI	☐ MALE ☐ FEMALE	BIRTHDATE	SOCIAL SECURITY NUMBER

ADDRESS		
CITY	STATE	ZIP

HOME PHONE	WORK/DAY PHONE	EMAIL ADDRESS

B. DEPENDENT MEMBERS TO BE ADDED OR DROPPED — ALL FIELDS REQUIRED

FAMILY MEMBERS TO BE ADDED OR DROPPED	FULL NAME (LAST, FIRST, MI)	SEX	RELATIONSHIP	BIRTHDATE	SOCIAL SECURITY NUMBER
☐ A ☐ D		☐ M ☐ F			
☐ A ☐ D		☐ M ☐ F			
☐ A ☐ D		☐ M ☐ F			
☐ A ☐ D		☐ M ☐ F			

C. OTHER INSURANCE - Do you or your covered dependents have other medical coverage? ☐ Y ☐ N If Yes, complete the following:

List all family members with medical coverage in addition to Anthem.

POLICY HOLDER	BIRTHDATE	EMPLOYER	INSURANCE COMPANY
LIST DEPENDENTS COVERED		EFFECTIVE DATE	CONTRACT NO/GROUP NO.

D. CONDITIONS OF ENROLLMENT/SUBSCRIBER SIGNATURE

I hereby apply for membership or request a change in membership in Henrico County General Government and Public Schools Benefit Plan administered by Anthem Blue Cross and Blue Shield and its affiliate HealthKeepers, Inc. (Anthem). I understand that my enrollment and benefits are in accordance with those described in the applicable Health Plan Document. I authorize 1) all health providers and insurers to furnish Anthem, and 2) all health providers and Anthem to furnish all insurers and health providers records concerning me or any of my covered individuals for whom information is requested for any purpose required for the coverage of benefits including, but not limited to, the coordination of payments with other insurers or in connection with the provision of medical care. I understand that I or my authorized representative is entitled to receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. I authorize my employer to deduct from my wages the amount required (if any) to cover my contribution for coverage. I understand that I or my authorized representative is entitled to receive a copy of this form containing this authorization for disclosure of information. A photographic copy of this authorization shall be valid as the original. I certify that all the above information is correct. For claim adjudication purposes, this authorization is valid for the duration of my coverage for health benefits through Henrico County General Government and Public Schools as administered by Anthem.

Subscriber Signature _____ **Date** _____

E. EMPLOYER INFORMATION (To be completed by Employer)

Group No.	Effective Date:
Employer's Signature	Date: