

# 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:

<input type="checkbox"/>	Single Core Plan MO	\$180.00
<input type="checkbox"/>	Single Buy Up Plan MO	\$240.00
<input type="checkbox"/>	Employee & Spouse Core Plan MO	\$995.00
<input type="checkbox"/>	Employee & Spouse Buy Up Plan MO	\$1,147.00
<input type="checkbox"/>	Employee & Children Core Plan MO	\$885.00
<input type="checkbox"/>	Employee & Children Buy Up Plan MO	\$1,037.00
<input type="checkbox"/>	Family Core Plan MO	\$1,007.00
<input type="checkbox"/>	Family Buy Up Plan MO	\$1,159.00
<input type="checkbox"/>	Dual Employee Family Core Plan MO	\$593.77
<input type="checkbox"/>	Dual Employee Family Buy Up Plan MO	\$745.77

<input type="checkbox"/>	Single Core Plan BW	\$90.00
<input type="checkbox"/>	Single Buy Up Plan BW	\$120.00
<input type="checkbox"/>	Employee & Spouse Core Plan BW	\$497.50
<input type="checkbox"/>	Employee & Spouse Buy Up Plan BW	\$573.50
<input type="checkbox"/>	Employee & Children Core Plan BW	\$442.50
<input type="checkbox"/>	Employee & Children Buy Up Plan BW	\$518.50
<input type="checkbox"/>	Family Core Plan BW	\$503.50
<input type="checkbox"/>	Family Buy Up Plan BW	\$579.50
<input type="checkbox"/>	Dual Employee Family Core Plan BW	\$296.89
<input type="checkbox"/>	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?  <input type="checkbox"/> Yes  <input type="checkbox"/> No  If yes, complete the information on the right	Name	Reason	Covered by:	Dates became effective	Medicare Numbers
		<input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> Part D	A. ___/___/___ B. ___/___/___ C. ___/___/___ D. ___/___/___	A. _____ B. _____ C. _____ D. _____
	Name	Reason	Covered by:	Dates became effective	Medicare Numbers
		<input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part C <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO      IF YES, PLEASE COMPLETE THE FOLLOWING REQUIREMENTS:			
2. HEALTH INSURANCE COMPANY		TELEPHONE NO.	
POLICY OR CERTIFICATE NO.		EFFECTIVE DATE	
COVERAGE TYPE	<input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> 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: \_\_\_\_\_

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



## 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

ARC ADMINISTRATORS  
P.O. BOX 12290  
LEXINGTON, KENTUCKY 40582

#### EMAIL

info@arcsvs.com

#### SECURE FAX

(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 <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION <input type="checkbox"/> PHARMACY <input type="checkbox"/>
EFFECTIVE DATE OF COVERAGE	TERMINATION DATE OF COVERAGE	IS COVERAGE
_____ - _____ - _____	_____ - _____ - _____	COBRA <input type="checkbox"/> RETIREE <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/>
WHO IS COVERED	IS COVERAGE COURT ORDERED	IS MEDICARE COVERAGE DUE TO
YOUR SPOUSE <input type="checkbox"/> YOUR CHILDREN <input type="checkbox"/>	YES (PROVIDE DOCUMENTATION) <input type="checkbox"/> NO <input type="checkbox"/>	DISABILITY <input type="checkbox"/> AGE <input type="checkbox"/> ESRD <input type="checkbox"/>
SPOUSE NAME (IF COVERED)	SPOUSE DATE OF BIRTH	IS SPOUSE POLICY HOLDER
	_____ - _____ - _____	YES <input type="checkbox"/> NO <input type="checkbox"/>
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 HOME <input type="checkbox"/> DIALYSIS CENTER <input type="checkbox"/>	IF HOME TRAINING START DATE ____-____-____
DATE OF KIDNEY TRANSPLANT ____-____-____	WAS TRANSPLANT SUCCESSFUL YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE YOU RESUMED DIALYSIS ____-____-____
WAS THERE A SECOND TRANSPLANT YES <input type="checkbox"/> NO <input type="checkbox"/>	WAS SECOND TRANSPLANT SUCCESSFUL YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE YOU RESUMED DIALYSIS ____-____-____

**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 SUBSTITUTE FOR “ORIGINAL MEDICARE” PARTS A AND B COVERAGE. THESE TRADITIONAL MEDICARE BENEFITS ARE PROVIDED BY A COMMERCIAL INSURANCE COMPANY BUT ALSO INCLUDE BENEFITS FOR PRESCRIPTION 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 employer**

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:  
P.O. Box 12290  
Lexington, KY 40582

Fax to:  
859-243-0381

Email to:  
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.