LINDSEY WILSON COLLEGE
ANTHEM HEALTH INSURANCE ELECTION FORM
FOR PLAN YEAR 2024

I hereby elect the following health insurance plan for the 2024 plan year:

☐	Single Core Plan MO	$180.00
☐	Single Buy Up Plan MO	$240.00
☐	Employee & Spouse Core Plan MO	$995.00
☐	Employee & Spouse Buy Up Plan MO	$1,147.00
☐	Employee & Children Core Plan MO	$885.00
☐	Employee & Children Buy Up Plan MO	$1,037.00
☐	Family Core Plan MO	$1,007.00
☐	Family Buy Up Plan MO	$1,159.00
☐	Dual Employee Family Core Plan MO	$593.77
☐	Dual Employee Family Buy Up Plan MO	$745.77

☐	Single Core Plan BW	$90.00
☐	Single Buy Up Plan BW	$120.00
☐	Employee & Spouse Core Plan BW	$497.50
☐	Employee & Spouse Buy Up Plan BW	$573.50
☐	Employee & Children Core Plan BW	$442.50
☐	Employee & Children Buy Up Plan BW	$518.50
☐	Family Core Plan BW	$503.50
☐	Family Buy Up Plan BW	$579.50
☐	Dual Employee Family Core Plan BW	$296.89
☐	Dual Employee Family Buy Up Plan BW	$372.89

☐ I waive participation in the 2024 health insurance plan year.

_____ _____

Print Name Employee ID#

_____ _____

Signature Date

GROUP HEALTH PLANS - EMPLOYEE APPLICATION/WAIVER
LINDSEY WILSON COLLEGE

❑ **NEW ENROLLMENT** ❑**CHANGE ENROLLMENT**

A. EMPLOYEE INFORMATION

LAST NAME | FIRST NAME | MI

PARTICIPANT SSN: ___ - ___ - ____ PARTICIPANT DOB: __ / __ / __

ADDRESS | CITY | STATE

ZIP CODE

PLAN TYPE: ☐ CORE ☐ BUY-UP

GENDER: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐ MARRIED ☐ SINGLE

HIRE DATE: __ / __ / __ Effective Date: _____

Termination Date: _____

B. COVERAGE YOU ARE REQUESTING

☐ EMPLOYEE ONLY ☐ EMPLOYEE & FAMILY

IF ENROLLMENT CHANGE PROVIDE QUALIFYING EVENT: _____

C. FAMILY INFORMATION - ENROLLMENT

SPOUSE: LAST NAME | FIRST NAME | MI

SPOUSE SSN: ___ - ___ - ____ SPOUSE DOB: __ / __ / __

GENDER: ☐ MALE ☐ FEMALE

CHILD: LAST NAME | FIRST NAME | MI

CHILD SSN: ___ - ___ - ____ CHILD DOB: __ / __ / __

GENDER: ☐ MALE ☐ FEMALE

CHILD: LAST NAME | FIRST NAME | MI

CHILD SSN: ___ - ___ - ____ CHILD DOB: __ / __ / __

GENDER: ☐ MALE ☐ FEMALE

CHILD: LAST NAME | FIRST NAME | MI

CHILD SSN: ___ - ___ - ____ CHILD DOB: __ / __ / __

GENDER: ☐ MALE ☐ FEMALE

Are you or any of your Dependents covered by **Medicare**? ☐ Yes ☐ No If yes, complete the information on the right	Name	Reason	Covered by:	Dates became effective	Medicare Numbers
		☐ Over 65 ☐ Disabled ☐ End Stage Renal Disease	☐ Part A ☐ Part B ☐ Part C ☐ Part D	A. ___/___/_____ B. ___/___/____ C. ___/___/____ D. ___/___/____	A. _____ B. _____ C. _____ D. _____
	Name	Reason	Covered by:	Dates became effective	Medicare Numbers
		☐ Over 65 ☐ Disabled ☐ End Stage Renal Disease	☐ Part A ☐ Part B ☐ Part C ☐ Part D	A. ___/___/_____ B. ___/___/____ C. ___/___/____ D. ___/___/____	A. _____ B. _____ C. _____ D. _____

D. PRIOR MEDICAL COVERAGE

1. ARE YOU OR ANY OF YOUR DEPENDENTS INSURED THROUGH ANY OTHER HEALTH INSURANCE PLAN WHILE COVERED UNDER THIS PLAN? ❑ **YES** ❑ **NO** **IF YES**, PLEASE COMPLETE THE FOLLOWING REQUIREMENTS:

2. HEALTH INSURANCE COMPANY		TELEPHONE NO.	
POLICY OR CERTIFICATE NO.		EFFECTIVE DATE	
COVERAGE TYPE	❑ INDIVIDUAL ❑ EMPLOYER SPONSORED	TERMINATION DATE	
LIST ALL COVERED MEMBERS		POLICY HOLDER NAME	

Premium Payment: I authorize my employer to deduct the requested premium contribution from my earnings.

Authorization to Release Information: I hereby authorize any physician or medical practitioner, hospital, or other organization, institution or person that has any medical records or knowledge of me or my family as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition or any and all such information to be given to ARC Administrators or its authorized Administrator or legal representative (including medical review specialists). Any information obtained will not be released by the insurance company except to persons or organizations performing business or legal services in connection with my application or claim, including but not limited to pre-certification of hospital admissions, Continued Stay Review, On-Site Concurrent Review or as may be otherwise lawfully required or as I further authorize. A photocopy of this authorization shall be valid as the original and is valid for thirty (30) months from the date shown below.

U.S. Resident: I understand that the coverage under this plan is available for United States Residents and benefits are not payable for medical expenses outside of the United States except while traveling.

My Answers Are True and Correct: I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all the questions asked. With the exception of health related factors, I understand that my intentional material misstatements or failure to report information may be used as the basis of rescission or termination of coverage for me or my dependents, if any. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any questions; or (c) instruct me not to disclose any particular medical condition on the application. I understand that no agent is authorized or has authority to alter the terms of the Group Master Policy.

❑ **WAIVER OF COVERAGE.** This is to certify that I have been given an opportunity to insure myself and/or my eligible dependents and I have DECLINED such coverage. I understand that 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 and my dependents in this plan, provided that I request enrollment within thirty-one (31) days of my other coverage ending. In addition, if I have a new dependent as a result of marriage, birth, adoption, party in a suit in which the adoption of child by me is sought or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within thirty-one (31) days after the marriage, birth, adoption, party in a suit in which the adoption of child by me is sought or placement for adoption. If I choose to enroll myself or my dependents, at a later date, for a reason other than the special reasons stated herein, I understand that I and/or my dependents may not enroll until my employer's next enrollment period.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is subject to civil and criminal penalties.

E. SIGNATURE

Phone Number: _____ Email Address: _____

_____ Date_____

Signature of Employee and Parent if Applicant is under the age eighteen (18) years

COORDINATION OF BENEFITS QUESTIONNAIRE

NAME	MEMBER PLAN NAME	MEMBER ID NUMBER
MAILING ADDRESS		
CITY	**STATE**	**ZIP CODE**

THIS FORM MUST BE COMPLETED ANNUALLY

YOUR HEALTH BENEFIT PLAN CONTAINS A COORDINATION OF BENEFITS (COB) PROVISION. THIS PROVISION COORDINATES THE BENEFITS YOU OR YOUR DEPENDENTS RECEIVE BY DETERMINING WHICH OF TWO OR MORE BENEFIT PLANS HAS THE PRIMARY RESPONSIBILITY OF PROCESSING AND PAYING A CLAIM AND THE EXTENT TO WHICH OTHER PLANS WILL CONTRIBUTE TOWARD THE COST OF A CLAIM.

TO PROCESS YOUR CLAIMS CORRECTLY WE REQUIRE THE INFORMATION REQUESTED AND APPRECIATE YOUR PROMPT AND ACCURATE REPLY. PLEASE RETURN THIS COMPLETED FORM TO:

MAIL	EMAIL	SECURE FAX
ARC ADMINISTRATORS P.O. BOX 12290 LEXINGTON, KENTUCKY 40582	info@arcsvs.com	(859) 243-0381

IF YOU HAVE ANY QUESTIONS REGARDING THIS QUESTIONNAIRE, COORDINATION OF BENEFITS OR IF THE INFORMATION BELOW CHANGES, PLEASE CONTACT ARC ADMINISTRATORS AT (855) 981-2583.

IN ADDITION TO THIS MEDICAL COVERAGE ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANOTHER HEALTH PLAN?

☐ **NO** PLEASE SKIP THE REMAINDER OF QUESTIONS; SIGN, DATE AND PROMPTLY RETURN THIS FORM

☐ **YES** PLEASE COMPLETE THE ENTIRE FORM; SIGN, DATE AND PROMPTLY RETURN THIS FORM

COORDINATION OF BENEFITS QUESTIONNAIRE

NAME	MEMBER PLAN NAME	MEMBER ID NUMBER

ALL INFORMATION IS REQUIRED

PLEASE INCLUDE A COPY OF YOUR ID CARD (FRONT & BACK) FOR OTHER COVERAGE

OTHER CARRIER NAME	OTHER CARRIER MAILING ADDRESS	OTHER CARRIER PHONE NUMBER
POLICY HOLDER NAME	**POLICY HOLDER DATE OF BIRTH**	**RELATIONSHIP TO YOU**
	______-_______-_______	
GROUP NUMBER	**MEMBER NUMBER**	**COVERAGE TYPE**
		MEDICAL ☐ DENTAL ☐ VISION ☐ PHARMACY ☐
EFFECTIVE DATE OF COVERAGE	**TERMINATION DATE OF COVERAGE**	**IS COVERAGE**
______-_______-_______	______-_______-_______	COBRA ☐ RETIREE ☐ MEDICARE ☐ MEDICAID ☐
WHO IS COVERED	**IS COVERAGE COURT ORDERED**	**IS MEDICARE COVERAGE DUE TO**
YOUR SPOUSE ☐ YOUR CHILDREN ☐	YES (PROVIDE DOCUMENTATION) ☐ NO ☐	DISABILITY ☐ AGE ☐ ESRD ☐
SPOUSE NAME (IF COVERED)	**SPOUSE DATE OF BIRTH**	**IS SPOUSE POLICY HOLDER**
	______-_______-_______	YES ☐ NO ☐
DEPENDENT NAME	**DEPENDENT DATE OF BIRTH**	**RELATIONSHIP TO YOU**
	______-_______-_______	
DEPENDENT NAME	**DEPENDENT DATE OF BIRTH**	**RELATIONSHIP TO YOU**
	______-_______-_______	
DEPENDENT NAME	**DEPENDENT DATE OF BIRTH**	**RELATIONSHIP TO YOU**
	______-_______-_______	
DEPENDENT NAME	**DEPENDENT DATE OF BIRTH**	**RELATIONSHIP TO YOU**
	______-_______-_______	
DEPENDENT NAME	**DEPENDENT DATE OF BIRTH**	**RELATIONSHIP TO YOU**
	______-_______-_______	

IF MEDICARE COVERAGE DUE TO END STAGE RENAL DISEASE (ESRD) PLEASE PROVIDE THE FOLLOWING		
DIALYSIS START DATE	**WHERE DO YOU RECEIVE DIALYSIS**	**IF HOME TRAINING START DATE**
_____-_____-_____	HOME ☐ DIALYSIS CENTER ☐	_____-_____-_____
DATE OF KIDNEY TRANSPLANT	**WAS TRANSPLANT SUCCESSFUL**	**DATE YOU RESUMED DIALYSIS**
_____-_____-_____	YES ☐ NO ☐	_____-_____-_____
WAS THERE A SECOND TRANSPLANT	**WAS SECOND TRANSPLANT SUCCESSFUL**	**DATE YOU RESUMED DIALYSIS**
YES ☐ NO ☐	YES ☐ NO ☐	_____-_____-_____

MEDICARE ADVANTAGE COVERAGE

IF YOU, YOUR SPOUSE OR ANY OF YOUR DEPENDENTS ARE COVERED BY A MEDICARE ADVANTAGE PLAN THIS MUST BE DISCLOSED BECAUSE YOUR ENROLLMENT IN THIS HEALTH PLAN MAY RESULT IN YOU NO LONGER BEING ENROLLED IN THE MEDICARE ADVANTAGE PLAN. THESE PLANS ARE OFTEN PROVIDED BY EMPLOYERS IN CONJUNCTION WITH RETIREMENT BENEFITS.

A MEDICARE ADVANTAGE PLAN IS A HEALTH INSURANCE PROGRAM THAT SERVES AS A SUBSTIUTE FOR "ORIGINAL MEDICARE" PARTS A AND B COVERAGE. THESE TRADITIONAL MEDICARE BENEFITS ARE PROVIDED BY A COMMERCIAL INSURANCE COMPANY BUT ALSO INCLUDE BENEFITS FOR PRESECRIPTION DRUGS, AND OFTEN INCLUDE OFFICE VISIT COPAYMENTS AND OTHER BENEFITS COMMON TO AN INSURANCE PLAN. THESE BENEFITS ARE NOT TYPICALLY PROVIDED BY MEDICARE PARTS A AND B.

MEDICARE ADVANTAGE CAN INCLUDE PRESCRIPTION DRUG COVERAGE AS PART OF THE PLAN AND IS SUBSIDIZED BY THE CENTER FOR MEDICARE SERVICES (CMS).

IF ANYONE IS COVERED BY A MEDICARE ADVANTAGE PLAN IS COVERED ON THIS PLAN PLEASE COMPLETE		
POLICY HOLDER NAME	**EFFECTIVE DATE**	**MEDICARE ADVANTAGE ID NUMBER**
	_____-_____-_____	
POLICY HOLDER NAME	**EFFECTIVE DATE**	**MEDICARE ADVANTAGE ID NUMBER**
	_____-_____-_____	

SIGNATURE: _____

DATE: _____-_____-_____

LINDSEY WILSON COLLEGE HEALTH BENEFIT PLAN

210 Lindsey Wilson Street, Columbia, KY 42728

270-384-7313

Employment Verification form for Spouse

****Any Spouse who is eligible for coverage through his/her own employer is not eligible for coverage from Lindsey Wilson College's health benefit plan.****

SECTION 1: This section to be completed by the participant (employee)

Participant (employee) name: _____ Participant Social Security number: XXX-XX-_____

SECTION 2: This section to be completed and signed by the spouse

Spouse name: _____ Spouse signature: _____

☐ **I am not employed** at this time and if I become employed, I will complete a new "Employment verification form" to terminate coverage for myself as of the date that coverage is available to me through my employer.

☐ **I am employed** at this time and authorize my employer to complete the information on this form.

SECTION 3: This section to be completed by the spouse s emp lo yer

Dear Employer:

Effective January 1, 2014, the Lindsey Wilson College Health Benefit Plan requires spouses to verify whether or not a spouse is eligible for coverage from the plan. For verification purposes, the employer must complete this "Employment Verification form" and return the completed form to the Lindsey Wilson College HR Office.

Please verify the following information:

☐ We **do not offer** medical insurance.

☐ We offer medical insurance but this **employee is not eligible** to enroll because: _____.

☐ We offer medical insurance, and this **employee is eligible to enroll** ___/___/_____in:
- □ Medical (date)
- □ Dental
- □ Vision

☐ We offer medical insurance, and this **employee is enrolled** effective ___/___/_____in:
- □ Medical (date)
- □ Dental
- □ Vision

☐ We offer medical insurance however, this **employee has chosen not to enroll** effective ___/___/_____in:
- □ Medical (date)
- □ Dental
- □ Vision

Company Name: _____

Company Benefits Representative: _____ _____

Name Signature

_____ _____

Telephone Date

Please return this form to: Lindsey Wilson College HR Office
210 Lindsey Wilson Street
Columbia, KY 42728
Or fax: 270 384 7373 Or Email: HR@LINDSEY.EDU

AUTHORIZATION TO VIEW DEPENDENT CLAIMS ONLINE

As a convenience to our participants ARC Administrators has established an online website where participants will be able to log in and view their individual health and dental claims. In addition to the individual participant's claims, upon written consent of the participant's dependents, the participant will be able to view their dependents health and dental claims as well. This authorization only has to be completed and returned to ARC Administrators if the participant wants to be able to view their dependents claims in the online system.

Section 1: This section to be completed by the participant (employee)

Participant (employee) Name:_____

Participant Member ID #:_____

Participant Signature:_____

Section 2: This section to be completed and signed by the spouse

By signing this authorization form I hereby give my spouse permission to view my health and dental claims in the online system.

Spouse Name: _____

Spouse Signature:_____

Section 3: This section to be completed and signed by any other covered dependent over the age of 18

By signing this authorization form I hereby give participant permission to view my health and dental claims in the online system.

Dependent Name:_____

Dependent Signature:_____

Dependent Name:_____

Dependent Signature:_____

Dependent Name:_____

Dependent Signature:_____

Completed Authorizations can be returned to ARC Administrators by the following methods:

Mail to:	Fax to:	Email to:
P.O. Box 12290 Lexington, KY 40582	859-243-0381	eligibility@arcsvs.com

Access to view participant's dependents health claims will not be granted without this completed authorization. If you have questions please contact us at 1-877-309-2955.