HMO Colorado
An Anthem Company

Anthem

Group Conversion
Application For Individual/Family Enrollment

FORM MUST BE FILLED OUT IN BLACK BALLPOINT OR TYPEWRITER — PLEASE PRINT

BROKER/AGENT | GENERAL AGENT

NAME (Last, First, Middle Initial) | SEX ☐ Male ☐ Female

STREET ADDRESS | BIRTHDATE (Mo.Day Yr)

CITY | STATE | ZIP CODE | HOME TELEPHONE ( )

SOCIAL SECURITY NUMBER If you do not provide, a number will be assigned for membership | WORK TELEPHONE ( )

OCCUPATION

COVERAGE DESIRED ☐ Individual ☐ Family

COVERAGE LEVEL ☐ Basic ☐ Standard

PLAN TYPE (Check one)

☐ HMO Health Benefit Plan (**IF HMO SELECTED, MUST ALSO COMPLETE BACK OF APPLICATION**) ☐ Preferred Provider Health Benefit Plan ☐ Indemnity Health Benefit Plan

MARITAL STATUS

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are you a permanent Colorado resident? ☐ Yes ☐ No

IF YOU AND YOUR SPOUSE ARE USING DIFFERENT LAST NAMES, CHECK APPLICABLE BOX

☐ Common Law ☐ Professional ☐ Maiden NOTE: If Common Law, Supply Affidavit

SPOUSE NAME, (**If applying for family coverage**) (Last, First, Middle Initial) | SOCIAL SECURITY NUMBER | BIRTHDATE (Mo. Day Yr.)

If you are ☐ Parent ☐ Trustee ☐ Legal Guardian of **Minor Applicant**

Name: _____

Social Security Number: _____
(Legal Guardian must send documentation)

EFFECTIVE DATE NEEDED

Month_____

FOR OFFICE USE ONLY

GROUP NUMBER | MASTER SECTION

EFFECTIVE DATE OF COVERAGE (Month, Day, Year)

Trans. Code | SPLIT

			T/M	S/V
BC				
BS				
SUPP.				

BC/BS/SUPP. WAIVER

Trans. Plan | F.C. | FCR

BC Orig. | BS Orig.

SUPP. ORIG.

BC Fam. | BS Fam.

Ref. No. | OC

PTD | PPTD

Request No./ Data Entry | CPDt

Pass

CERTIFICATE AND IDS MAILED

CHILDREN: I verify that the below named children are financially dependent on me, or are dependent on me as a result of a court order. (Attach a copy of the court order). For each dependent over age 19, an "Overage Dependent Enrollment Request" affidavit must be completed.

LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	BIRTHDATE Month Day Year

NAME OF BLUE CROSS BLUE SHIELD GROUP OR HMO PLAN YOU ARE TRANSFERRING OUT OF (Please note city and state of plan)

POLICY NUMBER: | ENDING DATE OF POLICY | CHECK ONE: ☐ Group Plan ☐ Individual Policy

NAME OF INDIVIDUAL OR FAMILY MEMBERS COVERED UNDER THIS POLICY:

APPLICANT SIGNATURE
(If signing for a minor - so indicate) X

IMPORTANT

If you selected HMO Health Benefit Plan you must also complete the backside of this application.

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HMO INFORMATION

Complete only if you select HMO as your Plan coverage.

PRIMARY CARE PHYSICIAN SELECTION

You must choose a primary care physician (PCP) for yourself and all family members. In order to be eligible for non-emergent services you must select a primary care physician and go to that one primary care physician to access your health care benefits. Use the HMO Colorado Physician List/Map for assistance.

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OVERAGE DEPENDENT AFFIDAVIT

I, the undersigned, verify and attest to the fact that my child(ren) is/are unmarried and financially dependent on me or dependent on me because of a court order and is/are therefore eligible for coverage under this policy. I understand that I am responsible for notifying Anthem Blue Cross and Blue Shield, HMO Colorado within 31 days of any changes in my dependent(s) status. I understand that Overage Dependent eligibility must be renewed each year until the maximum age limit has been reached, as specified by the Certificate. That coverage is dictated by the actual situation at the time services are rendered and if my child is not qualified as a "dependent", at the time services are provided, the charges for those services are not reimbursable and may become my sole responsibility. Anthem Blue Cross and Blue Shield, or HMO Colorado/HMO Nevada reserves the right to request, at anytime, proof of overage dependency.

(INITIAL)_____

	BIRTHDATE			SEX	FIRST NAME	M.I.	LAST NAME (if different than applicant)	PRIMARY CARE PHYSICIAN LAST NAME	.....FIRST NAME	MI	ESTABLISHED PATIENT	
	Mo.	Day	Yr.								Yes	No
01				Self								
02				Spouse								
03				☐ M ☐ F								
04				☐ M ☐ F								
05				☐ M ☐ F								
06				☐ M ☐ F								
07				☐ M ☐ F								
08				☐ M ☐ F								