



Exceptions to Standard Enrollment/ Translator's Statement

Name of Applicant	Social Security or ID No.
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The applicant must complete the appropriate section below that applies to their enrollment.

This form must be submitted with the Small Group Employer Application, and other required documents when applicable.

PART A – Small Group Employee Application over 60 days old

Purpose: To allow applicants to certify that the health status as submitted on the application has not changed since submission.

I, _____, certify that the submitted health status of myself and all listed dependents remains the same as shown on my application dated: ___/___/___.

If there have been any changes, please submit a new application.

Signature of Subscriber X	Date (Required)	Signature of Subscriber X	Date (Required)
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This does not apply to applications with signature dates older than six months. New applications will be required.

PART B – Statement of Accountability

(To be used when the Applicant cannot complete the application because of the reason(s) indicated below.)

I, (translator's name) _____, hereby warrant to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company that I completed the attached Small Group Employee Applications of the employee listed below because he/she did not speak enough English to complete the forms themselves. I further warrant to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company that I fully and clearly explained each item and question on the form to the employee before I entered the employee's response and that I am fluent in the language of the employee and qualified to explain the form and understand the employee's answers, and that he/she clearly and unambiguously told me that he/she understood each question and item.

I have also reviewed and explained this statement to each employee listed below, and I warrant that he/she has clearly and unambiguously told me that he/she understands both this translator's statement and that any misstatements or omissions may result in future claims being denied and/or the policy being rescinded.

Employees whose applications were completed by me:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Print Name	Title
Signature X	Date (Required)

EMPLOYER'S STATEMENT

The translator's statement above is correct to the best of my knowledge and belief. I understand that coverage may be rescinded should it be determined at a future date that there are misstatements in these application forms.

Signature (Company Officer) X	Title	Date
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IMPORTANT: The validity of this information is subject to the same conditions of application as those signed on ___/___/___ and will become part of the agreement between Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, and the above-listed member(s).

This addendum to your original application will be kept on file with Anthem Blue Cross.