Medical coverage administered by/
dental and vision coverage underwritten by:

Anthem
Community Insurance Company
or Anthem Insurance Companies, Inc.

OHIO FARM BUREAU EST. 1919
HEALTH BENEFITS PLAN

Employee Enrollment/Change Application

Ohio Farm Bureau Health Benefits Plan

Instructions:

Please read carefully, complete electronically, or in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply only to this employer.

Section 1: Employer/group use — Required. To be filled out by employer.

Employer name			Group no.	
Employer address		City	State	ZIP code
Requested effective date	Employee no.	Department name		

Section 2: Reason for application/change — Required

- ☐ New enrollment
- ☐ Annual open enrollment
- ☐ Annual open enrollment plan election change
- ☐ Add spouse/domestic partner or dependent (Fill in section 3)
- ☐ Cancel spouse/domestic partner or dependent
- ☐ Name change
- ☐ Address change

Event date/requested effective date: ____ (MMDDYYYY)

- ☐ New hire
- ☐ Rehire date: ____ (MMDDYYYY)
- ☐ COBRA — Qualifying event: _____
  Event date: ____ (MMDDYYYY)
- ☐ State Continuation Event date: ____ (MMDDYYYY)
- ☐ Enrollment in Medicare
- ☐ Waiver (To decline ALL benefits skip to section 11)

Section 3: Status change/event — Required, if you checked "Add dependent" option in section 2.

Event date: ____ (MMDDYYYY)

☐ Marriage ☐ Adoption (Attach legal documentation) ☐ Loss of benefits (reason): _____
☐ Birth ☐ Legal guardianship (Attach legal documentation) _____
☐ Divorce ☐ Death ☐ Terminated employment
☐ Other: _____

Section 4: Employee information — Required

☐ Add ☐ Change ☐ Cancel

Last name	First name	M.I.	Social Security no.* (Required)
Date of birth (MMDDYYYY) / Age	Sex ☐ Male ☐ Female	Marital status ☐ Single ☐ Married ☐ Divorced	
Home phone	Business phone	Email address	
Address	City	State	ZIP code
County	Retired: ☐ Yes ☐ No Disabled: ☐ Yes ☐ No Hospitalized: ☐ Yes ☐ No		
Occupation	Full-time hire date	Hours working per week	

Income reported by: ☐ W–2 ☐ 1099 ☐ Other: _____

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

Ohio Farm Bureau Federation is a member of American Farm Bureau Federation®, a national organization of farmers and ranchers including Farm Bureau® organizations in 49 other states and Puerto Rico, and is responsible for Farm Bureau membership and programs within the State of Ohio. Ohio Farm Bureau Federation programs and services are available only to Farm Bureau members within Ohio. Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Independent licensee of the Blue Cross and Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

Employee name: _____ Social Security no.* |___|___|___|___|___|___|___|___|___|

Section 5: Plan/type of benefits — Required. To decline a plan type, check "No benefits". If you are waiving all benefits, go to section 11.

Medical plan	
Plan selected: _____	Contract code: _____
Type of medical benefits: ☐ Employee only ☐ Employee+spouse/domestic partner ☐ Employee+child(ren) ☐ Family benefits ☐ No benefits	
Anthem Dental	
Plan selected: _____	Contract code: _____
Type of dental benefits: ☐ Employee only ☐ Employee+spouse/domestic partner ☐ Employee+child(ren) ☐ Family benefits ☐ No benefits	
Anthem Vision	
Plan selected: _____	Contract code: _____
Type of vision benefits: ☐ Employee only ☐ Employee+spouse/domestic partner ☐ Employee+child(ren) ☐ Family benefits ☐ No benefits	

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Employee name: _____ Social Security no.* _____

Section 6: Family information — Required. List only dependents you wish to enroll. 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.
Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under section 9, Significant Terms, Conditions and Authorizations, prior to answering the questions in section 6.

☐ Add ☐ Change ☐ Cancel

Spouse/domestic partner last name	First name	M.I.	Social Security no.* (Required)

Date of birth (MMDDYYYY)	Sex	Relationship to employee
	☐ Male ☐ Female	☐ Spouse ☐ Domestic partner

Currently hospitalized or disabled? ☐ Yes ☐ No If yes, give reason: _____

If spouse/domestic partner address is different than employee, please provide full address

☐ Add ☐ Change ☐ Cancel

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

Date of birth (MMDDYYYY)	Sex	Full-time student	Relationship to employee
	☐ Male ☐ Female	☐ Yes ☐ No	☐ Child ☐ Other: _____

Currently hospitalized or disabled? ☐ Yes ☐ No If yes, give reason: _____

Court ordered health care coverage? ☐ Yes ☐ No If yes, attach legal documentation.

If dependent address is different than employee, please provide full address

☐ Add ☐ Change ☐ Cancel

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

Date of birth (MMDDYYYY)	Sex	Full-time student	Relationship to employee
	☐ Male ☐ Female	☐ Yes ☐ No	☐ Child ☐ Other: _____

Currently hospitalized or disabled? ☐ Yes ☐ No If yes, give reason: _____

Court ordered health care coverage? ☐ Yes ☐ No If yes, attach legal documentation.

If dependent address is different than employee, please provide full address

Section 7: Other health coverage — Required

Do you and/or your dependents have other health coverage? ☐ Yes ☐ No If yes, complete below.

On the day your benefits begin, list family members, including yourself, who will be covered by any other health coverage

Provide name, phone number and address of the HMO or insurance company	Policy/certificate no.	Effective date (MMDDYYYY)

Policy/certificate holder name	Social Security no.*	Date of birth (MMDDYYYY)	Relationship to employee

Are you and/or your dependents enrolled in Medicare or Medicaid? ☐ Yes ☐ No If yes, complete below.

Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date

Medicare Part D ID no.	Medicare Part D carrier	Medicare Part D effective date	Medicare Part D term date

Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD and disability ☐ End Stage Renal Disease (ESRD)

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Employee name: _____ Social Security no.* _____

Section 8: Prior health coverage — Required

Have you and/or your dependents had prior health coverage? ☐ Yes ☐ No If yes, complete below.		
Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No	Policy/certificate no.	
Group name/ID no.	Date policy in effect	Date policy terminated
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? ☐ Yes ☐ No		
List prior carrier(s)	Date policy in effect	Date policy terminated
Please check the type of prior coverage: ☐ Employee ☐ Employee+Spouse/domestic partner ☐ Employee+child(ren) ☐ Family		
Termination reason ☐ Divorce/legal separation ☐ Employment terminated ☐ Employer/group contribution ceased ☐ Other ☐ Death of spouse/domestic partner ☐ COBRA/State Continuation coverage exhausted ☐ Group plan terminated		

Section 9: Significant 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 equivalent rate for the benefits applied for.
3. I am asking for the benefits 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 understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for benefits and that no right is created by my application for benefits.
5. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.
6. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for these benefits.
7. I certify each Social Security number listed on this application is correct. I understand that Anthem is required by the Internal Revenue Service to collect this information.
8. I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 CFR. Parts 160 & 164). I also understand that under the HIPAA Privacy Regulations, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

Authorization Section — Read carefully before signing.

I authorize any licensed physician, any other medical practitioner or provider, pharmacist, hospital, clinic, other medical or medically related facility, federal, state or local government agency, insurance or reinsuring company, including any health or other insurance company affiliated with Anthem, consumer reporting agency or employer having information available as to claims, diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me, and any non-medical information about me (but specifically excluding from this authorization any non-medical information that could be used to ascertain my sexual orientation or that I have a pending HIV test or that I have had negative HIV test results), to give any and all such information to authorized representatives of Anthem, its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem, and including, but not limited to any other mental or psychiatric records, medical, dental and hospital records (including psychiatric, alcohol, and drug abuse, and HIV/AIDS information) which may have been acquired in the course of examination or treatment. I understand that the information obtained by use of this authorization will be used by Anthem representatives to evaluate and adjudicate my current application for health coverage or any claims under such coverage, and may be re-disclosed to (a) any medical, investigative, financial or vocational specialist or entity, or (b) any other organization or person, employed by or representing Anthem solely to assist with the evaluation and adjudication of my current health insurance application or claim. Each such person or entity to whom this re-disclosure is made shall comply with the HIPAA Privacy Rule as regards any re-disclosed protected health information as applicable. I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

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

Employee name: _____ Social Security no.* |_|_|_|_|_|_|_|_|_|

Section 9: Significant Terms, Conditions and Authorizations (TERMS) — Continued.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of benefits. 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 benefits or premium equivalent rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of benefits. 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.

Fraud notice: 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 is guilty of insurance fraud.

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. 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 is as valid as the original. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.

I'm signing here because I want to get information about my benefits by email or electronically. This may include my benefit booklet 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. I understand if I change my mind after 30 months, I will need to let Anthem know. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization. Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Section 10: Signature — Required, if you are applying for benefits. Please review your application for errors or omissions.

Read section 9 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 Blue Cross and Blue Shield is required by the Internal Revenue Service to collect this information.

Employee name: _____ Social Security no.* _____

Section 11: Waiver/Declining coverage — Complete for yourself and/or any eligible dependents. Check all that apply.

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/domestic partner covered by employer's group medical coverage
☐ Medicare/Medicaid/VA
☐ Other — please explain: _____
☐ No coverage

Special Enrollment Rights for Medical Coverage Only (see Booklet or Certificate of Coverage for complete enrollment rights):
If you declined enrollment for yourself or your dependent(s) (including a Spouse) because of other health insurance or group health plan coverage,you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards your coverage or your dependent's other coverage). However, you must request enrollment within 31 days after coverage ends (or after the employer stops contribution toward the other coverage). In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- Either your or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a subsidy (state premium assistance program).

In these cases, you may be able to enroll yourself and your dependents provided that you request enrollment within 60 days of the loss of Medicaid/CHIP
or of the eligibility determination.

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/domestic partner 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/domestic partner covered by employer's group medical coverage
☐ Medicare/Medicaid/VA
☐ Other — please explain: _____
☐ No coverage

Sign here only if you are declining medical, dental and/or vision coverage.

Employee signature	Printed name	Social Security no.*	Date (MMDDYYYY)
X			

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Medical coverage administered by/
dental and vision coverage underwritten by:

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OHIO FARM BUREAU EST. 1919
HEALTH BENEFITS PLAN

Employee Health Questionnaire
Ohio Farm Bureau Health Benefits Plan

Group name						
Employee name	Height	Weight	Age	Social Security no.*	State of residence	Hours worked
Spouse/domestic partner name	Height	Weight	Age	Benefits: ☐ Employee only ☐ Employee/Spouse/domestic partner ☐ Employee/child(ren) ☐ Family		

Dependent 1	Height	Weight	Age	Dependent 2	Height	Weight	Age
Dependent 3	Height	Weight	Age	Dependent 4	Height	Weight	Age
Dependent 5	Height	Weight	Age	Dependent 6	Height	Weight	Age

Please answer the following questions for yourself AND any eligible dependents

Please note that no one will be denied benefits on an individual basis due to answers provided below.

1. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past five years, is currently hospitalized or been advised that medical treatment, diagnostic testing, surgery, or hospitalization is necessary with the exception of AIDS/HIV?
   ☐ Yes ☐ No
   If "Yes", please explain below.
2. Is anyone currently being treated or been advised to seek treatment or counseling for any of the following? . . . . . ☐ Yes ☐ No
   If "Yes ", please check condition(s) that apply.

☐ Cancer	☐ Kidney disorder	☐ Diabetes	☐ Chronic respiratory disease
☐ Chemical dependency	☐ Transplants	☐ Chemical dependency/alcoholism	☐ Muscular disorder
☐ Blood disorders	☐ Heart disease	☐ Brain tumor	☐ Mental illness
☐ Obesity	☐ Crohn's Disease/ulcerative colitis	☐ Back/spinal disorder	☐ Nervous system disorders
☐ High blood pressure	☐ Liver disease	☐ Stroke	

☐ Currently pregnant? If, yes, due date: ____ ☐ Other: _____
If "Yes", please explain below.

3. Do you or your dependents regularly take medication? . . . . . ☐ Yes ☐ No
   If "Yes", please explain below.
4. In the past five years have you or any of your dependents been diagnosed with AIDS or HIV? . . . . . ☐ Yes ☐ No
   If "Yes", please explain below.

Explain "Yes " answer to any question. Give complete details to avoid delay. Attach a separate sheet of paper if necessary.

Question no.	Individual name	Diagnosis	Treatment	Medication	Onset date	Treatment date(s)	Hospitalized	Surgery	Recovered
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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

Employee name: _____ Social Security no.* _____

I represent that all answers on this Questionnaire are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to benefits or premium equivalent rates. Material misrepresentations or significant omissions in this application may result in increased premium equivalent rates, or benefits being denied, rescinded or cancelled.

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 is guilty of insurance fraud.

NOTICE OF INFORMATION PRACTICES: I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by HIPAA Privacy Regulations (45 C.F.R. Parts 160 and 164). I also understand that under the HIPAA Privacy Regulations, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

I understand that the length of time such authorization shall remain valid shall be no longer than 30 months from the date the authorization is signed.

I agree that this executed Questionnaire will become part of the application and any contract issued on it.

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