Member Enrollment/Member Change Form

For questions about HMO Maine, HMO Choice: please call **1-800-527-7706**.
For questions about Blue Choice, CompCare or any other coverage: please call **1-800-482-0966**.
For questions about Lumenos H.S.A., H.R.A., H.I.A., H.I.A. Plus: please call **1-888-224-4896.**
All questions need to be completed before this application can be processed.

Anthem

DO NOT USE RED INK

1. Subscriber/Applicant Information

Current Anthem BCBS Contract Number, if any

Last Name | First Name | M.I.

Home Address Number and Street or P.O. Box | Apt. #

City | State | Zip Code

Home Telephone ( ) | Work Telephone ( )

Please check one:
The applicant is ☐ Active Employee ☐ Retired Employee ☐ COBRA ☐ Other:_____

2. Enrollment Reason

☐ New Hire ☐ Annual Enrollment
☐ New Group (initial enrollment) ☐ Portability or Qualifying Life Event
☐ Retiree – date of retirement _____
☐ COBRA – start date _____
COBRA qualifying event:_____
☐ Other_____

Anthem Use Only

Issued Effective Date	Firm Division Number
___/___/___	
Health Benefit Plan	**Waiting Period**

3. Change Status. Please check the reason(s) for change below.

Type of Change: ☐ Name Change ☐ Address Change ☐ Add Dependent ☐ Delete Dependent ☐ PCP Change
Reason for Change. Please check all that apply:
☐ Marriage ☐ Birth ☐ Adoption ☐ Death ☐ Divorce
☐ Involuntary Loss of Coverage ☐ Involuntary Loss of Medicaid ☐ Covered by Medicaid ☐ Covered by Other Insurance
☐ Annual Enrollment ☐ Entrance to the Military ☐ Discharge from the Military ☐ Court Order changing custody
☐ Court Order ☐ Other_____ **Date of Change or Event** _____

4. Membership Choices

☐ HMO Maine
☐ Full Service
☐ Blue Choice (deductible) $_____
☐ CompCare (deductible) $_____
☐ Other _____
☐ HMO Choice
☐ Blue Choice D
☐ Lumenos H.S.A.* Plan
☐ Lumenos H.R.A. Plan
☐ Lumenos H.I.A. Plan
☐ Lumenos H.I.A. Plus Plan

* Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.

5. Employer Information

Company Name: TSSD Services, Inc. | Group Number (if existing group): W108
Address: 79 Aviator Place Oakland Maine 04963

Date of Hire	Date of Rehire (if applicable)	Date Eligible	# Hours worked per week
___/___/___	___/___/___	___/___/___	

6. Applicant and Member Information *(list only family members you wish to enroll, delete or change)*

You may apply to cover your legal spouse, Domestic Partner (If applicable to your group—a completed Affidavit of Domestic Partnership must also be attached to this application) and unmarried children and stepchildren under 19 years of age. You may also apply to cover children and stepchildren 19 and older if they are unmarried. Contact your employer for specific eligibility rules for these dependents.

Sex	Names of Person(s) Last Name First Name M.I.	Is anyone covered by other insurance?	If disabled, date of disability	Social Security #	Birthdate	Full-Time Student	Primary Care Physician (PCP) • For *CompCare, BlueChoice* or *Full Service:* Do not complete this section. • For *HMO Maine* or *HMO Choice:* You must fill in PCP information for each member. • Recommended that you fill in PCP information for each member. For current listing of valid PCP's go to **anthem.com**.	Current Patient
☐ M ☐ F	Self	☐ Y ☐ N				☐ Y ☐ N	Name PCP Provider Number	☐ Y ☐ N
☐ M ☐ F	☐ Legal Spouse or ☐ Domestic Partner (DP)	☐ Y ☐ N				☐ Y ☐ N	Name PCP Provider Number	☐ Y ☐ N
☐ M ☐ F	Dependent	☐ Y ☐ N				☐ Y ☐ N	Name PCP Provider Number	☐ Y ☐ N
☐ M ☐ F	Dependent	☐ Y ☐ N				☐ Y ☐ N	Name PCP Provider Number	☐ Y ☐ N

Indicate name of college for student(s)_____

Are you or any family members currently claiming Workers' Comp Medical Benefits? ☐ Yes ☐ No *If yes, name of claimant:* _____

7. Prior Coverage Information - This section must be completed.

Have you or any other family member had health insurance coverage in the 90 days prior to your date of hire or the effective date of your new policy? ☐ Yes ☐ No ***If yes, please complete the following:***

	Self	Spouse/Domestic Partner	Dependents 1	2	3	4
Name of Insurance Company						
Certificate (Policy) Number						
Insurer's Telephone Number						
Date Coverage Began						
Date Coverage Ended or Is Coverage Still In Effect?						

8. Other Information

Is anyone listed on this application currently eligible for Medicare? ☐ Yes ☐ No *If yes, please complete the following for each person to be covered who is eligible for or covered by Medicare.*

Name(s) of Medicare Beneficiaries	Health Insurance Claim Number	Medicare Part A Effective Date	Medicare Part B Effective Date	Medicare Part D Effective Date	Check all reasons you qualified for Medicare Age 65	Disability	ESRD

9. Applicant Signature

I am requesting coverage for myself and all dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Agreement and Certificate of Coverage. I understand that, under the HMO Maine plan, each family member's care must be provided or arranged by his/her Primary Care Physician (PCP) except as described in my Certificate of Coverage.

Applicant Signature _____ Print Name _____ Date ___/___/___

10. Election Not To Enroll

I do not wish to enroll in a plan. Please check one: ☐ I have other coverage **OR** ☐ I do not have any other coverage.
I understand that the opportunity to enroll at any future date will be subject to the regulations of Anthem Blue Cross and Blue Shield.

Signature _____ Date ___/___/___