Anthem

Adams Central Community Schools

Group Number : _____

Enrollment Form

EMPLOYEE INFORMATION. Please verify the information below for accuracy. If incorrect, please contact your HR representative.

Name/Address	Date of Birth	Employee ID/SSN
	Division	Date of Hire
	Class 1	
	BillClass	SubGroup
	Effective Date	Gender

PLEASE PRINT IN BLACK OR BLUE INK. Read and complete all of this form. Please complete all grayed sections. If you need more space, attach a separate sheet of paper. Please use four digits for years (e.g. 1998, not 98).

Are you actively at work? Yes ☐ No ☐

Are you retired? Yes ☐ No ☐

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Occupation: _____

Phone: _____

Hours per week working for this employer: _____ **Email Address:** _____

BENEFIT SELECTION. Check the boxes that apply along with the appropriate coverage level.

Voluntary Dental

Regular dental check-ups can help in the detection of other health related issues. Gum and tooth disease have been linked to major health conditions like heart disease and stroke. That's why dental coverage is more important than ever.

Accept	Decline	Coverage level	Semi-Monthly Premium	18 Pay Premium
☐	☐	Employee ONLY	$18.43	$24.57
☐	☐	Employee + Spouse	$37.60	$50.13
☐	☐	Employee + Child(ren)	$46.58	$62.10
☐	☐	Employee + Family	$69.59	$92.78

Customer Service Phone Number: _____

DEPENDENT DESIGNATION

(Complete all details for Individuals applying for coverage: list names of all dependents.)

Last name, First name, M.I.	SSN (XXX-XX-XXXX)	Sex	Date of Birth (XX-XX-XXXX)	Age	Relationship (spouse/domestic partner or child)
	- -	☐ M ☐ F	/ /		Spouse/Domestic Partner
	- -	☐ M ☐ F	/ /		Child
	- -	☐ M ☐ F	/ /		Child
	- -	☐ M ☐ F	/ /		Child
	- -	☐ M ☐ F	/ /		Child

List address of all dependents if different from the applicant, including temporary address, e.g. college student.

Name/Address: _____ / _____

Name/Address: _____ / _____

ELIGIBILITY AND AUTHORIZATION

Employee Confirmation

My signature certifies that I (1) Apply for the coverages designated for which I am eligible under my employer's plan with the carrier. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health to the carrier. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature _____ Date _____ / _____ / _____

Premium calculations above may differ slightly based on rounding rules and other system factors, but will not vary significantly. Every effort has been made to match your premiums to the penny.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing false, incomplete, or misleading information commits a felony.

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.