HEALTH INSURANCE
OPEN ENROLLMENT APPLICATION
(Adoptive and Foster Parents)
CO-1048-SM REV. 5/2014

Return completed application to:
Anthem Blue Cross & Blue Shield
Attn: COBRA Unit
P.O. Box 719
North Haven, CT 06473-0719

TYPE OR PRINT

NAME (Person Receiving Benefit)	**CURRENT INSURANCE CARRIER**
MAILING ADDRESS	**TELEPHONE NUMBER**

I. MEDICAL INSURANCE

CHECK ONE BLOCK TO INDICATE THE TYPE OF COVERAGE YOU ARE ELECTING FOR YOURSELF AND YOUR COVERED DEPENDENTS

ANTHEM

- ☐ 1. State BlueCare POS
- ☐ 2. State BlueCare POE
- ☐ 3. State BlueCare POE Plus POE-G
- 4. State Preferred POS – **Current Enrollees Only**
- ☐ 5. Out of State Plan – **Only if Permanent Residence is Outside of Connecticut**

OXFORD

- ☐ 6. Oxford Freedom Select POS
- ☐ 7. Oxford HMO Select POE
- ☐ 8. Oxford HMO POE-G
- ☐ 9. Out of State Plan – **Only if Permanent Residence is Outside of Connecticut**

LIST INDIVIDUALS TO BE COVERED UNDER MEDICAL INSURANCE. ATTACH SHEETS TO LIST ADDITIONAL DEPENDENTS. IF ANY LISTED DEPENDENT AGE 19 OR OVER IS DISABLED, ATTACH SPECIAL APPLICATION FOR COVERED DEPENDENT, WHICH MAY BE OBTAINED FROM THE ANTHEM COBRA UNIT.

NAME (Person Receiving Benefits)	SEX ☐ F ☐ M	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SPOUSE'S NAME	SEX ☐ F ☐ M	DATE OF BIRTH	SOCIAL SECURITY NUMBER
DEPENDENT CHILD	SEX ☐ F ☐ M	DATE OF BIRTH	SOCIAL SECURITY NUMBER
DEPENDENT CHILD	SEX ☐ F ☐ M	DATE OF BIRTH	SOCIAL SECURITY NUMBER

COORDINATION OF BENEFITS – APPLICATION IS INVALID UNLESS THIS SECTION IS COMPLETED

WHEN YOU ARE COVERED BY THE HEALTH PLAN SELECTED, WILL YOU OR YOUR DEPENDENT(S) HAVE ANY OTHER COVERAGE? ☐ YES ☐ NO

IF YES, WHICH FAMILY MEMBER(S) WILL BE COVERED BY THAT INSURANCE (CHECK OFF AS MANY THAT APPLY)

☐ SELF ☐ SPOUSE ☐ CHILDREN (LIST NAMES)

NAME OF PLAN	ADDRESS:
POLICY NUMBER	NAME OF PERSON(S) POLICY ISSUED TO
EFFECTIVE DATE	COMPANY THROUGH WHICH COVERAGE OBTAINED

IS ANY MEMBER LISTED ABOVE ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO

IF YES GIVE MEDICARE PART A (HOSPITAL INSURANCE) AND MEDICARE PART B (MEDICAL INSURANCE) EFFECTIVE DATE(S)

SELF		SPOUSE		DEPENDENT CHILD		DEPENDENT CHILD	
PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)	PART A (MO/YR)	PART B (MO/YR)

II. DENTAL INSURANCE

CHECK BLOCK TO INDICATE THE COVERAGE YOU ARE ELECTING FOR YOURSELF AND YOUR COVERED DEPENDENTS.
NOTE: COVERAGE FOR DEPENDENT CHILDREN ENDS AT AGE 19

☐ **CIGNA BASIC DENTAL** ☐ **CIGNA ENHANCED DENTAL** ☐ **CIGNA DENTAL DHMO**

LIST INDIVIDUALS TO BE COVERED UNDER DENTAL INSURANCE:

NAME (Person Receiving Benefits)	SEX ☐ F ☐ M	DATE OF BIRTH	SOCIAL SECURITY NUMBER
SPOUSE'S NAME	SEX ☐ F ☐ M	DATE OF BIRTH	SOCIAL SECURITY NUMBER
DEPENDENT CHILD	SEX ☐ F ☐ M	DATE OF BIRTH	SOCIAL SECURITY NUMBER
DEPENDENT CHILD	SEX ☐ F ☐ M	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I hereby apply for membership in the plan(s) above. I understand that if I am changing plans, my current coverage will be canceled when my new coverage takes effect. I understand that the services will be available subject to the exclusions, limitations and conditions described by the health plan.

I certify that all information on this form is correct to the best of my knowledge and belief, and understand that providing false and/or incomplete information may result in the rescission of coverage and/or nonpayment of claims for myself or my eligible dependent(s).

SIGNATURE (Person Receiving Benefit)	**DATE**