Anthem Individual Enrollment/ Change Application

P.O. Box 14024
Roanoke, VA 24038-4024
www.anthem.com
Fax No. : 1-888-449-4807

To Be Completed By Agent/Producer

Producer Name ____________
Vendor Code # ____________
Producer Signature ____________
Producer Phone # ____________
Effective Date ____/____/____

For Office Use Only
Firm Division No.
U/W Rate Decision

Remember to Complete All Sections of this Application

PLEASE USE BLACK OR BLUE INK ONLY

1. Applicant Information

Please check appropriate item:
☐ **New Enrollment** ☐ **Change – Policy No.** ____________ ☐ **Add/Remove Dependent – Policy No.** ____________

Effective Date — If your application is approved, your coverage can start on any day of the month after the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.

Please choose the date you would like your coverage to start: ____/____/____ **MM/DD/YYYY**

NAME (LAST/FIRST/MIDDLE INITIAL)			HOME ADDRESS (NUMBER AND STREET)
Male / Female	DATE OF BIRTH MO. | DAY | YR.	SOCIAL SECURITY NUMBER	CITY/STATE/ZIP CODE
TELEPHONE NUMBERS HOME: WORK:			BILLING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)
EMAIL ADDRESS			CITY/STATE/ZIP CODE

2. Medical Coverage

Anthem will enroll all eligible family members unless otherwise instructed below.

☐ I, the Applicant, request that Anthem not enroll any eligible applicants unless ALL family members qualify.

Plan Name, In Network Coinsurance, Deductible Options | **Optional Benefits**

Select ONE Plan...then select ONE Deductible and any optional benefits.

☐ **Anthem Premier PPO**

(20% coinsurance)	☐ $500	☐ $1,500	☐ $2,500
(0% coinsurance)	☐ $2,500	☐ $3,500	☐ $5,000
	☐ $7,500	☐ $10,000	

☐ **Anthem SmartSense PPO** — ☐ **Enhanced Drug Benefit Rider**

(50% coinsurance)	☐ $2,500	☐ $3,500		
(30% coinsurance)	☐ $750	☐ $1,500	☐ $2,500	☐ $3,500
	☐ $5,000	☐ $7,500		
(0% coinsurance)	☐ $10,000	☐ $12,000		

HSA Compatible Plans

Select ONE Plan...then select ONE Deductible and any optional benefits.

☐ **Lumenos Health Savings Account Plus PPO**

Single

(20% coinsurance)	☐ $1,500	☐ $2,000	☐ $4,000
(0% coinsurance)	☐ $2,500	☐ $4,000	☐ $5,950

Family (more than one applicant)

(20% coinsurance)	☐ $3,000	☐ $4,000	☐ $8,000
(0% coinsurance)	☐ $5,000	☐ $8,000	☐ $11,900

☐ **Yes,** I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Anthem's banking partner. (Please fill in your social security number in Section 1.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Anthem's banking partner.

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3. Dependent Information

NAME (LAST/FIRST/MIDDLE INITIAL)	Add	Delete	Social Security Number	Sex	Date of Birth (mm/dd/yy)	Relationship to Applicant
Additional Adult (Spouse, Domestic Partner)			___ __ ____	☐ M ☐ F		
Dependent 1			___ __ ____	☐ M ☐ F		
Dependent 2			___ __ ____	☐ M ☐ F		
Dependent 3			___ __ ____	☐ M ☐ F		

☐ Yes ☐ No Are all applicants listed on this application legal residents of the United States and residents of the state in which you are applying for coverage?

If NO, who? ______

☐ Yes ☐ No Are all applicants listed on this application United States citizens?

If NO, who? ______

and how many months/years have they resided in the United States? ______years and ______months

4. Prior and Other Insurance Information - Please answer ALL of the following questions.

(A) Do you have any other health insurance policy or certificate in force? ☐ Yes ☐ No
(B) Have you had coverage within 120 days of the application? ☐ Yes ☐ No

If you answered "Yes" to A or B, please provide the following information:

Name of Other Insurance Company ______

Policy Number ______ Type of Coverage ☐ Group ☐ Individual Last Date of Coverage______

If the answer to question (A) is yes, do you intend to replace your current medical or health policy with the policy? ☐ Yes ☐ No

A completed, signed Health Statement must be enclosed with this completed, signed application. Important: Please attach copies of any certification or other documentation of prior creditable coverage furnished by previous carriers or employers, if available. This will help us process your application.

ANTHEM INDIVIDUAL PRODUCTS ARE ISSUED ON AN INDIVIDUAL BASIS AND ARE REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN.

I acknowledge receipt of an outline of coverage provided by the policy checked above. I certify that neither I nor any family member listed is eligible for Medicare. I understand the following: (a) that all coverage and services are subject to the Exclusions, Limitations and Conditions of the Subscriber Agreement or other Evidence of Coverage document: (b) that no benefits will apply until I receive written approval and confirmation of effective date, and my first month's paid premium has been processed by, Anthem Blue Cross and Blue Shield and; (c) that I will be responsible for notifying the Company of any change in dependent status or change of address. I understand that any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact may result in rescission of coverage and/or nonpayment of claims for myself or my dependents. I certify that my statements in this form and the attached Health Statement are true and complete to the best of my knowledge and belief.

5. Applicant's Signature
(if applicant is under 18, parent or guardian signature required.) ______ Date: / /

Other Adult's Signature
(covered person 18 or older) ______ Date: / /

6. Authorization for Use of Protected Health Information

The following authorization must be signed by all of the following persons if they are applying for coverage or changing existing coverage:

- the applicant;
- the applicant's spouse or domestic partner; and
- any Dependent Child age 18 or over.

If the authorization is not signed by all of the persons listed above who are seeking coverage, the application may be returned to you as incomplete or acted upon without regard to any person whose required signature was not included. This Authorization will expire 24 months following Anthem Blue Cross and Blue Shield's acceptance of coverage, if not previously revoked.

By signing below:

I authorize Anthem Blue Cross and Blue Shield, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield, to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, MIB, Inc., formerly Medical Information Bureau (MIB), and/or insurance support organizations. I further authorize Anthem Blue Cross and Blue Shield to disclose protected health information it may collect about me to MIB, for the MIB information exchange. MIB may re-disclose such information to other insurance companies pursuant to the MIB information exchange.

I also authorize any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans, medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations to furnish any medical records or health history information concerning me and any family member listed on my Application to Anthem Blue Cross and Blue Shield, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield. This information is needed to determine eligibility for coverage and Anthem Blue Cross and Blue Shield's acceptance of coverage requested for myself and/or any family members listed on my Application or so that a determination of coverage regarding a claim for specified benefits can be made.

This authorization is subject to revocation at any time by written notice to Anthem Blue Cross and Blue Shield, except to the extent that Anthem Blue Cross and Blue Shield has already taken action in reliance on this authorization. Any information received by Anthem Blue Cross and Blue Shield, pursuant to this authorization is subject to restrictions on disclosure to others as set forth under Federal and state laws.

IF LISTED ON YOUR APPLICATION, YOUR SPOUSE/DOMESTIC PARTNER AND EACH DEPENDENT CHILD OVER AGE 18 MUST SIGN BELOW.

SIGN HERE

Printed name of Applicant	Signature of Applicant* or Legal Representative X	Date of Birth / /	Date Signed / /
Printed name of Spouse or Domestic Partner	Signature of Spouse or Domestic Partner or Legal Representative X	Date of Birth / /	Date Signed / /
Printed name of Dependent Child over 18	Signature of Dependent Child over 18 X	Date of Birth / /	Date Signed / /
Printed name of Dependent Child over 18	Signature of Dependent Child over 18 X	Date of Birth / /	Date Signed / /

(or Custodial Parent's or Guardian's signature if applicant is under age 18)

A photocopy of this form will be as valid as the original.
You or an authorized representative have the right to receive a copy of this Authorization upon request.

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CONNECTICUT
INDIVIDUAL MARKETS HEALTH
STATEMENT

APPLICANT AND FAMILY INFORMATION

PLEASE USE BLACK OR BLUE INK ONLY

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

PART A
COMPLETE FOR YOU AND ANY FAMILY MEMBERS APPLYING FOR COVERAGE

	FIRST NAME	INITIAL	LAST NAME	HEIGHT	WEIGHT	DATE OF BIRTH	SEX M/F	SOCIAL SECURITY #
APPLICANT				/		/ /		
SPOUSE				/		/ /		
DEPENDENT				/		/ /		
DEPENDENT				/		/ /		
DEPENDENT				/		/ /		
DEPENDENT				/		/ /		

PART B

	YES	NO
1. IS ANY PERSON TO BE INSURED ELIGIBLE FOR MEDICARE?	☐	☐
2. HAS ANYONE HAD HEALTH OR LIFE INSURANCE MODIFIED, POSTPONED OR RATED? PLEASE SUBMIT DETAILS ____	☐	☐

PART C

	YES	NO
1. Are you or your spouse or any dependent to be insured currently disabled or unable to perform their normal activities?	☐	☐
2. Have you or any dependent to be insured been hospitalized, had surgery or been advised to have surgery within the past 5 years for any reason?	☐	☐
3. Are you or any dependent to be insured currently pregnant, or an expectant parent?	☐	☐
4. Are you or any dependents currently taking any medication? If yes, please specify medication and condition for which it is used:________________________	☐	☐
5. Do you or any dependents have any conditions or symptoms for which a physician or other medical care provider has not been consulted?	☐	☐
6. Have you or any dependent had medical expense in excess of $5,000 in the last 12 months?	☐	☐
7. Have you, your spouse or any dependent used tobacco products within the past 12 months?	☐	☐

If cigarettes, please list the name of each applicant and how many cigarettes they smoke per day.

____

PART D

1. Have you or any dependent to be insured ever had or been told they had, or been medically counseled, consulted or treated for any of the following? (Check **yes** or **no** and **circle the disorder**)

		YES	NO
A.	Chest pain, heart attack, heart murmur, heart trouble, rapid slow or irregular heartbeat, other diseases of the heart, circulatory system or blood vessels, varicose veins, phlebitis, anemia or other disorder of the blood?	☐	☐
B.	Cancer, tumor or lymph node enlargement? Indicate type of cancer and location ____________________	☐	☐
C.	Sexually transmitted disease?	☐	☐
D.	Mental, emotional, nervous disorder, depression, anxiety, psychotherapy or counseling of any kind?	☐	☐
E.	Brain disorder, neurologic problems, seizure disorder, any disorder of the central nervous system, stroke or paralysis?	☐	☐
F.	Alcohol or drug use, abuse and/or dependency?	☐	☐
G.	Medical diagnosis of AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex)?	☐	☐
H.	Any disorder of the male/female reproductive organs including infertility and complications of pregnancy?	☐	☐
I.	Back, neck, bone, joint problems, Lupus, arthritis or autoimmune disorder?	☐	☐
J.	Diabetes? If so, specify date of diagnosis, type of treatment, amount of medications (if any): ____________________	☐	☐
K.	Any disorder of the stomach, intestines, gallbladder or esophagus?	☐	☐
L.	Any disorder of the lungs or respiratory system or Tuberculosis?	☐	☐
M.	Any disorder of the kidneys, bladder or urinary tract?	☐	☐
N.	Any disorder of the liver or pancreas?	☐	☐
O.	Any disorder of the endocrine system or glands?	☐	☐

PART E

Within the last two years have you or any dependent to be insured ever had, been told they had, consulted or treated for any of the following:

	YES/NO			YES/NO			YES/NO	
a. Asthma	☐	☐	d. Ear problems	☐	☐	g. Lyme Disease	☐	☐
b. Bronchitis	☐	☐	e. Eye problems	☐	☐	h. Nose/Throat/Sinus problems	☐	☐
c. Chiropractic Care	☐	☐	f. Headaches/Migraines	☐	☐	i. Skin problems/Allergies	☐	☐

PART F

	YES	NO
Have you or any dependent had an examination or treatment for any illness or injury other than those stated above?	☐	☐

GIVE DETAILS ON THE FOLLOWING QUESTIONS BELOW.

Simply listing the name of a primary physician or referring to a physician's name will not be considered a substitute for listing full detailed answers to the questions on this and the previous page.

If you checked (✓) yes to any question, please provide a complete explanation in Part G below.

PART G

DETAILS TO HEALTH HISTORY

If more space is needed, attach separate page which must be signed and dated.

Question Number	Person Affected	Condition/Diagnosis	Treatment (Surgeries/Medications)	Treatment Dates from/to	Date of Full Recovery	Name, Address, Phone Number of Physician, Hospital/Institution
				_________		
				_________		
				_________		
				_________		
				_________		
				_________		
				_________		

I hereby represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief, and understand these said answers and statements form the basis upon which insurance will be made effective. I understand that any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact about medical history could result in the denial of an otherwise valid claim and rescission, voiding or reformation of insurance.

Date__________Applicant Signature____

(If applicant is under 18, parent or guardian signature is required.)

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Payment Methods for Individual Health Coverage
Connecticut

Anthem®

Please complete in blue or black ink.

Applicant / Member Name (Please Print):	**Primary Applicant's Social Security Number:**

INITIAL PREMIUM PAYMENT IS REQUIRED WITH APPLICATION. PLEASE CHOOSE ONE:

- ☐ Automatic Bank Payment (complete Section A). **If you choose this option, you must also select the Automatic Bank Payment option for future premiums.**
- ☐ Check or Money Order attached (make payable to Anthem Blue Cross and Blue Shield)*

*When you provide a check as payment, you authorize us to either use the information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic fund transfer, funds will be withdrawn from your account as soon as the day of approval, and you will not receive your check back from your financial institution.

FUTURE PREMIUM PAYMENTS

Method of payment (you must select one):

- ☐ Monthly Automatic Bank Payment
  (You must complete Section A)
- ☐ Bill me monthly for future premiums.

A. Automatic Bank Payment – If you have selected this option for your initial payment, your bank account may be debited the applicable month's premium as soon as the day of approval. I hereby authorize Anthem Blue Cross and Blue Shield to initiate a withdrawal on or about the 5th business day of each month from the bank account named below. NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Automatic Bank Payment and will be billed monthly.

- ☐ Checking Account
- ☐ Savings Account **(account number will be different than that of checking account)**. Check with your financial institution to be sure automatic recurring deductions are allowed against this account.

Provide your Bank Account Information here:

9-Digit Bank Routing Number	Bank Account Number
|___|___|___|___|___|___|___|___|___|	

I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions (and corrections to premium deductions) from the bank account indicated, and the designated financial institution to debit the same account. **I understand that the initial premium amount may vary as a result of change(s) during the underwriting process and that following premium amounts may vary as a result of change(s) I make once enrolled.** These may include, but are not limited to, adding and deleting dependents or moving my residence. I understand that Anthem's rights with each premium deduction are the same as if I submit a check signed by me. This authorization is in effect until I provide Anthem thirty (30) days written notice that I no longer desire this service, and Anthem and the designated financial institution have the right to discontinue the premium deductions if they wish to do so. **I also understand that a service charge may be incurred for any withdrawal not honored.**

Authorized Signature (as it appears on the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

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