Colorado Individual Enrollment Application

Anthem BlueCross BlueShield

Anthem Blue Cross and Blue Shield
P.O. Box 9041
Oxnard, CA 93031-9041

Please make sure you have completed the PRESCREENING QUESTIONNAIRE process before you proceed with this application. If you need to locate the questionnaire, please visit Anthem.com.

IMPORTANT: PREMIUM PAYMENT IS REQUIRED TO BE SUBMITTED WITH YOUR APPLICATION. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. Applications received with no premium payment will be returned which may impact your eligibility for coverage. If you have any questions, please call 1-877-373-9821.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one): ☐ New Coverage ☐ Change Anthem Individual policy coverage - Policy No. _____ ☐ Add dependent(s) to current coverage - Policy No. _____

Effective date requested: 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**

NOTE: If you are adding a dependent or changing coverage, the effective date will always be the first of the month following approval.

FamilyElect℠ Option: If you want one medical plan for ALL family members, please select a plan in **Section E** on page 2. If you want to select a different medical plan for each family member, see Section E for the 4-digit **Medical Plan Code** in parentheses and indicate below in Sections B, C & D.

PLEASE NOTE - A dependent child under the age of 19 must choose the same plan as the parent/legal guardian over the age of 19.

Section B – Applicant Information (Please print.)

Last Name	First Name	MI	Social Security Number*			**Medical Plan Code**	
Home Address (street and P.O. Box if applicable)			City			State	ZIP
Billing Address (street and P.O. Box if different from above)			City			State	ZIP
Marital Status ☐ Single ☐ Married ☐ Domestic Partner	Maiden Name (if applicable)		Height (Ft./In.) /	Weight (Lbs.)	Sex ☐M ☐F	Age	Date of Birth (mm/dd/yyyy) / /
Daytime Phone Number ( )	Evening Phone Number ( )		Fax Number ( )			Email*	

Provide your communication method of choice for all underwriting correspondence during the review of your application: ☐ Email ☐ Fax ☐ Mail

Language Choice (Optional) ☐ English ☐ Spanish

Do you read and write English? ☐ Yes ☐ No
If NO, the translator must sign and submit a Statement of Accountability (Section N)

Section C – Spouse or Domestic Partner Information

Last Name	First Name	MI	Social Security Number*			**Medical Plan Code**	
Relationship ☐ Spouse ☐ Domestic Partner	Maiden Name (if applicable)		Height (Ft./In.) /	Weight (Lbs.)	Sex ☐M ☐F	Age	Date of Birth (mm/dd/yyyy) / /

Language Choice (Optional) ☐ English ☐ Spanish

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary.)

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your children, or your spouse or domestic partner's children, or a child subject to legal guardianship (to the end of the calendar month in which they turn 26). (List all dependents beginning with the eldest.)

First, MI (last name if different)	Social Security Number*	Sex	Age	Date of Birth (mm/dd/yyyy)	Height Ft. / In.	Weight Lbs.	**Medical Plan Code**
		☐M ☐F		/ /	/		
		☐M ☐F		/ /	/		
		☐M ☐F		/ /	/		

☐ **Yes** ☐ **No** Has any person listed on this application lived (not traveled) outside the U.S. for the past three (3) consecutive months?
If YES, who? _____

☐ **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

** This information is used for internal purposes only.*

Agent Name/TIN

Section E – Medical Coverage (Select ONE plan, then select ONE deductible and any optional riders.)

If you want one medical plan for all family members, please select a box below.

Family members 19 years of age and older may select a different medical plan/policy by using the FamilyElect℠ option. To do so, refer to the 4-digit medical plan codes in parentheses below and indicate your medical coverage choices in Sections B, C & D on page 1 for each family member. **PLEASE NOTE** - A dependent child under the age of 19 must choose the same plan as the parent/legal guardian over the age of 19.

For Tonik plans, applicants must be age nineteen (19) or older and each applicant will be enrolled on his/her own policy.

Anthem Blue Cross and Blue Shield will enroll all eligible family members unless otherwise instructed. If you do not desire this, check the box below.

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

Tonik	☐ 5000 (068R)		
CoreShare Plus	☐ 750 - 50% w Facility Copay (065R)	☐ 1500 - 50% w Facility Copay (065S)	☐ 2500 - 50% w Facility Copay (065T)
	☐ 3500 - 50% (065U)	☐ 5000 - 50% (065V)	☐ 7500 - 50% (065W)
ClearProtection	☐ 1000 - 70% (01HA)	☐ 3300 - 70% (01HB)	☐ 5000 - 70% (01HC)
SmartSense Plus	☐ 1000 - 70% w Standard (01GF)	☐ 1000 - 70% w Rx Upgrade (01GG)	☐ 2000 - 70% w Standard (01GH)
	☐ 2000 - 70% w Rx Upgrade (01GJ)	☐ 3500 - 70% w Standard (01GK)	☐ 3500 - 70% w Rx Upgrade (01GL)
	☐ 6000 - 70% w Standard (01GM)	☐ 6000 - 70% w Rx Upgrade (01GN)	
Premier	☐ 1000 - 75% (01GP)	☐ 1500 - 75% (01GQ)	☐ 2500 - 75% (01GT)
	☐ 3500 - 75% (01GU)	☐ 5000 - 75% (01GV)	☐ 6000 - 75% (01GW)
HSA Compatible Plans			
Lumenos HSA Plus - Individual Policy	☐ 3000 - 100% (0LJW)	☐ 4500 - 100% (0LJX)	☐ 5950 - 100% (0LJY)
Lumenos HSA Plus - Family Policy	☐ 3500 - 100% (01H3)	☐ 5500 - 100% (01H5)	☐ 7500 - 100% (01H7)
	☐ 11,900 - 100% (01H8)		

☐ Yes, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Anthem will provide your information to Anthem's banking partner. (Please fill in your social security number in section B.)

☐ No, I DO NOT want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above.

Other To apply for a plan/policy not listed, write in the name here:

☐ _____

Section F – Dental Coverage Selection

PPO Plan ☐ Anthem Blue Individual PPO Dental Plan (DE12)

Enhanced Tonik Dental ☐ PPO Dental (DR54)

☐ YES, I wish to add dental coverage (at an extra cost per individual). If YES, select coverage type (applies to individuals listed on this application only):

☐ Applicant ☐ Spouse or Domestic Partner ☐ All Children ☐ Selected Children: _____

☐ If myself or any listed family members are declined for medical coverage, still enroll **all members selected above.**

Section G – Anthem Life Insurance Company's Term Life Insurance

☐ YES, in addition to my medical coverage, I wish to apply for term life insurance (at an extra cost per individual).

Do you, the applicant, own an existing life policy or annuity contract? ..... ☐ Yes ☐ No

If you answered "Yes" to the above question, inform the agent with whom you are working (if any), who will provide you an "Important Notice: Replacement of Life Insurance...."

By applying for this proposed life policy, do you intend to replace, discontinue or change any existing life policy? ..... ☐ Yes ☐ No

Provide information below. Applicants must meet Anthem Life Insurance Company's underwriting guidelines to qualify for term life insurance coverage. Applicants under the age of one year are not eligible for life insurance. All term life policies terminate on the month you turn age 65.

Applicants	Coverage Amount (select one)	Beneficiary**	Relationship	Beneficiary Street Address City/State/ZIP
☐ Applicant	☐ $15,000 (BV79) ☐ $75,000 (DZ07)* ☐ $25,000 (CV30) ☐ $100,000 (DZ08)* ☐ $50,000 (CV29)*	Primary:		
		Contingent:		
☐ Spouse ☐ Domestic Partner	☐ $15,000 (BV79) ☐ $75,000 (DZ07)* ☐ $25,000 (CV30) ☐ $100,000 (DZ08)* ☐ $50,000 (CV29)*	Primary:		
		Contingent:		
☐ All Children	☐ $15,000 (BV79) ☐ $75,000 (DZ07)* ☐ $25,000 (CV30) ☐ $100,000 (DZ08)* ☐ $50,000 (CV29)*	Primary:		
		Contingent:		
☐ Selected Children _____ _____	☐ $15,000 (BV79) ☐ $75,000 (DZ07)* ☐ $25,000 (CV30) ☐ $100,000 (DZ08)* ☐ $50,000 (CV29)*	Primary:		
		Contingent:		

DO NOT SUBMIT PREMIUM FOR ANY LIFE INSURANCE – IF ACCEPTED YOU WILL BE BILLED.

* Amounts above $25,000 are not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to $25,000.

** **If a beneficiary is not listed** and a policy is issued, death benefits will be paid in accordance with the Beneficiary Provision of the Policy.

Section H – The Health Insurance Portability and Accountability Act (HIPAA)

If you can answer YES to all of the following statements, you may meet the definition of a "federally eligible individual" and be considered HIPAA eligible.

	YES	NO
1. I have had in the past 18 months, creditable coverage, the most recent of which was under a group health plan (including a government plan or church plan).	☐	☐
If YES, please provide group name _____ and telephone number _____		
2. I am NOT eligible for coverage under a group health benefit plan, Medicare or Medicaid and do NOT have other health benefit plan coverage.	☐	☐
3. My most recent coverage was NOT terminated as a result of nonpayment of premium or fraud.	☐	☐
4. If offered, I accepted continuation coverage and exhausted such benefits (i.e., State Continuation Coverage or COBRA).	☐	☐
Date State Continuation or COBRA coverage ended: _____/_____/_____ MM/DD/YYYY		
Do you or anyone on this application qualify for HIPAA?	☐	☐

If YES, list name(s) of qualified applicant(s):

1) _____ 2) _____ 3) _____ 4) _____

Section I – Employer Funded Insurance

1. Will an employer of fifty (50) or fewer eligible employees be paying for or reimbursing any applicant through wage adjustment, a health reimbursement arrangement or otherwise for any portion of the premium on the policy being applied for? ☐ Yes ☐ No

If you answered "No", you may stop and continue to Section J of this application.

2. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve months prior to the date of this application? ☐ Yes ☐ No

If the answer to question 1 is "Yes," the applicant cannot be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

Although the policy being applied for cannot be funded by an employer, the applicant may still be eligible for coverage paid for himself or herself. If the applicant wishes to apply for an individual policy of insurance where the applicant will pay the premiums, the applicant should continue completing the rest of the application and answer question 3.

3. Do you agree to apply for an individual policy of insurance and pay all the premiums without the financial assistance of your employer? ☐ Yes ☐ No

Section J – Other Health Coverage (Please answer ALL of the following questions.)

Anthem Blue Cross and Blue Shield credits prior coverage toward the pre-existing period for applicants who apply and are accepted for coverage and who request an effective date within 90 days after termination of qualifying prior coverage as required by law. Pre-existing condition limitations do not apply to applicants under the age of nineteen (19), if applying for non-grandfathered coverage. To obtain credits for the pre-existing period, please complete the following:

	YES	NO
Have you had coverage in the last 90 days?	☐	☐
Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation	☐	☐

If YES, give name and reason: _____

_____

_____ Start date of coverage: _____/_____/_____ End date of coverage: _____/_____/_____

Replacement Coverage Information

To the best of your knowledge:

a) Do you have another insurance policy or contract in force?	☐	☐
If YES, with which company? _____ If YES, do you intend to replace your current accident and sickness insurance with this contract?	☐	☐
b) Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy?	☐	☐
If YES, with which company? _____ What kind of policy? _____		
c) Are you covered for medical assistance through the state Medicaid program?	☐	☐
As a Specified Low Income Medicare Beneficiary (SLMB)?	☐	☐
As a Qualified Medicare Beneficiary (QMB)?	☐	☐
For other Medicaid medical benefits?	☐	☐

- You normally do not require more than one policy.
- If you purchase this policy, you may want to evaluate your existing health care coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplement policy.
- If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program.

If you answered "YES" to any of the above, please provide the following information:

Certificate/Policyholder Number	Plan Name	State	Most Recent Coverage Start Date / /	Type of Policy
Applicant Names			Date Policy Paid Through / /	
Certificate/Policyholder Number	Plan Name	State	Most Recent Coverage Start Date / /	Type of Policy
Applicant Names			Date Policy Paid Through / /	

Section K – Health History - For Each Family Member (IMPORTANT: This section has two steps)

STEP 1 - ***All questions must be answered or the application will be returned.***

GIVE COMPLETE DETAILS IN STEP 2 FOR ALL SELECTED CHECK BOXES OTHER THAN THE "NO TO ALL" CHECK BOXES FOR QUESTIONS 1 - 14 BELOW.

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.

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. We are relying on the information you provide to determine whether you are eligible for coverage. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician(s) to clarify your specific condition. We have the right to review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, do not assume we will review all of your medical records before approving your application. If we issue coverage to you and then discover an act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact, we may rescind your coverage, even after it has been issued. This means that you may lose your health benefits including coverage for treatment already received. Rescission may occur even if we review your medical records or seek medical confirmation of your health information as part of processing your application. Even if you currently have health insurance coverage or had prior coverage with Anthem Blue Cross and Blue Shield, you must fully disclose and answer all health history questions.

PLEASE NOTE: The health history questions apply to ANY medical advice, diagnosis, care or treatment that you received or that a healthcare provider recommended that you receive for any of the conditions listed.

1. Bone, Joint and Muscle Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Arthritis (osteo-, rheumatoid or other)
- ☐ B. Back, neck, muscle, disc or tendon problems
- ☐ C. Bursitis
- ☐ D. Gout
- ☐ E. Fibromyalgia
- ☐ F. Osteopenia
- ☐ G. Ankylosing Spondylitis
- ☐ H. Osteoporosis
- ☐ I. TMJ (Temporomandibular Joint) disorder
- ☐ J. Other bone, joint or muscle problems
- ☐ K. **NO to all bone, joint and muscle problems**

2. Brain and Nerve Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Headaches requiring prescription medication
- ☐ B. Migraines
- ☐ C. MS (Multiple Sclerosis)
- ☐ D. Alzheimer's Disease or Dementia
- ☐ E. Muscular Dystrophy
- ☐ F. Parkinson's Disease
- ☐ G. Paralysis
- ☐ H. Seizures or convulsions
- ☐ I. Head Injury
- ☐ J. Stroke or Transient Ischemic Attack (TIA)
- ☐ K. Other brain or nerve problem
- ☐ L. **NO to all brain and nerve problems**

3. Breathing or Lung Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Asthma
- ☐ B. Bronchitis
- ☐ C. COPD (Chronic Obstructive Pulmonary Disorder)
- ☐ D. Cystic fibrosis
- ☐ E. Emphysema
- ☐ F. Pneumonia
- ☐ G. Sleep apnea
- ☐ H. Tuberculosis
- ☐ I. Other breathing or lung problems
- ☐ J. **NO to all breathing or lung problems**

4. Cancer, Cyst or Tumor

Has any applicant ever been diagnosed with or received treatment for any of the following conditions :

- ☐ A. Cancer
- ☐ B. Basal cell
- ☐ C. Squamous cell
- ☐ D. Melanoma
- ☐ E. Polyp or Papilloma
- ☐ F. Cyst, growth, lump, mass or tumor
- ☐ G. Other cancer, cyst or tumor disorder
- ☐ H. **NO to all cancer, cyst or tumors**

Section K – Health History - For Each Family Member (IMPORTANT: This section has two steps) (continued)

5. Congenital (birth) or Developmental Disorders

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Autism
- ☐ B. Cerebral Palsy
- ☐ C. Cleft palate and/or lip
- ☐ D. Mental retardation
- ☐ E. Other congenital or developmental disorders
- ☐ F. **NO to all congenital or developmental disorders**

6. Eyes, Ears, Nose and Throat Disorders

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Allergies including hay fever and rhinitis
- ☐ B. Cataracts
- ☐ C. Detached retina
- ☐ D. Deviated nasal septum or polyps
- ☐ E. Ear infections (more than 2 in the last 12 months)
- ☐ F. Sinus infections (more than 2 in the last 12 months)
- ☐ G. Eye infections other than pink eye
- ☐ H. Glaucoma
- ☐ I. Hearing loss or cochlear implants
- ☐ J. Problems with tonsils or adenoids
- ☐ K. Other eyes, ears, nose or throat problems
- ☐ L. **NO to all eyes, ears, nose and throat problems**

7. Kidney or Bladder Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Bladder infections
- ☐ B. Pyelonephritis or Kidney infection
- ☐ C. Kidney failure
- ☐ D. Dialysis
- ☐ E. Kidney stones
- ☐ F. Urinary tract infections or problems
- ☐ G. Other kidney or bladder problems
- ☐ H. **NO to all kidney or bladder problems**

8. Nervous, Mental, Emotional or Behavioral Health Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Alcohol abuse
- ☐ B. Drug abuse
- ☐ C. Attention Deficit Disorder (ADD/ADHD)
- ☐ D. Bipolar Disorder
- ☐ E. Obsessive Compulsive Disorder
- ☐ F. Depression
- ☐ G. Anxiety
- ☐ H. Eating Disorder
- ☐ I. Panic Disorder
- ☐ J. Schizophrenia
- ☐ K. Other mental health problems
- ☐ L. **NO to all nervous, mental, emotional or behavioral health problems**

9. Male or Female Reproductive Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Cyst on ovary or problems with ovaries
- ☐ B. Uterine fibroids
- ☐ C. Endometriosis or Pelvic Inflammatory Disease
- ☐ D. Infertility (problems getting pregnant or in vitro fertilization)
- ☐ E. Abnormal pap smear or mammogram
- ☐ F. Sexually transmitted disease such as HPV (Human Papilloma Virus)
- ☐ G. Herpes or genital or anal warts
- ☐ H. Impotence or erectile dysfunction
- ☐ I. Disorders of the testicle
- ☐ J. Prostate problems
- ☐ K. Other female or male reproductive problems
- ☐ L. **NO to all male or female reproductive problems**

10. Heart, Blood and Blood Vessel Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Anemia
- ☐ B. Sickle cell anemia
- ☐ C. Hemophilia
- ☐ D. Leukemia
- ☐ E. Heart murmur or irregular heartbeat
- ☐ F. Aneurysm
- ☐ G. Angina (Chest Pain)
- ☐ H. Blood clots or phlebitis
- ☐ I. Heart disease or heart attack
- ☐ J. Heart valve disease or disorder
- ☐ K. High blood pressure (Hypertension)
- ☐ L. High cholesterol or triglycerides
- ☐ M. Raynaud's disease
- ☐ N. Varicose veins
- ☐ O. Pacemaker
- ☐ P. Other heart, blood or blood vessel problems
- ☐ Q. **NO to all heart, blood and blood vessel problems**

Section K – Health History - For Each Family Member (IMPORTANT: This section has two steps) (continued)

11. Metabolic, Immune System and Endocrine Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. HIV, AIDS or AIDS related complex
- ☐ B. Diabetes or high blood sugar
- ☐ C. Hormone or growth hormone disorders
- ☐ D. Lupus or SLE (Systemic Lupus)
- ☐ E. Thyroid or adrenal disorders
- ☐ F. Scleroderma
- ☐ G. Gaucher's disease
- ☐ H. Other metabolic, immune system and endocrine problems
- ☐ I. **NO to all metabolic, immune system and endocrine problems**

12. Skin Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Acne
- ☐ B. Psoriasis
- ☐ C. Rosacea
- ☐ D. Eczema or dermatitis
- ☐ E. Fungal infections
- ☐ F. Recurring or unresolved skin lesions (sores)
- ☐ G. Keratosis
- ☐ H. Severe burns
- ☐ I. Shingles
- ☐ J. Other skin disorders
- ☐ K. **NO to all skin problems**

13. Stomach, Intestinal and Liver Problems

Within the last FIVE years, has any applicant been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Colitis
- ☐ B. Chronic diarrhea
- ☐ C. Irritable bowel syndrome (IBS)
- ☐ D. Colon polyps
- ☐ E. Crohn's disease
- ☐ F. Gallstones or gallbladder disorder
- ☐ G. Diverticulitis or diverticulosis
- ☐ H. GERD (Gastroesophageal Reflux, or Acid Reflux)
- ☐ I. Hemorrhoids
- ☐ J. Hepatitis A
- ☐ K. Hepatitis B
- ☐ L. Hepatitis C, D, or E
- ☐ M. Hepatitis – type unknown
- ☐ N. Hernia
- ☐ O. Jaundice
- ☐ P. Liver disease/cirrhosis
- ☐ Q. Pancreatitis
- ☐ R. Ulcers
- ☐ S. Obesity surgery
- ☐ T. Constipation
- ☐ U. Other stomach, intestinal or liver problems
- ☐ V. **NO to all stomach, intestinal and liver problems**

14. Unexplained Problems or Symptoms in the last year

Within the last 12 MONTHS, has any applicant had any of the following signs or symptoms for which you have NOT seen a doctor or other healthcare provider:

- ☐ A. Chest pain
- ☐ B. Dizziness
- ☐ C. Loss of consciousness/blackouts
- ☐ D. Pain in back, abdomen (stomach) or pelvis
- ☐ E. Numbness or tingling in the limbs
- ☐ F. Abnormal or recurrent bleeding (not related to menstruation)
- ☐ G. Shortness of breath or trouble breathing
- ☐ H. Lump or unexplained growth
- ☐ I. Tiredness that does not go away
- ☐ J. Weight loss of more than 10 pounds for reasons other than a weight loss program
- ☐ K. **NO to all unexplained problems or symptoms**

Section K – Health History - For Each Family Member (IMPORTANT: This section has two steps) (continued)

STEP 1 (continued) - ***All questions must be answered or the application will be returned.***

GIVE COMPLETE DETAILS IN STEP 2 FOR ANY LIFESTYLE OR OTHER QUESTIONS 15 - 24 ANSWERED "YES."

Lifestyle Questions

Tobacco Use

		YES	NO
15. a) Within the last **12 MONTHS**, has any applicant used tobacco products or smoking cessation products?	Applicant	☐	☐
	Spouse or Domestic Partner	☐	☐
b) If cigarettes, have you smoked 40 or more per day?	Applicant	☐	☐
	Spouse or Domestic Partner	☐	☐

Alcohol and Drugs

	YES	NO
16. Has any applicant ***ever*** used illegal drugs or been advised by a doctor or other healthcare provider to discontinue or decrease alcohol or drug use?	☐	☐

Other Questions

	YES	NO
17. Is any applicant a candidate to receive or the recipient of an organ or bone marrow transplant?	☐	☐
18. Is any applicant currently pregnant (includes positive pregnancy test), an expectant parent, or in the process of adoption or surrogate pregnancy?	☐	☐
19. Within the last **FIVE** years has any applicant had breast or other implants, internal fixation (pins, rods, screws, plates), joint replacement, prosthetic device, monitoring device, defibrillator, pacemaker, heart valve replacement, shunt, stent, or neuro stimulator?	☐	☐
20. Within the last **12 MONTHS**, has any applicant been evaluated or treated in an emergency room or urgent care for any condition ***other than*** flu, sinus infection, pregnancy, bladder infection, hives, or for a sprain/strain that resolved in less than one month?	☐	☐
21. Within the last **FIVE** years, has any applicant had treatment or surgery in a hospital or outpatient facility ***other than***: childbirth, fracture of a single bone in the hand, foot, arm or lower leg, hernia repair, hysterectomy, insertion of ear tubes in a child, tonsillectomy, tubal ligation, vasectomy, removal of appendix, or removal of gall bladder and was the procedure more than 3 months ago with no current treatment?	☐	☐
22. Has any applicant been advised by a healthcare provider to have testing, examination, evaluation, treatment, therapy, or surgery that has not yet been completed?	☐	☐
23. Within the last **12 MONTHS**, has any applicant received a prescription or taken any prescribed medication ***other than*** birth control for contraception, thyroid medication, or short term (10 days or less) antibiotics?	☐	☐
24. Within the last **THREE** years, has any applicant been convicted of DUI two or more times?	☐	☐

Section K – Health History - For Each Applicant (IMPORTANT: This section has two steps) (continued)

STEP 2

Prescription Medications

List ***ALL*** medications taken within the last 12 MONTHS by any applicant listed on this application. Use an additional sheet of paper if necessary. All additional pages must be signed and dated by the primary applicant.

Applicant Name	Medication/Dosage/Frequency	Illness for which Medication is Prescribed	Date Prescribed (mm/dd/yyyy)	Date Discontinued (mm/dd/yyyy)	Name, Phone No. of Physician or Hospital
Example: Mary	Amoxicillin 250 mg 4x day	Tonsillitis	08/01/2008	09/01/2008	**Name:** Dr. John Doe **Phone:** 555-555-1000
					Name: **Phone:**
					Name: **Phone:**
					Name: **Phone:**
					Name: **Phone:**
					Name: **Phone:**

☐ **Please check box if an additional sheet(s) of paper has been completed for this section.**

Health History

Give complete details below for all selected check boxes other than the 'no to all' check boxes for questions 1-14 and all Lifestyle or Other questions answered "YES" (see example below). Not providing complete details will delay the application process. Use an additional sheet of paper if necessary. All additional pages must be signed and dated by the primary applicant.

Question Number	Patient First Name	Name of Hospital, Clinic and/or Person Providing Care	Specific Diagnosis & Treatment	Name & Dosage of Medication & Dates of Use		Duration of Condition		Was Surgery Performed?		Description of Surgery/ Procedures & Date(s) (mm/yyyy)	Still Under Treatment
				Begin (mm/yyyy)	End (mm/yyyy)	Begin (mm/yyyy)	End (mm/yyyy)	YES	NO		
Example: #6	Mary	Dr Joe Doe	Tonsillitis	Amoxicillin 250 mg 4x day 08/2008	09/2008	08/2008	09/2008	☑	☐	Tonsillectomy 09/2008	☐
								☐	☐		☐
								☐	☐		☐
								☐	☐		☐

☐ **Please check box if an additional sheet(s) of paper has been completed for this section.**

Section L – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

I, the undersigned, understand that under the Anthem Blue Cross and Blue Shield plan for which I am applying, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use an in-network hospital or physician.

CURRENT HEALTH COVERAGE: If you currently have health coverage, we strongly recommend that you maintain your current coverage and request an effective date of 75 days from the date of application. This will help ensure that your application is processed before you surrender your present insurance.

AGREEMENT

By applying for coverage, I, the undersigned, agree to the following:

1. Anthem Blue Cross and Blue Shield may decline my application. No coverage comes into effect until Anthem approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Anthem at its discretion.

2. Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Anthem nor any affiliated company shall have any liability to me or anyone else listed on it, except for the obligation to return the money submitted with this application. If this application is not accepted, I will not be entitled to benefits or coverage from Anthem.

3. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross and Blue Shield underwriting policy or the terms of any Anthem coverage.

4. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)

5. In no event shall Anthem Blue Cross and Blue Shield or any affiliated company have any liability to the applicant if the application is not approved, except for the obligation to return the money submitted with this application if this application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by Anthem.

6. I understand Anthem Blue Cross and Blue Shield may use any information prior to the effective date of coverage in considering my application, including medical conditions that occur after my signature and before the original effective date.

7. I understand that it is mandatory that I notify Anthem Blue Cross and Blue Shield, in writing, immediately if I (the applicant) or any other person for whom coverage is sought received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date or the date underwriting approves, whichever is later. I understand that in this situation, Anthem Blue Cross and Blue Shield has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be delayed or reformed or, for applicants age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, benefits denied due to the illness, injury or condition being treated as a preexisting condition.

8. By signing this application I understand that Anthem Life Insurance Company has the right to deny any application for term life coverage, and if it does, I will be notified in writing. I understand that if Anthem Life declines this coverage, no benefits will be payable. I understand that I am responsible for reading and accurately completing this application, and I must communicate any changes to my status. I also understand that all other conditions of my medical application apply for the life application.

9. I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is mentally competent; he or she is at least 18 years old; is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.

I agree to update Anthem in writing with any additional medical history which relates to any of the preceding questions and of which I became aware after the date of this application, but before the effective date of coverage.

Section L – Significant Terms, Conditions and Authorizations (TERMS) (continued)

Rescission of Membership

I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered in this application, Anthem Blue Cross and Blue Shield may revoke my coverage. This means Anthem may cancel membership as if it never existed. Also, after approval for membership, if an act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact, is discovered by Anthem that was not provided to Anthem prior to the effective date of the policy, the plan may revoke coverage.

I understand that if my coverage is revoked, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for enrollment. I also understand that I may be required to pay for any claims that were paid while a member and that Anthem will refund all amounts paid by me except amounts owed to Anthem. I have personally read and completed this application. If I am accepted, this application will become part of the contract between Anthem Blue Cross and Blue Shield and me. I agree to abide by the terms of that contract.

REQUIREMENT FOR BINDING ARBITRATION:

I UNDERSTAND AND AGREE THAT ANY AND ALL DISPUTES BETWEEN ANTHEM AND ME MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT. UNDER THIS BINDING ARBITRATION REQUIREMENT, ANTHEM AND I ARE GIVING UP THE CONSTITUTIONAL RIGHT TO HAVE THE DISPUTE DECIDED IN A COURT OF LAW BY A JURY.

BEFORE COMMENCING ARBITRATION, THE PARTY SEEKING ARBITRATION MUST HAVE EXHAUSTED ALL LEVELS OF APPEAL AND REVIEW SET FORTH IN THE CERTIFICATE. ANY SUCH ARBITRATION WILL BE GOVERNED BY THE PROCEDURES AND RULES ESTABLISHED BY THE AMERICAN ARBITRATION ASSOCIATION. THE LAW OF THE STATE IN WHICH THE POLICY WAS ISSUED AND DELIVERED TO THE POLICYHOLDER SHALL GOVERN THE DISPUTE. THE DECISION IN ARBITRATION IS BINDING UPON BOTH ANTHEM AND ME. THE AWARD GIVEN IN ARBITRATION MAY BE ENFORCED OR REVIEWED IN ANY COURT THAT HAS PROPER JURISDICTION. IN THE EVENT ANY PERSON SUBJECT TO THIS ARBITRATION CLAUSE INITIATES LEGAL ACTION OF ANY KIND, THE OTHER PARTY MAY APPLY FOR A COURT OF COMPETENT JURISDICTION TO ENJOIN, STAY OR DISMISS ANY SUCH ACTION AND DIRECT THE PARTIES TO ARBITRATE IN ACCORDANCE WITH THIS PROVISION. THE QUESTION OF WHAT DISPUTES ARE SUBJECT TO THIS ARBITRATION CLAUSE SHALL BE DETERMINED BY THE ARBITRATOR.

If an Applicant does not read English, the translator must sign and submit a Statement of Accountability for translating this entire application (see Section N).

NOTICE:

By signing this contract you are agreeing to have ANY and ALL disputes against Anthem Blue Cross and Blue Shield decided by neutral arbitration and you are giving up your right to jury OR COURT trial for both medical malpractice claims and any other disputes. *Signatures Required.*

IMPORTANT: ALL APPLICANTS OVER AGE 18 MUST PERSONALLY READ, AGREE TO, SIGN AND DATE THIS APPLICATION.

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)

Section M – 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, which 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.

I understand that I may revoke this Authorization at any time while Anthem Blue Cross and Blue Shield is determining eligibility for the coverage requested. To do so, I must submit a completed Authorization Revocation Form to Anthem Blue Cross and Blue Shield. An Authorization Revocation Form is available by calling 1-877-373-9821, going to our website, www.anthem.com/co, or writing to: Anthem Blue Cross and Blue Shield, P.O. Box 9041, Oxnard, CA 93031. If I revoke this Authorization after I initially apply for coverage, I understand that I/we will not be considered by Anthem Blue Cross and Blue Shield for enrollment in one of its medically underwritten health plans. If I revoke this Authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by recipient and, in some circumstances, may no longer be protected by federal regulations governing the privacy of health information.

SIGN HERE

Printed name of Applicant/Member	Signature of Applicant* or Legal Representative X	Date Signed / /
Printed name of Spouse or Domestic Partner or Dependent Child age 18 or over listed on Application	Signature of of Spouse or Domestic Partner or Dependent Child* age 18 or over listed on Application X	Date Signed / /
Printed name of Dependent Child age 18 or over listed on Application	Signature of Dependent Child* age 18 or over listed on Application X	Date Signed / /

If listed on your application or change form, your spouse/domestic partner and each dependent child age 18 or over must sign above.

If a legal representative signs on behalf of the applicant or spouse or domestic partner, a copy of the legal representative's authority must be attached to the application.

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.

Section N – Statement of Accountability

To be completed when the applicant cannot complete the application.

NOTE: Translator must be 18 years or older to translate the application on behalf of the applicant.

I, _____ , personally read and completed this Individual Enrollment Application for the applicant named below because:

☐ Agent assisted application ☐ Applicant does not read English ☐ Applicant does not speak English

☐ Applicant does not write English ☐ Other (explain): _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the: ☐ Applicant Or by _____

I also translated and fully explained the " Significant Terms, Conditions and Authorizations (TERMS)."

Translator Signature ***(Required)***: X	Date ***(Required)***

I confirm that the application was translated on my behalf.

Applicant Signature ***(Required)***: X	Date ***(Required)***

Section O – Agent Certification

To be completed by your Anthem Blue Cross and Blue Shield-Appointed Agent.

1. Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting? ..... ☐ Yes ☐ No

2. Did you see the proposed subscriber (and spouse/domestic partner, if applying) at the time this application was executed? ..... ☐ Yes ☐ No

If NO, please explain: _____

3. To the extent not already identified in Section J of this application, I have listed in an attachment to this application any other accident or sickness policies I have sold to the applicants in the past five years. With respect to those policies listed on the attachment, I will also identify those that are currently in force.

4. I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent Signature X		Date
Agent Name (please print)		Agent Street Address / Suite No. / Personal Mail Box (PMB) No.
Agent ID No. (TIN)	Sub-Agent ID Number	City/State/ZIP
Agent Phone No.	Agent Fax No.	Agent Email Address

Breakdown of funds collected (If term life was selected, do not collect premium - applicant will be billed.)**:**

Total Medical funds $ _____ + Total Dental funds $ _____ = **Total funds collected $** _____

Agent: Please mail this application to the following address:

Anthem Blue Cross and Blue Shield
P.O. Box 9041
Oxnard, CA 93031-9041

OR

Fax to: (800)327-9255

Section P – Determination of Self-employed Business Group of One

An applicant who answers "Yes" to all four questions below and, if required by Anthem Blue Cross and Blue Shield, who can document their answers, meets the legal definition of a "self-employed business group of one" in Colorado:

1. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?
2. Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?
3. Do you have gross income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue Service forms 1040, Schedule C, F or SE, or other forms recognized, by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years?

   Note: "Substantial part of your income "means income derived from business activities of the business group of one that are sufficient to pay for the annual premiums for the business group of one's health benefit plan.
4. Do you work a minimum of 24 hours a week on a permanent basis?

Can you answer "Yes" to the four questions above? ..... ☐ Yes ☐ No

Applicant's Statement

I (print name), _____, attest that the answers to the questions contained in this form are true and correct.

Applicant's Signature X	Date

Applicant's Business

Business Group of One Disclosure

As required by Colorado law, please read the following disclosure, and if you qualify as a business group of one, print and sign your name in the spaces below.

I, (print name) _____, meet the definition of a self-employed business group of one as attested to on the Determination of Self-Employed Business Group of One above. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods, as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three-year period.

I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, the carrier's overall cost and utilization trends, the underwriting methodology used to evaluate individual coverage, my age, and a factor that reflects the cost of care where I live. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier's overall cost and utilization trends ("index rate,") my age, my family size, and a factor that reflects the cost of care where I live. I have been given a Colorado Health Plan Description Form showing the benefits under Colorado's small group Standard Health Benefit plans, I have also been given a Colorado Health Benefit Plan Description Form for the plan for which I am applying.

Applicant's Name (please print)	Applicant's Business Name
Applicant's Signature X	Date

Anthem BlueCross BlueShield

Notice To Applicant Regarding Replacement Of Accident And Sickness Insurance

According to your application, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

☐ **Additional benefits**

☐ **No change in benefits, but lower premiums**

☐ **Fewer benefits and lower premiums**

☐ **Other** (please specify) _____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy for applicants age nineteen (19) and older applying for non-grandfathered coverage. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
2. State law provides that your replacement policy or contract may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer or Other Representative* **X**	Date
Typed Name and Address of Issuer or Producer	
Applicant's Signature **X**	Date

*Signature not required for direct response sales.

Access to the MIB

Anthem BlueCross BlueShield

Information regarding your insurability will be treated as confidential. Anthem Blue Cross and Blue Shield or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734

Information for consumers about MIB may be obtained on its website at www.mib.com.

Anthem Blue Cross and Blue Shield, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

CONV0016086 MIB Rev. 11/12

Payment Methods for Individual Applications – Colorado

Anthem

Applicant / Member Name:	Primary Applicant's SSN:

(Premium Payment is required. Please choose from Option 1 or 2.)

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Checking Account Automatic Premium Payment (complete Section A)

☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. If you choose one of these options, you will receive a bill every month thereafter.

☐ Paper Check* ☐ Electronic Check (complete Section B) ☐ Credit / Debit Card (complete Section C)

DO NOT SUBMIT PREMIUM FOR ANY LIFE INSURANCE – IF ACCEPTED, YOU WILL BE BILLED.

A. Monthly Checking Account Automatic Premium Payment – By providing your check information, you authorize us to electronically debit your bank account. If you have selected this option, your bank account will be debited one month's premium as soon as the day of approval. This will include all products selected, including dental and/or life. Subsequent premium amounts will be debited on the day you request below:

Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during underwriting, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross and Blue Shield to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross and Blue Shield premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and will be billed monthly. **You will incur a service charge for any withdrawal not honored.**

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

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Check Number	Amount
				$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield to charge my card for a one time initial debit upon approval. I understand that if this option is selected, my account will be debited one month of premium as soon as the day of approval. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **We accept Visa and MasterCard.**

Card Number: Expiration Date: Cardholder Zip Code:

|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___| |__|__| / |__|__| |__|__|__|__|__| – |__|__|__|__|

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize us either to use 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.