Individual Blue℠ Enrollment and Change Form

Please attach your Family Health Statement

Reason for Completing form: ☐ New subscriber ☐ Change in membership status ☐ Voluntary cancellation ☐ Change of Name/Address **Deductible** ☐ **$2,500** ☐ **$5,000** **Maternity Benefits** ☐ **Yes** ☐ **No**

Change in status due to: Date of Event ______________ ☐ Marriage ☐ Divorce/Legal Separation ☐ Death ☐ Retirement ☐ Other ______________

☐ Dependent no longer eligible: Name ______________ ☐ Birth: Name______________ ☐ Adoption: Name______________

PLEASE USE BLUE OR BLACK INK AND PRINT FIRMLY

SUBSCRIBER INFORMATION:

NAME ______________ (FIRST / INIT / LAST) **Do you reside in New Hampshire more than 6 months per year?** ______________

ADDRESS ______________ (STREET/P.O. BOX / CITY / STATE / ZIP) **MEMBERSHIP REQUESTED** ☐ SINGLE ☐ SELF/CHILD(REN) ☐ SELF/SPOUSE ☐ FAMILY

OCCUPATION ______________ (SELF / SPOUSE) **HOME PHONE** ( ) ______________

COMPLETE FOR EACH PERSON TO BE COVERED

FIRST INIT LAST	SOCIAL SECURITY #	BIRTH DATE	SEX	RELATIONSHIP
Subscriber				SELF
Spouse				

NOTE: IF ELECTING DEPENDENT COVERAGE, PLEASE LIST ALL ELIGIBLE CHILDREN, AND a) complete a Dependent Student Certification Form if dependent has reached the age of 19 and is attending an accredited school full time; or, b) complete a Certification for a Mentally or Physically Incapacitated Dependent Child form if your child is disabled, incapable of self-support, and over the age of 19. The form must also be completed by your physician.

Dependent				
Dependent				
Dependent				

PLEASE ANSWER THESE QUESTIONS:

Do you or any other family member have health coverage from another health plan? (Including another BCBS plan)?

☐ Yes ☐ No If yes, name and address of insurer ______________

Name of insured ______________ Date of birth ______________ Policy # ______________ Effective Date ______________ ☐ Single ☐ Two Person ☐ Family

Will the coverage you are now electing replace another health insurance? You should not cancel your other policy until you know the effective date of your new policy.

☐ Yes ☐ No If yes, name and address of insurer ______________

Policy # ______________ Effective Date of Policy______________ End Date of Policy ______________

Are you or any of your dependents eligible for Medicare or Medicaid?

☐ Yes ☐ No If yes, identification #______________

Name ______________

Are all of your eligible dependents applying for coverage?

☐ Yes ☐ No If not, why? ______________

I hereby authorize Anthem Blue Cross and Blue Shield (Anthem BCBS) to institute the action indicated above. I understand that my Family Health Statement is part of this application. To the best of my knowledge and belief, all of the information I provide is accurate and true. I will submit documentation of such to Anthem BCBS upon request. I understand that any significant misrepresentation or omission may cause Anthem BCBS to terminate or void my coverage, in accordance with New Hampshire law.

If you have listed a dependent that does not have your last name, please indicate why.

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SUBSCRIBER SIGNATURE ______________ **DATE** ______________ **BROKER SIGNATURE** ______________ **DATE** ______________

For Office Use Only

Effective Date______________
Processed by ______________
Processed on ______________

Remarks:

Group/Division # ______________

Date Received

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WHITE COPY - ANTHEM BCBS CANARY COPY - SUBSCRIBER PINK COPY - BROKER