Hiland Dairy Foods Company, LLC
Medical, Dental & Vision Application

☐ New ☐ Add/Delete Dependent ☐ Open Enrollment Effective Date: ___________________

Anthem BCBS and MetLife Dental provide administrative claims payment services only and do not assume any financial risk or obligation with respect to claims.

Please complete in ink and return to employer. Use extra sheets of paper if necessary.

1. Type of Coverage

Anthem BCBS **Medical** PPO	MetLife **Dental**	MetLife **Vision**
☐ Employee only	☐ Employee only	☐ Employee only
☐ Employee + Spouse	☐ Employee + Spouse	☐ Employee + Spouse
☐ Employee + Child(ren)	☐ Employee + Child(ren)	☐ Employee + Child(ren)
☐ Employee + Family	☐ Employee + Family	☐ Employee + Family
☐ No Coverage	☐ No Coverage	☐ No Coverage

2. Adding to Existing Coverage

Event Date: ________________________

☐ Marriage ☐ Birth
☐ Adoption* ☐ Legal Guardianship*
☐ Name Change*
☐ Other _______________________

*Requires legal documentation

3. Deleting Coverage

Event Date: ____________________

☐ Divorce* ☐ Child's Marriage
☐ Dependent Age Limit ☐ Death
☐ Other _______________________

*Requires legal documentation

A marriage license is required when enrolling a spouse; birth certificates are required for dependent children.

4. Employee Information (please print)

Last Name	First Name and M.I.	Date of Birth	☐ Male ☐ Female	Social Security Number	☐ Single ☐ Divorced ☐ Married
Home Address		City		State	Zip
Telephone Number	Email Address			Occupation	Full Time Hire Date

5. Family Information (Spouse and Dependents – please print)

Dependent 1

Last Name	First Name and M.I.	Date of Birth	☐ Male ☐ Female	Social Security Number	Relationship to Applicant: ☐ Spouse ☐ Son ☐ Daughter ☐ Other (specify)
If dependent's address is different than applicant's address, please provide full address					

Dependent 2

Last Name	First Name and M.I.	Date of Birth	☐ Male ☐ Female	Social Security Number	Relationship to Applicant: ☐ Spouse ☐ Son ☐ Daughter ☐ Other (specify)
If dependent's address is different than applicant's address, please provide full address					

Dependent 3

Last Name	First Name and M.I.	Date of Birth	☐ Male ☐ Female	Social Security Number	Relationship to Applicant: ☐ Spouse ☐ Son ☐ Daughter ☐ Other (specify)
If dependent's address is different than applicant's address, please provide full address					

Dependent 4

Last Name	First Name and M.I.	Date of Birth	☐ Male ☐ Female	Social Security Number	Relationship to Applicant: ☐ Spouse ☐ Son ☐ Daughter ☐ Other (specify)
If dependent's address is different than applicant's address, please provide full address					

Dependent 5					
Last Name	First Name and M.I.	Date of Birth	☐ Male ☐ Female	Social Security Number	Relationship to Applicant: ☐ Spouse ☐ Son ☐ Daughter ☐ Other (specify)
If dependent's address is different than applicant's address, please provide full address					

Dependent 6					
Last Name	First Name and M.I.	Date of Birth	☐ Male ☐ Female	Social Security Number	Relationship to Applicant: ☐ Spouse ☐ Son ☐ Daughter ☐ Other (specify)
If dependent's address is different than applicant's address, please provide full address					

FOR ADDITIONAL DEPENDENTS, PLEASE USE A PIECE OF PAPER AND INCLUDE THE SAME INFORMATION AS LISTED ABOVE.

Significant Terms, Conditions and Authorizations (TERMS) regarding Anthem BCBS

Please read this section carefully before signing the application:

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield administered benefit plan.
2. I authorize deduction from my wages/pension, if necessary for the required payment for the benefit for which I, or any dependents, have applied.
3. I am applying for the benefit selected on this application. If I select a coverage, or combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is/are hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for benefits.
6. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of enrollment. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to benefits or rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my benefits.

Kentucky: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.
Your health benefit plan will be administered by one of the following companies based upon the state in which your employer is located:

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.
In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.
In Ohio: Anthem Blue Cross and Blue Shield is the trade name Community Insurance Company.

Thank you for choosing Anthem Blue Cross and Blue Shield.

6. Read the TERMS section above carefully before signing. Please review your application for errors or omissions.	
By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.	
Applicant Signature	Date Signed

7. Waiver of Medical and Dental Coverage

I certify that I have been given an opportunity to apply for the employer's group health plan benefits, and after careful consideration, have decided not to take advantage of this offer. Reason for waiver of coverage:

- Already protected by coverage of ☐ Spouse ☐ Parent ☐ Other (*specify*) ____________________________
- ☐ No Coverage

In the event I wish to apply for such benefits hereafter, I may do so, subject to established procedures.

If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 30 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group benefit booklet, if a dependent or I are late enrollees. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after the marriage, birth, adoption or placement of adoption.

Applicant Signature	Date Signed