

Employer Enrollment Application For 2-100 Employee Small Groups¹ Colorado



Please complete in black ink only.

Section A: Application Type			
<input type="checkbox"/> New enrollment <input type="checkbox"/> Change(s) Group No. _____	Rating Type: <input type="checkbox"/> Age Rates <input type="checkbox"/> Composite Rates (If nothing selected, default is age)	Requested effective date (MM/DD/YYYY)	
Section B: Company Information			
Legal company name		Employer tax ID no. (required)	
Doing Business As (DBA)			
Company street address			
City	County	State	ZIP code
Billing address — If different from above			
City		State	ZIP code
Organization type: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Government unit/agency <input type="checkbox"/> Limited Liability Company (LLC) <input type="checkbox"/> Organization exempt from Income Tax <input type="checkbox"/> Labor union trust <input type="checkbox"/> Other: _____			
SIC code — Required	Type of business (be specific)	Date business established	
Company contact name		Title	
Primary phone no.	Fax no.		
Email address			
Additional company contact name		Title	
Primary phone no.	Fax no.		
Email address			
Does group have a cafeteria plan under IRS Section 125? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete below.			
Legal name		Federal tax ID no.	No. of employees employed

¹ A small group must have at least one eligible employee, in addition to the business owner. A spouse cannot be the only eligible employee.

Section C: Type of Coverage**1. Medical Coverage – I choose to offer:** Designated plan 1-3 enrolling employees (choose one plan) Designated plan(s) 4+ enrolling employees (choose a single plan or mix of plans) – Limit five plans

	Anthem Gold	Anthem Silver	Anthem Bronze
PPO: Anthem PPO Network	<input type="checkbox"/> (2UX5) PPO 500/20%/4750 <input checked="" type="checkbox"/> (2UXB) PPO 500/20%/5750 <input type="checkbox"/> (2UXD) PPO 1000/20%/4000 <input type="checkbox"/> (2UXE) PPO 1500/20%/4000 <input type="checkbox"/> (2UYB) PPO 2000/20%/4000 <input type="checkbox"/> (2UXP) PPO 2250/0%/2250 HSA	<input type="checkbox"/> (2UX6) PPO 2000/30%/6000 <input type="checkbox"/> (2UXG) PPO 2000/50%/7350 <input type="checkbox"/> (2UXW) PPO 2500/30%/5000 <input type="checkbox"/> (2UWY) PPO 3000/30%/5000 <input type="checkbox"/> (2UXQ) PPO 4500/30%/7150 <input type="checkbox"/> (2UYD) PPO 5300/25%/6450 <input type="checkbox"/> (2V5E) PPO 6800/40%/7350 CP 15 <input type="checkbox"/> (2V5D) PPO 6800/40%/7350 CP 40 <input type="checkbox"/> (2UXV) PPO 2700/20%/4500 w/HSA <input type="checkbox"/> (2UWD) PPO 3675/0%/3675 w/HSA	<input type="checkbox"/> (2UWU) PPO 6350/30%/7150 <input type="checkbox"/> (2UY8) PPO 6675/0%/7350 <input type="checkbox"/> (2V5C) PPO 7350/0%/7350 <input type="checkbox"/> (2UWA) PPO 4440/50%/6550 w/HSA <input type="checkbox"/> (2UXR) PPO 6650/0%/6650 w/HSA
HMO: Pathway Network	<input type="checkbox"/> (2UY4) Pathway HMO 1500/0%/7150 <input type="checkbox"/> (2UWP) Pathway HMO 1500/20%/4000 <input type="checkbox"/> (2V3L) Pathway HMO 2000/0%/7150 <input type="checkbox"/> (2UY6) Pathway HMO 2500/20%/4250	<input type="checkbox"/> (2UXX) Pathway HMO 3000/20%/7150 <input type="checkbox"/> (2V5G) Pathway HMO 3500/30%/7350 <input type="checkbox"/> (2UWE) Pathway HMO 3675/0%/3675 w/HSA <input type="checkbox"/> (2UXH) Pathway HMO 4750/20%/7150 <input type="checkbox"/> (2UWJ) Pathway HMO 5000/20%/7000	<input type="checkbox"/> (2UY2) Pathway HMO 6600/30%/7350 <input type="checkbox"/> (2UXS) Pathway HMO 6650/0%/6650 w/HSA
HMO: Mountain Enhanced Network	<input type="checkbox"/> (2UY5) Mountain Enhanced HMO 1500/0%/7150 <input type="checkbox"/> (2UWR) Mountain Enhanced HMO 1500/20%/4000 <input type="checkbox"/> (2V3M) Mountain Enhanced HMO 2000/0%/7150 <input type="checkbox"/> (2UY7) Mountain Enhanced HMO 2500/20%/4250	<input type="checkbox"/> (2UXY) Mountain Enhanced HMO 3000/20%/7150 <input type="checkbox"/> (2V5F) Mountain Enhanced HMO 3500/30%/7350 <input type="checkbox"/> (2UWF) Mountain Enhanced HMO 3675/0%/3675 w/HSA <input type="checkbox"/> (2UXK) Mountain Enhanced HMO 4750/20%/7150 <input type="checkbox"/> (2UWK) Mountain Enhanced HMO 5000/20%/7000	<input type="checkbox"/> (2UY3) Mountain Enhanced HMO 6600/30%/7350 <input type="checkbox"/> (2UXT) Mountain Enhanced HMO 6650/0%/6650 w/HSA

NOTE for Mountain Enhanced HMO Network:

Employer groups must be headquartered in one of these counties to enroll: Archuleta, La Plata, Mesa, Montezuma, Summit or Eagle.

Choose your medical contribution for each month – only one choice is allowed.

Contribution option 1: Traditional option—We will contribute: _____% per employee _____% per dependent (optional).

Contribution option 2: Flat dollar amount option \$ _____

For Health Savings Account plans. Group wants to establish Health Savings Account (HSA) with Anthem Blue Cross and Blue Shield (Anthem) facilitating with a banking service provider. Group will establish Health Savings Account (HSA) but does not want Anthem to facilitate in the creation of the account.**Riders/Optional Benefits—select additional optional benefits.**

All medical plans listed above are Calendar Year. If you want your Medical plan to be based on Plan Year, then you can select from the list provided below.

NOTE: These plans cannot be combined with Calendar Year plans.

 (2UWV) Anthem Bronze PPO 6350/30%/7150 (2UXL) Anthem Silver Mountain Enhanced 4750/20%/7150 (2UXJ) Anthem Silver Pathway HMO 4750/20%/7150 (2UWQ) Anthem Gold Mountain Enhanced HMO 1500/20%/4000 (2UWN) Anthem Gold Pathway HMO 1500/20%/4000**NOTE:** There are other state mandated plans available; please speak to your broker. Other use: _____

2. Dental Coverage

Anthem Dental Family and Anthem Dental Family Enhanced plans include certified pediatric dental essential health benefits. All other plans including Anthem Dental Prime and Anthem Dental Complete with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.

Contract codes—Indicate the contract code(s) for the dental plan(s) chosen. The codes can be found on the proposal/quote output.

Contract code 1: _____ Contract code 2: _____ No dental coverage selected

Choose your dental contribution for each month:

_____ % per employee _____ % per dependent (optional)

Select premium level: (Subject to underwriting approval)

Base premium Bundled premium Medical Lock premium Medical Lock and Bundled premium

Is this plan intended to replace any existing group dental coverage? Yes No

If yes, please complete the information below for each group dental insurance plan you now have.

Insurer	Type of plan (DHMO, PPO)	Effective Date	Proposed termination date

Participation Requirements

Medical Lock (Packaged Enrollment): Enrollment and tiering must be identical on both the Anthem medical and Anthem dental plans. Example: enrollees with Single medical coverage must also have Single dental coverage; enrollees with Family medical coverage must also have Family dental coverage.

3. Vision Coverage – you may choose a maximum of two plans.

No vision coverage at this time

Employer-Sponsored Plans

Voluntary Plans

Contract codes – Indicate the contract code(s) for the vision plan(s) chosen. The codes can be found on the proposal/quote output.

Contract code 1: _____ Contract code 2: _____

Choose your vision contribution for each month. Your contribution must be the same for all plans.

Employer-Sponsored plans require employers to contribute between 50% and 100%.

For Voluntary plans employers may contribute between 0% and 49%.

We will contribute: _____ % per employee _____ % per dependent (optional).

Select premium level: (Subject to underwriting approval)

Base premium Bundled premium Medical Lock premium Medical Lock and Bundled premium

Participation Requirements

Medical Lock (Packaged Enrollment): All members enrolled in an Anthem medical plan must enroll in Anthem vision. Tiering must be identical on the medical and vision plans. Example: enrollees with Single medical coverage must also have Single vision coverage; enrollees with Family medical coverage must also have Family vision coverage.

4. Life/AD&D and Disability Coverage – Check all that apply. A minimum of two employees must enroll.			
Life/AD&D products		Disability products	
Select products and group contribution percentage:		Select products and group contribution percentage:	
Product choice	Percentage	Product choice	Percentage
<input type="checkbox"/> None		<input type="checkbox"/> None	
<input type="checkbox"/> Basic Life & AD&D	_____ %	<input type="checkbox"/> Short Term Disability	_____ %
<input type="checkbox"/> Basic Dependent Life	_____ %	<input type="checkbox"/> Long Term Disability	_____ %
<input type="checkbox"/> Optional Supplemental/Voluntary Life and AD&D*	_____ %	<input type="checkbox"/> Voluntary Short Term Disability*	_____ %
<input type="checkbox"/> Optional Supplemental/Voluntary Dependent Life*	_____ %	<input type="checkbox"/> Voluntary Long Term Disability*	_____ %
*Available for Groups of 10+		*Available for Groups of 10+	
If disability benefits are selected, indicate whether the employee pays disability premiums on a pre or post tax basis.			
Short Term Disability	Voluntary Short Term Disability	Long Term Disability	Voluntary Long Term Disability
<input type="checkbox"/> Pre Tax	<input type="checkbox"/> Pre Tax	<input type="checkbox"/> Pre Tax	<input type="checkbox"/> Pre Tax
<input type="checkbox"/> Post Tax	<input type="checkbox"/> Post Tax	<input type="checkbox"/> Post Tax	<input type="checkbox"/> Post Tax
Are more than 50% of eligible employees in the group related by marriage or blood? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Life/AD&D and/or Disability Eligibility Probationary Period/Waiting Period			
Would you like to waive the eligibility probationary period/waiting period for ALL existing employees at initial group enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the eligibility probationary period/waiting period for new eligible employees enrolling in Life/AD&D and/or Disability plans after the group's coverage effective date the same as the medical policy eligibility period? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Class number	Coverage description (Ex. Life, Short Term Disability, Long Term Disability, etc.)	Description of eligibility probationary period (Ex. Date of hire, First of month following 60 days of continuous employment, etc.)	
Will rehired employees be eligible to reinstate their Life/AD&D and/or Disability coverage at the level of coverage they had on their last day worked? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, length of time the group has to rehire an employee under this provision: <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 9 months <input type="checkbox"/> 12 months			
Eligible employees must be actively at work, and must satisfy any applicable waiting period. Minimum work hours required for eligible full-time employees is 30 hours per week unless otherwise indicated.			
Prior Coverage			
Has this group had coverage within 30 days of this application's signature date? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Will this plan replace current	If yes, carrier name	Termination Date (MM/DD/YYYY)	
Life/AD&D coverage <input type="checkbox"/> Yes <input type="checkbox"/> No			
Disability coverage <input type="checkbox"/> Yes <input type="checkbox"/> No			
Participation Requirements			
Basic Life, Basic Accidental Death & Dismemberment, Short Term Disability: 100% participation required on non-contributory plans and 75% participation required on contributory plans.			
Long Term Disability: 100% participation required on all non-contributory plans. 100% participation required for contributory plans of two or three eligible employees. 75% participation required on contributory plans with four or more eligible employees.			
Basic Dependent Life: 100% participation required on non-contributory plans.			
Optional Supplemental/Voluntary Life/Accidental Death & Dismemberment: The greater of five enrolled employees or 20% participation required.			
Voluntary Short Term Disability and Voluntary Long Term Disability: The greater of 10 enrolled employees or 20% participation required.			

Section D: Eligibility

1. Average total number of employees during the prior calendar year (including employed owners/officers): _____
2. Number of eligible full-time employees (minimum 30 hours per week) (see above for Life/Disability eligibility minimum hours): _____
3. Are employees working 24-29 hours per week covered (see above for Life/Disability eligibility minimum hours)? Yes No
4. Number of employees enrolling in:
 Medical: _____ Dental: _____
 Vision: _____ Life/Disability: _____
5. Number of eligible DECLINING employees: _____
6. Number of part-time employees: _____
7. Number of employees working outside of Colorado: _____
8. Will coverage be restricted to a certain classification of employees or employees working a certain number of hours per week? Yes No
 If yes, please explain what class(es) or number of work hours are required (must be between 24 and 40 hours)

9. Probationary period/waiting period for **new employees/rehires**:
 First of month after hire date
 1 month 2 months

The standard effective date is first of the month following the waiting period/probationary period.

10. Would you like to waive the probation/waiting period for all existing employees at initial enrollment? Yes No
11. Under the Medicare Secondary Payer rules, which one applies for your group?
 Medicare is primary (less than 20 employees)
 Anthem Blue Cross and Blue Shield is primary (20 or more employees)
 Anthem Blue Cross Blue Shield is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.
12. Is your company currently subject to COBRA (employed 20 or more total employees on at least 50% of the working days in the previous calendar year)? Yes No
13. Has this group had prior Medical coverage within 12 months of this application? Yes No
 If yes, list carrier name: _____
 Termination date: _____

Section E: Ownership

Please account for 100% of the ownership, regardless of eligibility. Insert an additional sheet if necessary.

Last name	First name	M.I.	Percentage of ownership	Eligible
			_____%	<input type="checkbox"/> Yes <input type="checkbox"/> No
			_____%	<input type="checkbox"/> Yes <input type="checkbox"/> No
			_____%	<input type="checkbox"/> Yes <input type="checkbox"/> No
			_____%	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section F: Electronic Access of Group Information by Agent/Producer/Broker/General Agent

We, the employer, hereby authorize the agent/producer/broker/general agent whose name is attached to this application to use the EmployerAccess system of Anthem Blue Cross and Blue Shield to access the group's information, such as but not limited to enrollees, plan selections, and bills/invoices. Such agent/ producer/broker/general agent is also hereby authorized to use the EmployerAccess system of Anthem Blue Cross and Blue Shield to make changes to the group's information on behalf of the group, such as but not limited to adding/deleting plans, adding/deleting employees, and or changing employee demographic information. These authorizations shall terminate if the group's designated agent/producer/broker/general agent changes.

The agent/producer/broker/general agent must maintain original employee/member enrollment documentation, and shall make them available upon Anthem's request.

Check this box ONLY in the group elects to opt-out of authorizing the agent/producer/broker/general agent to access and change the group's information on behalf of the group.

Section G: General Agreement**Please read this section carefully before signing the application.****The following subsection is for Medical/Dental/Vision Applicants:****Please check the box that applies:**

- We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employee Retirement Income Security Act of 1974), apply to obtain the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.
- We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employee Retirement Income Security Act of 1974) and therefore not subject to ERISA, apply to obtain the coverage indicated.

Employer understands and certifies the following, and if approved for coverage, agrees by payment of the required premiums, and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable.
2. To make the coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Anthem or their designated agent(s), any information required in connection with administration of the coverage. Original source documents, including but not limited to employee/member enrollment documentation, shall be made available upon Anthem's request.
4. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.
5. That statements, except for medical coverage, of medical history will be required of employees, and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem.
6. That approval for this coverage may cancel any prior contracts and/or coverage with Anthem effective immediately preceding the effective date of the employer's coverage.
7. To pay Anthem by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and state-mandated continued group coverage and/or conversion process, if applicable.
8. That claims filed by or on behalf of members may, at Anthem's option, be suspended if premiums are not timely received.
9. If applicable, employer will receive on behalf of members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.
10. The advance premium check does not create temporary or interim coverage and that receipt and deposit of that payment does not guarantee issuance of coverage. Rather, issuance of coverage is expressly conditioned on Anthem's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem except to refund the payment. The employer will be responsible for returning to individual.
11. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem may be different than the coverage applied for herein. In that event, Anthem shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.
12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any misstatements on employees' application or failure to report new medical information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rates as of the effective date of coverage.
13. The entire application for Group coverage has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
14. All employees applying for coverage are employees of the employer and receive salary or wages documented on state and/or federal payroll reports. Eligible full-time employees must work at least 30 hours per week (25 in OH if the employer is a "small employer" as defined by Ohio law, or if employer participates in a trust to which a group policy has been issued which contains a minimum 25 hours per week eligibility requirement), must be actively at work (or excepted as explained above), and must have satisfied any applicable eligible waiting period.
15. The requested coverage is not in effect unless and until this application is approved by Anthem, that approval of coverage shall be evidenced by issuing Group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem.
16. The employer acknowledges that he has signed the attached benefit proposals indicating the coverages requested.
17. The broker listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.
18. This small group off-exchange product is not eligible for a premium tax credit.

19. The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits.
20. By signing below, I, the employer, agree that Anthem can deliver plan materials and related items, including but not limited to benefit booklets, summaries, billing statements, notices of non-payment and cancellation and other notices, via email or other electronic means. I agree that I will provide and update Anthem with a current email address. I understand that at any time I can request a free copy of these materials by mail, by contacting Anthem at 1-800-922-4770 or via the EmployerAccess system.

The following subsection is for Life, AD&D and/or Disability Applicants:

The undersigned employer and/or authorized representative hereby requests that it be approved for insurance coverage through Anthem Life Insurance Company (Anthem Life). Employer understands and represents to the best of his knowledge and belief the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under Anthem Life trust policy(ies), if applicable;
2. To make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed;
3. To maintain records and furnish to company or their designated agent(s), any information required in connection with administration of the insurance coverage;
4. To provide notice of applicable conversion rights to eligible employees and eligible dependents;
5. That statements of medical history will be required of employees and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Company for life and disability insurance;
6. That approval for this insurance may cancel any prior contracts and/or coverage with Company effective immediately preceding the effective date of the employer's coverage;
7. To pay Company by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership;
8. That claims filed by or on behalf of members may, at Company's option, be suspended if premiums are not received timely;
9. The employer will receive, on behalf of members, all notices delivered by Company, and immediately forward such notices to persons involved, at their last known address;
10. The advance premium check does not create temporary or interim insurance coverage and that receipt and deposit of that payment does not guarantee issuance of insurance coverage. Rather, issuance of insurance coverage is expressly conditioned on Company's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these Conditions are met, there shall be no liability on the part of Company, except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees;
11. That in order for Company to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Company, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Company may be different than the coverage applied for herein. In that event, Company shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued;
12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Company by the employer. Company reserves the right to review such rates upon receipt of all individual applications and modify the rates, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the group's coverage or premium rate as of the effective date of coverage;
13. The entire application for Group Insurance has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief;
14. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work full-time (unless otherwise approved by Company in writing) and meet any other eligibility requirements for coverage;
15. that an employee not actively at work on the policy effective date or the employee's eligibility date will not be covered until such employee returns to active work.
16. The requested coverage is not in effect unless and until this application is approved by Company, that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Company.

Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. §638:20.

Fraudulent Insurance Acts

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Sign here	Company officer signature	Printed name	Title	Date (MM/DD/YYYY)
	X			
Accepted by Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado authorized representative		Printed name	Date (MM/DD/YYYY)	

Section H: Agent/Producer/Broker Certification

- I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.
- I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
- I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado to attribute such additions or changes to me.
- I have advised the employer that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado reviews and approves the application and the employer receives a written notice from Anthem Blue Cross and Blue Shield Anthem Life and/or HMO Colorado.
- I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Anthem shall be paid to an agent/broker/producer not appointed/approved by Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado.
- I have advised the client not to terminate any existing coverage until receiving written notification from Anthem Blue Cross and Blue Shield, Anthem Life and/or HMO Colorado that the coverage being applied for by this application is accepted.

Writing payable/sub-agent/producer/broker			%	Second writing payable/sub-agent/producer/broker			%
Agency name		Agency ID no.		Agency name		Agency ID no.	
Agent/producer/broker name				Agent/producer/broker name			
Agent/producer/broker ID no.				Agent/producer/broker ID no.			
Payable/sub-agent/producer/broker ID no. if different				Payable/sub-agent/producer/broker ID no. if different			
Street address				Street address			
City		State	ZIP code	City		State	ZIP code
Phone no.		Fax no.		Phone no.		Fax no.	
Email address				Email address			
Signature		Date (MM/DD/YYYY)		Signature		Date (MM/DD/YYYY)	

For General Agent/Producer/Broker use only

General agent/producer/broker name BENEFITMALL, INC.		Agent/producer/broker ID no. MDPHQKNKRY	
Street address		City	State ZIP code

Sales Representative and Account Manager

Sales representative name		Sales representative ID no.	
Street address		City	State ZIP code
Account manager name		Account manager ID no.	

Anthem USE ONLY	Group no.	Tracking no.	Effective date (MM/DD/YYYY)