National General Benefits Solutions

Employee Enrollment Form

EMPLOYER INFORMATION (must be completed)	
Company Name/DBA:	Company Address:

You must complete this form in its entirety in order for you or your dependents to be covered under the employer's group health plan. If you are waiving coverage for yourself or your dependents, it must be clearly indicated on this form. If you do not complete this form in its entirety for yourself or your dependents at least 5 business days prior to the effective date, you or your dependents may not be eligible for coverage until the next open enrollment period.

TO BE COMPLETED BY EMPLOYEE (if applying or waiving coverage)

BENEFIT PLAN:	GROUP NUMBER:

A - EMPLOYEE (Primary Applicant)

Legal Name: (Last)	(First)	(MI)

Social Security Number:	Gender: ☐ M ☐ F	Birth Date (mm/dd/yyyy):	**Average number of hours worked per week?**	**Date employed Full-Time: (mm/dd/yyyy)**

Home Street Address	City	State	Zip
Mailing Address (if different)	Mailing Address City	Mailing Address State	Mailing Address Zip
Home Phone: Cell Phone:	Work Phone Best Time to Call:	Email Address: **Job Title**:	

Status: ☐ Single ☐ Married Employee Status: ☐ W2 ☐ 1099 ☐ Owner/Partner	Check One: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA ☐ Cal-COBRA COBRA effective date(mm/dd/yyyy) ________	Earnings Basis: ☐ Salaried ☐ Hourly ☐ Commission

NEW ENROLLMENT or WAIVER, please check one:

☐ New Hire ☐ Qualifying Life Event:________________ Date: (mm/dd/yyyy) ________
☐ Re-hire ☐ COBRA
☐ Open Enrollment ☐ Waiver of Coverage (complete section B)
☐ New Group ☐ Other: ________________

B - WAIVER OF COVERAGE – DO NOT COMPLETE IF ENROLLING FOR COVERAGE

Complete and sign if waiving any or all coverages for self. All eligible employees must be listed as either enrolling or waiving coverage when first eligible.

Indicate the waiver reason below.

☐ Individual Medical ☐ Medicare/Medicaid ☐ COBRA/Continuation ☐ Tricare ☐ Spouse's/Parent Employer Plan
☐ Cost/Do not want (NO health coverage will exist) ☐ Other: ________________

Neither I nor my dependents have been induced or pressured to decline coverage by my employer, the agent, or National General Benefits Solutions. My dependents and I have waived such coverage of our own accord.

Signature:	Date:
Printed Name:	Date employed Full-Time:

C – ONLY TO BE COMPLETED BY ADDITIONS TO EXISTING GROUPS OR FOR CHANGES TO EXISTING COVERAGE

Requested effective date: / / (Subject to Underwriting approval)

1. Groups with multiple medical plans, indicate which plan you are requesting.* Medical Plan #:______________
2. If dental coverage offered, are you electing? ☐ Yes ☐ No If yes, list those enrolling______________________________
   If multiple dental plans are offered, which plan are you requesting? * Dental Plan ________________
3. If vision coverage offered, are you electing? ☐Yes ☐ No If yes, list those enrolling______________________________

**Please contact your employer for the plan options/descriptions which are identified on your employer's billing statement and/or quote.*

4. If enrolling outside of your employer's open enrollment period, indicate the special enrollment reason (documentation may be required)

a) ☐ Marriage ☐ Birth ☐ Adoption ☐ Court ordered (copy of court order required)

For any event in a, list date of event ____/____/____

b) ☐ Divorce/Separation ☐ Involuntary loss of coverage, state reason for loss______________________________
☐ COBRA/Continuation exhausted ☐ Other______________________________

For any event in b, list coverage termination date ____/____/____

**Certificate of Creditable Coverage is required for all loss of coverage special enrollment events*

D – PERSONS TO BE COVERED

(Include yourself and all family members to be insured. If more space is needed, attach an additional sheet)

☐ Employee Only ☐ Employee Spouse ☐ Employee Child(ren) ☐ Family: Employee, Spouse, & Child(ren)

Include yourself & all family members to be insured **Last Name**	**First Name**	**Relationship & Gender**	**Date of Birth (MM/DD/YYYY)**	**Social Security Number**	**Tobacco Use**
		Employee ☐ M ☐ F	XXXXXX	XXXXXXXXX	☐ Yes ☐ No
		Spouse ☐ M ☐ F			☐ Yes ☐ No
		Child ☐ M ☐ F			
		Child ☐ M ☐ F			
		Child ☐ M ☐ F			
		Child ☐ M ☐ F			
		Child ☐ M ☐ F			

E – ADDITIONAL INSURANCE COVERAGE INFORMATION

1. Will any current medical plan remain active if coverage is approved?	☐ Yes ☐ No
a) If "Yes", for whom? b) Please provide carrier and ID/Group number	
2. Are you, your spouse or any dependent children currently covered under Medicare Part A, B, or D?	☐ Yes ☐ No
If "Yes", for whom?	
If yes, will coverage remain active if the coverage for which you are applying is approved?	☐ Yes ☐ No

F - Medical History

	Height	Weight	Own a Motorcycle?		Convicted of a moving violation in the last year?		Convicted of a DUI/OWI in the last 5 years?	
Employee			☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No
Spouse			☐ Yes	☐ No	☐ Yes	☐ No	☐ Yes	☐ No

Complete all questions below and check all that apply in Question 1. Complete Section G on the next page by providing complete details for each Yes answer and for all conditions checked in Question 1.

1. Have you or any of your dependents included on this enrollment form within the past _5 years_ received treatment, testing, consulted with or received a diagnosis from a physician or provider for any of the following?........................☐ Yes ☐ No

☐ AIDS or HIV
☐ Alcohol or Drug Use, Abuse, or Dependency
☐ Arthritis or other Skeletal Disorder
  ☐ Osteoarthritis ☐ Rheumatoid
  ☐ Other
☐ Back Disorders
  ☐ Chiro ☐ Sprain/strain
  ☐ Surgery ☐ Other
☐ Blood Disorders (including anemia)
☐ Cancer or Tumor; Stage_______
  ☐ Local (confined to the organ where it began)
  ☐ Regional (spread to nearby lymph nodes/organs)
  ☐ Distant/Metastasis (spread to distant organs)
☐ Chest Pain
☐ Diabetes Mellitus Date of onset____/____/____
  ☐ Pre-Diabetes ☐ Diet Controlled
  ☐ Type I ☐ Type II
  ☐ Insulin Dependent ☐ Insulin Pump
☐ Diabetic Related Disorders
  ☐ Heart disease ☐ Nephropathy
  ☐ Neuropathy ☐ Peripheral Vascular Disease
  ☐ Retinopathy ☐ Stroke
☐ Digestive Disorders
  ☐ Crohn's Disease ☐ Ulcerative Colitis
  ☐ Other
☐ Ear/Eye/Nose/Throat Disorders
☐ Endocrine Disorders
☐ Fracture/Broken Bone
☐ Heart Disorders
  ☐ Angioplasty ☐ Bypass
  ☐ Heart Attack ☐ Other
☐ High Cholesterol
☐ High Blood Pressure
☐ Hodgkin's/Lymphoma/Leukemia
☐ Immune Disorders
☐ Infertility
☐ Kidney Disorders
☐ Knee Injury or Disorder
☐ Liver Disorder/Hepatitis
  ☐ Hepatitis B ☐ Hepatitis C
  ☐ Hepatitis D ☐ Other
☐ Lupus
  ☐ Discoid
  ☐ Systemic Lupus Erythematosus
☐ Mental, Nervous or Behavioral Disorder
  ☐ Inpatient Treatment ☐ Outpatient Treatment
  ☐ ADHD/ADD ☐ Anxiety
  ☐ Bipolar disorder ☐ Depression
  ☐ Other
☐ Migraine or Chronic Headache
☐ Multiple Sclerosis (MS)
☐ Muscle Disorders
☐ Nervous System Disorders
☐ Paralysis
☐ Partial or Total Disability
☐ Physical Disorder or Deformity
☐ Reproductive Disorders
☐ Respiratory/Lung Disorders
  ☐ Asthma ☐ Chronic Bronchitis
  ☐ COPD ☐ Other
☐ Seizures
☐ Sexually Transmitted Disease
☐ Stroke or Transient Ischemic Attack
☐ Thyroid Disorder
  ☐ Hyperthyroidism ☐ Hypothyroidism
  ☐ Growth Disorder ☐ Other
☐ Transplant
  ☐ Solid Organ ☐ Blood or Marrow
☐ Urinary Disorders
☐ Vascular Disorders

2. In the last 5 years, have you or any of your dependents included on this enrollment form:
   a. Been diagnosed with or treated for any condition(s) not identified above? ....☐ Yes ☐ No
   b. Been advised of the necessity or possibility of any future hospitalization, treatment, testing or surgery?...☐ Yes ☐ No

3. Are you or any of your dependents included on this enrollment form currently pregnant? ....☐ Yes ☐ No
   a. If yes, Indicate due date____/____/____
   b. Is a Cesarean Section anticipated?..☐ Yes ☐ No
   c. Are multiple births expected?..☐ Yes ☐ No
   d. Are you/your dependent experiencing or anticipating any other complications?........☐ Yes ☐ No

4. Have medications been prescribed in the past _18 months_ for you and/or any dependents included on this enrollment form. (Include pills, creams, injections, liquids, inhalers, pumps, etc.) ....☐ Yes ☐ No

G – DETAILS

Please provide FULL DETAILS to any yes/checked answers in section F; including the name of the Applicant(s), condition(s), treatment(s), medication(s), and dates. If more space is needed please attach a separate page with details; include the Employee's name.

Question	Person	Condition/Diagnosis	Dates Treated	Treatment including Medications and Dosage	Date Last Taken	Prognosis

H – ***** NOTICE OF FEDERAL MANDATES ****** INITIAL NOTICE ABOUT SPECIAL ENROLLMENT RIGHTS*****

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your, or your dependents', other coverage).

You must, however, request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents.

Effective April 1, 2009 a federal mandate took effect that allows for a Special Enrollment Period, which is outlined below.

A Special Enrollment Period will be provided for an employee and his/her dependent(s) who are eligible, but not enrolled, for coverage under the terms of the employer's plan to enroll for coverage if either of the following conditions are met:

a) The employee or dependent is covered under a Medicaid plan or under a State child health plan and coverage of the employee or dependent under that plan is terminated as a result of loss of eligibility for coverage. The request for coverage under the employer's group health plan must be submitted no later than 60 days following the date of termination of such prior coverage under Medicaid or a State child health plan.

b) The employee or dependent becomes eligible for assistance under a Medicaid plan or under a State child health plan. The request for coverage under the employer's group health plan must be submitted no later than 60 days following the date the employee or dependent is determined to be eligible for suchassistance.

I – APPLICATION Authorization and Signature:

I hereby represent that I am an employee of the participating employer and that the statements and answers to the questions on this enrollment form are true and complete to the best of my knowledge and belief. I understand that the statements and answers contained herein will be used by The Association Benefits Solutions, marketed as National General Benefits Solutions ("NGBS") to determine eligibility for coverage under the Self-Funded Program ("Program") for myself and persons listed on this enrollment form as my spouse and/or dependent children.

I understand and acknowledge that I have elected to participate in the Section 125 plan offered by my employer, and I agree that my qualified insurance premiums may be paid by my employer through pre-tax salary/earnings reductions. I further acknowledge that my Social Security contribution and subsequent Social Security benefit will be slightly reduced.

I understand that (1) the answers given will be the basis of any coverage provided; (2) any material misrepresentation or failure to provide complete information to questions on this enrollment form may be used as a basis for changing rates or terminating coverage; (3) if coverage is not approved, I, my spouse and/or dependent children are not entitled to benefits; (4) if I, my spouse and/or dependent children waive coverage and decide to apply for coverage at a later date, evidence of eligibility may be required and benefits may be deferred for a specified period of time; and (5) coverage will not be effective until my employer receives notice that this enrollment form has been approved by NGBS.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, pharmacy or pharmacy-related entity, pharmacy benefits manager (PBM) or PBM-related entity, insurance or reinsurance company or employer, having information about me or my minor children to provide all such information as may be requested to NGBS, its legal representative or any medical records retrieval service NGBS may engage.

This authorization includes any and all information any of the foregoing may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data and EKGs. This information may also be disclosed to any medical records company engaged by NGBS. Although federal regulation requires that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by NGBS pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand and agree that in connection with my application for coverage under the Program: (1) NGBS may obtain consumer reports which may include credit information, a driver history report, and/or personal or privileged information from third parties; (2) such information may be disclosed to affiliated or unaffiliated third parties without my prior permission but only as permitted or required by law; (3) upon my written request, NGBS will inform me if a consumer report was requested and the name and address of the consumer reporting agency that furnished the report; (4) I may also request access to and correction of information NGBS has collected on me; (5) NGBS may request and use subsequent consumer reports in updating and renewing any insurance or health coverage afforded in connection with this Application; and (6) NGBS will furnish a more detailed explanation of its information practices upon my request.

In connection with this application for health plan coverage, NGBS will review my credit report or obtain or use an insurance credit score based on the information contained in that credit report. NGBS may use a third party in connection with the development of my insurance credit score. I may request that my credit information be updated and if I question the accuracy of the credit information, NGBS will, upon my request, reevaluate me based on corrected credit information from a consumer reporting agency. I hereby authorize NGBS to obtain consumer reports on me.

I understand that this authorization is required in order to enable NGBS to make eligibility or enrollment determinations relating to me, my spouse and/or my dependents or for NGBS to make underwriting or risk rating determinations. If I refuse to sign or revoke this authorization, or refuse to authorize NGBS to obtain a consumer report on me, NGBS may refuse to consider my application for enrollment.

I understand that I may revoke this authorization at any time by notifying NGBS in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, National Health Insurance Company, 4455 LBJ Freeway, Ste 375, Dallas, TX 75244. Such revocation will not be valid to the extent NGBS has taken action in reliance on the authorization prior to its revocation. This authorization expires upon the earliest of the following: denial of my application, declination of enrollment, or when I am no longer covered under the Program, but in no event will this authorization be in effect for longer than 24 months from the date signed.

I acknowledge that knowing and willful misstatements in this enrollment form may constitute health care fraud, a criminal violation of 18 US Code Section 1347 (punishable by up to 10 years in prison).

Employee/Primary Applicant Signature:____Date: _______________

The National General Benefits Solutions (NGBS) Self-Funded Program provides tools for employers owning small to mid-sized businesses to establish a self-funded health benefit plan for their employees. The benefit plan is established by the employer and is not an insurance product. For employers in the NGBS Self-Funded Program, stop-loss insurance is underwritten by Integon National Insurance Company in CO, CT, NY and VT; Integon Indemnity Corporation in FL; and National Health Insurance Company in all other states where offered.

Employee Enrollment Application
For 51+ employee groups
Wisconsin

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.

To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Please complete electronically or in blue or black ink only.

Employer name	Group no.	Subsection

Section 1: Employee information

Last name	First name	M.I.	Social Security no.* (required)

Birthdate (MMDDYYYY)	Home address

City	County	State	ZIP code

Sex	Marital status	Primary phone no.
☐ Male ☐ Female	☐ Single ☐ Married ☐ Domestic Partner	

Employee email address

Employment status	Hire date (MMDDYYYY)	No. of hours worked per week
☐ Full time ☐ Part time ☐ Disabled ☐ Retired		

Primary Care Physician (PCP) name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Section 2: Reason for application – Select one

☐ New enrollment
☐ Annual open enrollment (not applicable to life and disability)
☐ New hire
☐ Rehire – Rehire date: ________ (MMDDYYYY)
☐ Marriage – Date of marriage: ________ (MMDDYYYY)
☐ Birth of child
☐ Add dependent (Fill in section 4)
☐ Loss of eligibility for other coverage – Date previous coverage ended: ________ (MMDDYYYY) (not applicable to life and disability)
☐ COBRA – Select qualifying event (not applicable to life and disability)
  ☐ Left employment ☐ Reduction in hours ☐ Death ☐ Medicare
  ☐ Loss of dependent child status ☐ Divorce or legal separation ☐ Covered employee's Medicare entitlement
  Qualifying event date: ________ (MMDDYYYY)
☐ Waiver (To decline ALL coverage skip to section 8.)

Additional qualifying events for Life and Disability

☐ Marriage/Domestic Partnership/Civil Union ☐ Divorce/terminate Domestic Partnership/Civil Union
☐ Birth, adoption of child, legal guardianship of child ☐ Death of spouse ☐ Death of child
☐ Spouse left employment and lost group life insurance – applicable only for Life
☐ Change in class from full-time to part-time/part-time to full-time
Qualifying event date: ________ (MMDDYYYY)

*Anthem Blue Cross and Blue Shield (Anthem) is required by the Internal Revenue Service to collect this information.

Life and Disability products underwritten by Anthem Life Insurance Company. Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin (BCBSWI), Compcare Health Services Insurance Corporation (Compcare) and Wisconsin Collaborative Insurance Company (WCIC). BCBSWI underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare or WCIC; Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Social Security no.* (required)

Section 3: Type of coverage

Medical coverage

Large Group 51–99 options

☐ Blue Access PPO
☐ Blue Access PPO HSA
☐ Blue Access PPO HSA with Copay
☐ Anthem Link Blue Connection EPO
☐ Blue Preferred Plus POS
☐ Blue Preferred Plus POS HSA
☐ Blue Preferred Plus POS HSA with Copay
☐ Well Priority Blue Priority POS
☐ Well Priority Blue Priority POS HSA
☐ Well Priority Blue Priority POS HSA with Copay

☐ Add HRA Wrap (Administered by Anthem)

Large Group 100+ options

☐ Blue Access PPO
☐ Blue Access PPO HSA
☐ Blue Access PPO HSA with Copay
☐ Blue Access PPO HRA
☐ Blue Access PPO HRA with Copay
☐ Blue Access PPO Deductible First HRA
☐ Anthem Link Blue Connection EPO
☐ Blue Preferred Plus POS
☐ Blue Preferred Plus POS HSA
☐ Blue Preferred Plus POS HSA with Copay
☐ Blue Preferred Plus POS HRA
☐ Blue Preferred Plus POS HRA with Copay
☐ Blue Preferred Plus POS Deductible First HRA
☐ Anthem Blue Priority POS
☐ Anthem Blue Priority POS HSA
☐ Anthem Blue Priority POS HSA with Copay
☐ Well Priority Blue Priority POS
☐ Well Priority Blue Priority POS HSA
☐ Well Priority Blue Priority POS HSA with Copay
☐ Well Priority Blue Priority POS HRA
☐ Well Priority Blue Priority POS HRA with Copay
☐ Well Priority Blue Priority POS Deductible First HRA

☐ Add HRA Wrap (Administered by Anthem)

Member medical coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Flexible Spending Account (FSA) coverage – More than one plan may be selected, depending on employer offerings.

☐ Healthcare FSA (excluded if you have an HSA plan)
☐ Limited-Purpose FSA (for dental and vision services)
☐ Dependent Care FSA
☐ Commuter Parking
☐ Commuter Transit
☐ No FSA coverage at this time

Dental coverage

☐ Prime Essential Choice ☐ Complete Essential Choice ☐ Other: ______________________________

Member dental coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Vision coverage

☐ Vision

Member vision coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + child(ren) ☐ Family ☐ No coverage

Life and disability coverage

If you select life and/or disability coverage over the guaranteed issue amount or are a late entrant an Evidence of Insurability form may be sent to you to complete.

☐ Basic Life
☐ Basic Life and Accidental Death and Dismemberment
☐ Basic Dependent Life
☐ Supplemental/Voluntary Life and Accidental Death and Dismemberment . . . . $______________ (employee amount)
☐ Supplemental/Voluntary Dependent Life Spouse . . . . $______________ (spouse amount)
☐ Supplemental/Voluntary Dependent Life Child . . . . $______________ (child amount)
☐ Voluntary Accidental Death and Dismemberment . . . . $______________ (employee amount)
☐ Voluntary Accidental Death and Dismemberment Family Plan (Spouse and Child coverage)
☐ Voluntary Accidental Death and Dismemberment Spouse Only (no Child coverage)
☐ Voluntary Accidental Death and Dismemberment Child Only (no Spouse coverage)
☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income – For employer/Anthem use	Occupation	Life and disability class no. – For employer/Anthem use
$______________		

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Life and disability coverage – Continued

Beneficiary designation – Attach a separate sheet if necessary.

	Name of beneficiary	Percentage	Social Security no.	Relationship to applicant	Age
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse consent for designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA, and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following.

Authorization

I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy.

I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

In CA, NV, and WA, Spouse also includes your registered Domestic Partner.

Spouse/Domestic Partner signature	Spouse/Domestic Partner name	Date (MMDDYYYY)
X		

Group Accident, Critical Illness, and Hospital Indemnity Insurance

☐ **Group Accident Insurance** – Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Accident plan offered please select: ☐ Low Plan ☐ High Plan

☐ **Group Critical Illness Insurance** – Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Critical Illness plan offered please select: ☐ Low Plan ☐ High Plan
Have you smoked or used tobacco products in the last 12 months? ☐ No ☐ Yes, explain product used: ______________________

☐ **Group Hospital Indemnity Insurance** – Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Hospital Indemnity plan offered please select: ☐ Low Plan ☐ High Plan

If any person to be covered by a Critical Illness or Hospital Indemnity plan is a resident of CA, GA, NY, or CO, please answer the following question:

Will all applicants who reside in CA, GA, NY, or CO, when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy, an employer sponsored health plan, or an HMO that provides essential health benefits? ☐ Yes ☐ No (Please note that if the response is No, such applicants are not eligible for coverage)

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Group Accident, Critical Illness, and Hospital Indemnity Insurance beneficiary designation

Beneficiary designation – Attach a separate sheet if necessary.

	Name of beneficiary	Percentage	Social Security no.	Relationship to applicant	Age
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

Section 4: Coverage information – All fields required. Attach a separate sheet if necessary.

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26 unless they qualify as a disabled person). List all dependents beginning with the eldest.

Spouse/Domestic Partner last name | First name | M.I. | Social Security no.* (required)

Sex ☐ Male ☐ Female | Disabled ☐ Yes ☐ No | Birthdate (MMDDYYYY) | Relationship to applicant ☐ Spouse ☐ Domestic Partner

PCP name | PCP ID no. | Existing patient? ☐ Yes ☐ No

Dependent last name | First name | M.I. | Social Security no.* (required)

Sex ☐ Male ☐ Female | Disabled ☐ Yes ☐ No | Birthdate (MMDDYYYY) | Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ____________

PCP name | PCP ID no. | Existing patient? ☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter: ____________

Dependent last name | First name | M.I. | Social Security no.* (required)

Sex ☐ Male ☐ Female | Disabled ☐ Yes ☐ No | Birthdate (MMDDYYYY) | Relationship to applicant ☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ____________

PCP name | PCP ID no. | Existing patient? ☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter: ____________

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 4: Coverage information – Continued.

Dependent last name	First name	M.I.	Social Security no.* (required)

Sex	Disabled	Birthdate (MMDDYYYY)	Relationship to applicant
☐ Male ☐ Female	☐ Yes ☐ No		☐ Biological child of applicant/spouse/domestic partner ☐ Other If other, what is relationship? ____

PCP name	PCP ID no.	Existing patient?
		☐ Yes ☐ No

Does this dependent have a different address? ☐ Yes ☐ No
If yes, please enter: ____

Section 5: Prior and other group coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No
If yes, give name: ____

Medicare ID no.	Part A effective date (MMDDYYYY)	Part B effective date (MMDDYYYY)	Medicare eligibility reason (check all that apply)
			☐ Age ☐ Disability ☐ ESRD: Onset date: ____ (MMDDYY)

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date (MMDDYYYY)

Are you or a family member previously or currently covered by a Medicare, medical and/or dental plan? ☐ Yes ☐ No
If yes, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Policyholder name	Dates (if applicable) (MMDDYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Medical ☐ Dental ☐ Orthodontia					Start: End:

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 6: Terms, Conditions, and Authorizations (TERMS)

Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield (Anthem) facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem at any time.

1. I understand that I may not assign any payment under my Anthem program.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

Life and/or Disability Authorization Section – Read carefully before signing.

1. Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.

This authorization, for purposes of processing this application form, is valid from the date signed for a period of 30 months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. For the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization shall remain valid for the term of coverage of the policy for an accident and sickness insurance benefit and for the duration of the claim if the claim is not for an accident and sickness insurance benefit. A photocopy and/or electronic copy is as valid as the original. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.

I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan, including my Spouse/Domestic Partner/Civil Union Partner. I am acting as their agent and representative.

I have read and accept the Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescision or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

I certify each Social Security number listed on this application is correct.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 7: Signature – Required if you are applying for coverage. Please review your application for errors or omissions.

Read section 6 carefully before signing.

I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature	Date (MMDDYYYY)
X	

*Anthem is required by the Internal Revenue Service to collect this information.

Social Security no.* (required)

Section 8: Waiver/Declining coverage

Medical coverage

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:
- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: ____________
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: ____________
- ☐ No coverage

Dental coverage

Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:
- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: ____________
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: ____________
- ☐ No coverage

Vision coverage

Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/domestic partner ☐ Dependent(s)

Reason for declining coverage – check all that apply:
- ☐ Covered by spouse's/domestic partner's group coverage
- ☐ Enrolled in other insurance – Please provide company name and plan: ____________
- ☐ Enrolled in individual coverage
- ☐ Spouse covered by employer's group medical coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: ____________
- ☐ No coverage

Life and disability coverage

***Life/AD&D** coverage declined for: ☐ Myself
Spouse, Domestic Partner and dependent coverage not available if life coverage is waived/declined.

Dependent Life coverage declined for: ☐ Spouse/domestic partner and dependents

Supplemental/Voluntary coverage declined for: ☐ Myself

Supplemental/Voluntary Dependent Life coverage declined for: ☐ Spouse/domestic partner and dependents

Voluntary Short Term Disability coverage declined for: ☐ Myself

Voluntary Long Term Disability coverage declined for: ☐ Myself

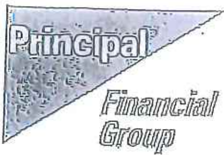
Reason for declining coverage – check all that apply:
- ☐ Life/AD&D declined for religious reasons
- ☐ Do not elect to enroll in Dependent Life
- ☐ Do not elect to enroll in Supplemental/Voluntary coverage
- ☐ Do not elect to enroll in Supplemental/Voluntary Dependent Life coverage
- ☐ Do not elect to enroll in Voluntary Short Term Disability
- ☐ Do not elect to enroll in Voluntary Long Term Disability

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Social Security no.	Date (MMDDYYYY)
X			

*Anthem is required by the Internal Revenue Service to collect this information.



Mailing Address
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver-WI

PLEASE USE BLACK INK
PLEASE ENTER DATES AS MM/DD/YYYY

Company name	Division level	Account number/unit number
CND Specialties Inc	All Members	

Employee Information

Name	Social security number

Mailing address (street)	Birth date	☐ male ☐ female

(city)	(state)	(ZIP code)

Do you have an eligible spouse or domestic partner or child(ren)?
☐ yes ☐ no

Date employed full-time	Hours worked per week	Job occupation/class	Location

Email address	Phone number

Salary amount (for owners, include business income)	Salary mode
	☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly

Payroll mode	Employer ZIP code	Employer county
☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly	53019	FOND DU LAC

Eligible Dependent Information (Complete if you are electing benefits for your spouse or domestic partner or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		☐ male ☐ female		☐ Spouse ☐ domestic partner
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**

* If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court? ☐ yes ☐ no

** When your child, who is developmentally or physically disabled, reaches/exceeds the maximum age, an Application to Continue Disabled Child form must be completed and reviewed to determine eligibility.

Is your spouse or domestic partner employed by this company?
☐ yes ☐ no

Coverage	Employee	Spouse or Domestic Partner*	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Group Term Life	[X] Elect	[ ] Elect [ ] Decline	[ ] Elect [ ] Decline
Short Term Disability	[X] Elect		

*NOTE: Domestic Partners can only be added if your employer allows this coverage. If enrolling a Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60485).

Group Term Life Beneficiary Designation (Complete if covered for group term life coverage.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below. Additional beneficiaries can be added as an attachment.

Primary Beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor [ ]	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor [ ]	Percentage

Contingent Beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor [ ]	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor [ ]	Percentage

The right to make future changes is reserved by the employee. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form (GP55229).

Declining Coverage

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

- [ ] spouse's or domestic partner's group coverage
- [ ] individual insurance
- [ ] other coverage offered by my employer
- [ ] other ____________________

Employee Agreement (Read and sign)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse coverage, I cannot enroll after retirement.
- If I refuse life, disability, or critical illness coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life Insurance Company.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, fraud or intentional misrepresentations can cause changes in my coverage, including cancellation back to the effective date.

- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life, disability and critical illness coverage. Information will not be used for any purposes prohibited by law.
- I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.

A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature X________________________________ **Date Signed** ______________

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

UTMA Beneficiary Designation

Company Name

CND Specialties Inc

Account/Unit Number

Employee Information

Your name (last, first, middle initial)

Social security number

NOTE: This form is a supplement to Employee Enrollment and Waiver.

Minor Beneficiary – UTMA: ONLY COMPLETE IF THE BENEFICIARY LISTED IS A MINOR.

If any proceeds become payable to a beneficiary who is then a "minor" as defined in the applicable Uniform Transfers to Minors Act, as specified herein, such proceeds shall be paid to ______________________________
(Name)

____
(Address)

as custodian for such beneficiary:

(Check One Only) See instructions on Page 2.

☐ under the Iowa Uniform Transfers to Minor Act.

☐ under the Uniform Transfers to Minor Act of the state where the beneficiary shall reside at the time of payment. In the event the beneficiary resides in California or Ohio at the time of payment, the custodianship is to continue until the beneficiary reaches the age of ___ for California (insert 18, 19, 20, 21, 22, 23, 24 or 25) or ___for Ohio (insert 18, 19, 20 or 21).

In the event a substitute custodian is needed, the following is/are nominated, in the order named:

Name | Address

Name | Address

If no state is specified (by name or description) above, or if the state so specified has not enacted the Uniform Transfers to Minors Act, or if the law of the state so specified does not provide for such payment to a custodian, the custodianship shall be established under the Iowa Uniform Transfers to Minors Act. If the specified Uniform Transfers to Minors Act would require the beneficiary's custodianship to terminate at or before the time of payment, the proceeds payable to that beneficiary shall be paid to the beneficiary rather than to a custodian.

Signature

Read important instructions on Page 2 before signing.

Signature of employee

Date signed

Note: make a copy of Page 1 for your records and distribute copy to employee.

Minor Beneficiary - UTMA Instructions - Please Note the Following:

1. You may wish to consult with your attorney about the completion of this beneficiary designation. The following comments are of a general nature and are not intended to be legal advice, or to substitute for legal advice.

2. **Naming a custodian and substitutes.** A custodian must be named in the blank following the words "paid to" in the designation. It is strongly recommended that you also name at least one (and preferably two or more) substitute custodians on the lines provided for that purpose. A substitute custodian would serve if, at the time of payment, the first-named custodian is deceased or otherwise unable or unwilling to serve. The custodian (and each substitute) listed on the beneficiary designation should be either: (1) an individual who is now an adult; or (2) a trust company, such as a financial institution with a trust department.

3. **Specifying the state law.** You may specify that the custodianship be established under the Iowa Uniform Transfers to Minors Act, regardless of where the minor lives. Principal Life Insurance Company is based in Iowa and therefore may transfer funds to a custodian in any state for the benefit of a minor in any state if the beneficiary designation specifies that the transfer shall be made under the Iowa Uniform Transfers to Minors Act. The Iowa Uniform Transfers to Minors Act defines a "minor" as an individual who has not reached age 21.

   Alternatively, you may specify that the custodianship be established under the law of whatever state the beneficiary may live in at the time of payment. If this happens to be a state that has not enacted the Uniform Transfers to Minors Act, the designation specifies that the custodianship will be established under the Iowa Uniform Transfers to Minors Act. If there is a possibility that the minor beneficiary will live in California or Ohio at the time of payment, you may wish to fill in one or both of the blanks specifying the age at which the custodianship is to terminate (see below). The ability to specify such an age in the beneficiary designation is a unique feature of the Ohio and California Uniform Transfers to Minors Acts.

   The state specified in the designation may affect the age at which the beneficiary will have control of the money. Under the Uniform Transfers to Minors Act as enacted in many states, a custodianship created pursuant to a beneficiary designation terminates when the beneficiary reaches the legal age of majority (usually 18), even though custodianships created pursuant to a lifetime gift may terminate at a later age. However, under the Iowa Uniform Transfers to Minors Act, and in a few states, a custodianship created pursuant to a beneficiary designation continues until the beneficiary reaches age 21. As noted above, custodian nominations under the California Uniform Transfers to Minors Act may specify an age (up to the age of 25) for the custodianship to terminate. If no age is specified, the California custodianship will terminate at age 18. Custodianships under the Ohio Transfers to Minors Act terminate at age 21 unless the beneficiary designation specifies that it will terminate at age 18, 19 or 20.

Summary of Benefits
Anthem Dental Essential Choice PPO

Anthem Blue Cross Blue Shield Dental Complete Network

Effective Date: 05-01-2022

WELCOME TO YOUR DENTAL PLAN!

Regular dental checkups can help find early warning signs of certain health problems, which means you can get the care you need to get healthy. So, don't skimp on your dental care, good oral care can mean better overall health!

Powerful and easily accessible member tools.

- **Ask a Hygienist:** Dental members can simply email their dental questions to a team of licensed dental professionals who in turn will respond in approximately one business day.
- **Dental Health Risk Assessment:** We want our dental members to better understand their oral health and their risk factors for tooth decay, gum disease and oral cancer. This easy to use online tool can help them do this.
- **Dental Care Cost Estimator:** In order to help our dental member better understand the cost of their dental care, we offer access to a user-friendly, web-based tool that provides estimates on common dental procedures and treatments when using a network dentist.
- **Mobile Capabilities:** With our latest mobile application, members can find a network dentist as well as view their claims. Our application is available for both Android and Apple phones.

Dentists in your plan network.

- You'll save money when you visit a dentist in your plan network because Anthem and the dentist have agreed on pricing for covered services. Dentists who are not in your plan network have not agreed to pricing, and may bill you for the difference between what Anthem pays them and what the dentist usually charges.
- To find a dentist by name or location, go to anthem.com or call dental customer service at the number listed on the back of your ID card.

Ready to use your dental benefits?

- Choose a dentist from the network
- Make an appointment
- Show the office staff your member ID card
- Pay any deductible or copay that is part of your plan

Need to contact us?

See the back of your ID card for how to call, write or email us.

Your dental benefits at a glance

The following benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your policy.

	In-Network	Out-of-Network
Coverage Year	Calendar Year	
Office Visit Copay		
Annual Benefit Maximum • Per insured person • Diagnostic & Preventive Services are applied to the Annual Benefit Maximum	$1500	$1500
Annual Maximum Carryover	No	No
Orthodontic Lifetime Benefit Maximum • Per eligible person	Not applicable	Not applicable
Annual Deductible • Per insured person • Family maximum	$50 3x single member deductible	$50 3x single member deductible
Deductible Waived for Diagnostic/Preventive Services	Yes	Yes
Out-of-Network Reimbursement	90th percentile	

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin (BCBSWI), Compcare Health Services Insurance Corporation (Compcare) and Wisconsin Collaborative Insurance Company (WCIC). BCBSWI underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare or WCIC; Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

10/2020

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period

Diagnostic & Preventive Services
• Periodic dental exam
  o Limited to 2 per 12 months
• Teeth cleaning (prophylaxis)
  o Limited to 2 per 12 months; combined with periodontal maintenance
• Bitewing X-rays
  o Limited to 1 set per 12 months
• Full-Mouth or Panoramic X-rays
  o Limited to 1 per 60 months
• Fluoride application
  o Limited to 1 per 12 months through age 18
• Sealant application
  o Limited to 1 per 60 months through age 18
	100% coinsurance	100% coinsurance	No Waiting Period

Basic (Restorative) Services
• Consultation (second opinion); only with X-rays and no other services
  o Limited to 1 per 12 months
• Space maintainer insertion covered at Diagnostic & Preventive level
  o Limited to 1 per tooth space per lifetime through age 18
• Amalgam (silver-colored) filling
  o Limited to 1 per tooth per surface per 24 months
• Composite (tooth-colored) filling
  o Limited to 1 per tooth per surface per 24 months; posterior (back) fillings paid as an amalgam (silver-colored filling)
• Brush biopsy (cancer test)
  o Not covered
	80% coinsurance	80% coinsurance	No Waiting Period

Endodontics (Non-Surgical) • Root Canal (permanent teeth only) o Limited to 1 per tooth per 1 lifetime	50% coinsurance	50% coinsurance	No Waiting Period
Endodontics (Surgical) • Apicoectomy and apexification (permanent teeth only) o Limited to 1 per tooth per 1 lifetime	50% coinsurance	50% coinsurance	No Waiting Period

Periodontics (Non-Surgical)
• Periodontal maintenance
  o Limited to 4 per 12 months; combined with teeth cleanings
• Scaling and root planning when the tooth pocket has a depth of four millimeters or greater
  o Limited to 1 per quadrant per 24 months
	50% coinsurance	50% coinsurance	No Waiting Period

Periodontics (Surgical) • Periodontal surgery (osseous, gingivectomy, graft procedures) o Limited to 1 per quadrant per 36 months	50% coinsurance	50% coinsurance	No Waiting Period
Oral Surgery (Simple) • Simple extraction o Limited to 1 per tooth per 1 lifetime	50% coinsurance	50% coinsurance	No Waiting Period
Oral Surgery (Complex) • Surgical extraction o Limited to 1 per tooth per 1 lifetime	50% coinsurance	50% coinsurance	No Waiting Period
Major (Restorative) Services • Crowns, onlays, veneers o Limited to 1 per tooth per 60 months	50% coinsurance	50% coinsurance	No Waiting Period

Prosthodontics
• Dentures and bridges
  o Limited to 1 per tooth/arch per 60 months
• Implant placement
  o Limited to 1 per tooth/arch per 60 months
• Implant prosthodontics
  o Limited to 1 per tooth/arch per 60 months; paid as an implant crown, bridge, and/or denture
	50% coinsurance	50% coinsurance	No Waiting Period

Repairs/Adjustments
• Crown, denture, and bridge repairs
  o Limited to 1 per 12 months; not within 6 months of placement.
• Denture and bridge adjustments
  o Limited to 2 per 12 months; not within 6 months of placement
	50% coinsurance	50% coinsurance	No Waiting Period

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Dental Services (continued)	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
Orthodontic Services o Not covered	Not covered	Not covered	
Temporomandibular Joint Disorder (TMJ) • X-rays, splints, and surgical procedures including arthroscopy and orthotic devices o Not covered	Not covered	Not covered	
Cosmetic Teeth Whitening o Not covered *NOTE: Cosmetic benefits, such as teeth bleaching, in an insurance policy may have income tax implications for both employer groups and plan members. For example, the dollar value of the cosmetic benefit may be considered part of an individual's taxable income. For more information concerning the tax ramifications of cosmetic insurance benefits, please consult a legal or tax advisor.*	Not covered	Not covered	

Additional Services and Programs

Anthem Whole Health Connection - Dental℠

- For members with certain health conditions, additional dental benefits are available without a deductible or waiting periods. Eligible services are paid at 100% and won't reduce your coverage year annual maximum (if applicable)

Accidental Dental Injury Benefit

- Provides members 100% coverage for accidental injuries to teeth up to the coverage year annual maximum (if applicable). No deductibles, member coinsurance, or waiting periods apply

Extension of Benefits

- Following termination of coverage, members are provided up to 60 days to complete treatment started prior to their termination of coverage under the plan and eligible services will be covered

International Emergency Dental Program

- Provides emergency dental benefits while working or traveling abroad from licensed, English-speaking dentists. Eligible covered services will be paid 100% with no deductibles, member coinsurance, or waiting periods and won't reduce the member coverage year annual maximum (if applicable)

Additional Limitations & Exclusions

Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.

Services provided before or after the term of this coverage - Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

Orthodontics (unless included as part of your dental plan benefits) including orthodontic braces, appliances and all related services

Cosmetic dentistry (unless included as part of you dental plan benefits) provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

Drugs and medications including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

Analgesia, analgesic agents, and anxiolysis nitrous oxide, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

Waiting periods for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan. There is a 24 month waiting period for replacement of congenitally missing teeth or teeth extracted prior to coverage under this plan.

This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your policy. **In the event of a discrepancy between the information in this summary and the policy, your policy will prevail.**

NOTICE: LIMITED BENEFITS WILL BE PAID WHEN NONPARTICIPATING PROVIDERS ARE USED. You should be aware that when you elect to utilize the services of a nonparticipating provider for a covered service, benefit payments to such non-participating provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy. YOU RISK PAYING MORE THAN THE COINSURANCE, DEDUCTIBLE AND CO-PAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Nonparticipating providers may bill enrollees for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payment for covered services with no additional billing to the enrollee other than co-payment, coinsurance and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card or visiting our website at Anthem.com.

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin (BCBSWI), Compcare Health Services Insurance Corporation (Compcare) and Wisconsin Collaborative Insurance Company (WCIC). BCBSWI underwrites or administers PPO and indemnity policies and underwrites the out of network benefits in POS policies offered by Compcare or WCIC; Compcare underwrites or administers HMO or POS policies; WCIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Blue View Vision℠
FS.B.10.10.150.150
Effective 1/1/2020

Welcome to your Blue View Vision plan!

You have many choices when it comes to using your benefits. As a Blue View Vision plan member, you have access to one of the nation's largest vision networks. You may choose from many private practice doctors, local optical stores, and national retail stores including LensCrafters®, Target Optical®, Sears Optical®, JCPenney® Optical and most Pearle Vision® locations. You may also use your in-network benefits to order eyewear online at Glasses.com and ContactsDirect.com. To locate a participating network eye care doctor or location, log in at **anthem.com**, or from the home page menu under Care, select **Find a Doctor**. You may also call member services for assistance at **1-866-723-0515**.

Out-of-Network – If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt, and file a claim for reimbursement up to your maximum out-of-network allowance.

YOUR BLUE VIEW VISION PLAN BENEFITS	IN-NETWORK	OUT-OF-NETWORK	FREQUENCY
Routine Eye Exam			
A comprehensive eye examination	$10 Copay	Reimbursed Up To $42	Once every calendar year
Eyeglass Frames			
One pair of eyeglass frames	$150 Allowance, then 20% off any remaining balance	Reimbursed Up To $45	Once every other calendar year
Eyeglass Lenses *(instead of contact lenses)*			
One pair of standard plastic prescription lenses o Single vision lenses o Bifocal lenses o Trifocal lenses	 $10 Copay $10 Copay $10 Copay	 Reimbursed up to $40 Reimbursed up to $60 Reimbursed up to $80	Once every calendar year
Eyeglass Lens Enhancements *When obtaining covered eyewear from a Blue View Vision provider, you may choose to add any of the following lens enhancements at no extra cost*			
o Transitions Lenses (for a child under age 19) o Standard polycarbonate (for a child under age 19) o Factory Scratch Coating	$0 Copay $0 Copay $0 Copay	No allowance when obtained out-of-network	Same as covered eyeglass lenses
Contact Lenses *(instead of eyeglass lenses)* *Contact lens allowance will only be applied toward the first purchase of contacts made during a benefit period. Any unused amount remaining cannot be used for subsequent purchases in the same benefit period, nor can any unused amount be carried over to the following benefit period.*			
o Elective conventional (non-disposable) OR	$150 Allowance, then 15% off any remaining balance	Reimbursed up to $95	Once every calendar year
o Elective disposable OR	$150 Allowance *(no additional discount)*	Reimbursed up to $95	
o Non-elective (medically necessary)	Covered in full	Reimbursed up to $210	

This is a primary vision care benefit intended to cover only routine eye examinations and corrective eyewear. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. Benefits are payable only for expenses incurred while the group and insured person's coverage is in force. This information is intended to be a brief outline of coverage. All terms and conditions of coverage, including benefits and exclusions, are contained in the member's policy, which shall control in the event of a conflict with this overview. This benefit overview is only one piece of your entire enrollment package.

EXCLUSIONS & LIMITATIONS (not a comprehensive list – please refer to the member Certificate of Coverage for a complete list)

Combined Offers. Not to be combined with any offer, coupon, or in-store advertisement.
Excess Amounts. Amounts in excess of covered vision expense.
Sunglasses. Plano sunglasses and accompanying frames.
Safety Glasses. Safety glasses and accompanying frames.
Not Specifically Listed. Services not specifically listed in this plan as covered services.
Lost or Broken Lenses or Frames. Any lost or broken lenses or frames are not eligible for replacement unless the insured person has reached his or her normal service interval as indicated in the plan design.
Non-Prescription Lenses. Any non-prescription lenses, eyeglasses or contacts. Plano lenses or lenses that have no refractive power.
Orthoptics. Orthoptics or vision training and any associated supplemental testing

OPTIONAL SAVINGS AVAILABLE FROM BLUE VIEW VISION IN-NETWORK PROVIDERS ONLY		In-Network Member Cost (after any applicable copay)
Retinal Imaging – at member's option, can be performed a time of eye exam		Not more than $39

Eyeglass lens upgrades
When obtaining eyewear from a Blue View Vision provider, you may choose to upgrade your new eyeglass lenses at a discounted cost. Eyeglass lens copayment applies.
	o Transitions lenses (Adults)
	o Standard Polycarbonate (Adults)
	o Tint (Solid and Gradient)
	o UV Coating
	o Progressive Lenses[1]
	  o Standard
	  o Premium Tier 1
	  o Premium Tier 2
	  o Premium Tier 3
	  o Premium Tier 4
	o Anti-Reflective Coating[2]
	  o Standard
	  o Premium Tier 1
	  o Premium Tier 2
	  o Premium Tier 3
	o Other Add-ons
		$75
		$40
		$15
		$15
		
		$55
		$85
		$95
		$110
		$175
		
		$45
		$57
		$68
		$85
		20% off retail price

Additional Pairs of Eyeglasses Anytime from any Blue View Vision network provider	o Complete Pair o Eyeglass materials purchased separately	40$ off retail price 20% off retail price
Eyewear Accessories	Items such as non-prescription sunglasses, lens cleaning supplies, contact lens solutions, eyeglass cases, etc.	20% off retail
Contact lens fit and follow-up A contact lens fitting and up to two follow-up visits are available to you once a comprehensive eye exam has been completed.	o Standard contact lens fitting[3] o Premium contact lens fitting[4]	Up to $55 10% off retail price
Conventional Contact Lenses	Discount applies to materials only	15% off retail price

[1] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

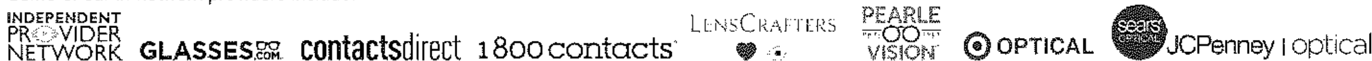
[2] Please ask your provider for his/her recommendation as well as the available progressive brands by tier.

[3] Standard fitting includes spherical clear lenses for conventional wear and planned replacement. Examples include but are not limited to disposable and frequent replacement.

[4] Premium fitting includes all lens designs, materials and specialty fittings other than standard contact lenses. Examples include but are not limited to toric and multifocal.

Cannot be combined with any other offer. Discounts are subject to change without notice. Discounts are not covered benefits under your vision plan and will not be listed in your certificate of coverage. Discounts will be offered from in-network providers except where State law prevents discounting of products and services that are not covered benefits under this plan. Discounts on frames will not apply if the manufacturer has imposed a no discount on sales at retail and independent provider locations.

Some of our in-network providers include:



ADDITIONAL SAVINGS AVAILABLE THROUGH ANTHEM'S SPECIAL OFFERS PROGRAM
Savings on items like additional eyewear after your benefits have been used, non-prescription sunglasses, hearing aids and even LASIK laser vision correction surgery are available through a variety of vendors. Just log in at **anthem.com**, select discounts, then Vision, Hearing & Dental.

* Discounts cannot be used in conjunction with your covered benefits.

OUT-OF-NETWORK

If you choose to receive covered services or purchase covered eyewear from an out-of-network provider, network discounts will not apply and you will be responsible for payment of services and/or eyewear materials at the time of service. Please complete an out-of-network claim form and submit it along with your itemized receipt to the fax number, email address, or mailing address below. To download a claim form, log in at **anthem.com**, or from the home page menu under Support select Forms, click Change State to choose your state, and then scroll down to Claims and select the Blue View Vision Out-of-Network Claim Form. You may instead call member services at 1-866-723-0515 to request a claim form.

TO FAX: 866-293-7373
TO EMAIL: oonclaims@eyewearspecialoffers.com
TO MAIL: Blue View Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

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