# Colorado
# Individual Enrollment Application

Please complete in blue or black ink only.

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

## 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:** If your application is approved your coverage can start on any day of the month as early as the date you signed your application providing we receive it within 10 days of that date. We will notify you of your actual effective date in writing.

**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.

## 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 ☐ Korean ☐ Chinese (C/M) ☐ Other_____

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) / / |
| | | | | | | | |

**NOTE:** Domestic Partner is the applicant's same-sex Domestic Partner, and requires that the applicant and Domestic Partner have completed an Affidavit of Domestic Partnership to be eligible for coverage.

Language Choice (Optional) ☐ English ☐ Spanish ☐ Korean ☐ Chinese (C/M) ☐ Other_____

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

If this is an application for a Family Contract, list all eligible dependents. This includes all unmarried, dependent children, stepchildren, or legally adopted children under age 19 or up to the age of 24. All children listed below who are between the ages of 19 through 24 must either reside with the applicant or be financially dependent on the applicant.

| 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? _____

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

Agent Name/TIN





06-00050 1/09

## 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.**

You can also select a different medical plan for each family member 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.

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.**

| | | | |
|---|---|---|---|
| **BluePreferred** | ☐ 500/5000 (BK84) | ☐ 2000/5000 (BK86) | ☐ 3000/10,000 (CQ94) |
| | ☐ 1000/5000 (BK85) | | |
| **Lumenos HSA** | ☐ 1500/3000/70% (EK49) | ☐ 5000/10000/100% (EK64) | |
| | ☐ 2500/5000/100% (EK52) | | |
| **Lumenos HIA** | ☐ 1500/3000/70% (EK86) | ☐ 5000/10000/100% (EL07) | |
| | ☐ 2500/5000/100% (EK95) | | |
| **Lumenos HIA Plus** | ☐ 5000/10000/100% (EK79) | | |
| | ☐ 2500/5000/100% (EK67) | | |
| **SmartSense** | ☐ 500/GenRx (Z276) | ☐ 1500/GenRx (Z278) | ☐ 2500/GenRx (Z280) |
| | ☐ 5000/GenRx (Z282) | ☐ 7500/GenRx (Z323) | |
| | ☐ 500/CompRx (Z284) | ☐ 1500/CompRx (Z286) | ☐ 2500/CompRx (Z288) |
| | ☐ 5000/CompRx (Z290) | ☐ 7500/CompRx (Z329) | |
| **Other** | ☐ _____ | | |

☐ 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.

## Section F – Dental Coverage Selection

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

☐ 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

**Blue Preferred Term Life™**

☐ 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 | Birthday (mm/dd/yyyy) | 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: | | / / | |

* 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.

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

## 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 | | |
| **Can you answer YES to the statements above?** ..... | ☐ | ☐ |
| **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 – 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. To obtain credits for the pre-existing period, please complete the following:

| | YES | NO |
|---|---|---|
| Have you had coverage in the last 90 days? | ☐ | ☐ |

**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 J – Health History (IMPORTANT: This section has two steps)

**STEP 1: Health history questions must be answered by each/every person applying for coverage.**

***Health History Questionnaire — All questions must be answered or the application will be returned.***

**GIVE COMPLETE DETAILS IN STEP 2 (page 7) FOR ALL QUESTIONS ANSWERED "YES".**

**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. 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 later discover that you intentionally misrepresented or omitted information you know in response to a question, 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. ***(If you have questions about how to complete this application call 1-877-373-9821 before signing.)***

| | YES | NO |
|---|---|---|
| **1.** Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test) or urine test, x-ray(s), CAT scan, MRI, or mammogram? | ☐ | ☐ |
| **2.** Have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition? | ☐ | ☐ |
| **3.** Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? | ☐ | ☐ |
| **4.** (This question applies to all females age 13 years and older.) Has it been more than 40 days since your last menstrual period? (If you answered Yes, check any reasons that apply.) | ☐ | ☐ |
| A. Pregnant | ☐ | ☐ |
| B. Due to birth control method | ☐ | ☐ |
| C. Due to breast feeding | ☐ | ☐ |
| D. Hysterectomy or menopause | ☐ | ☐ |
| **5.** Are you pregnant or an expectant father, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months? | ☐ | ☐ |
| **6.** Do you have implants, prosthesis or retained hardware? | | |
| A. Breast implants | ☐ | ☐ |
| B. Eye/limb prosthesis | ☐ | ☐ |
| C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump | ☐ | ☐ |
| D. Joint replacement/internal fixations (i.e. pins, plates, rods etc.), neurostimulators | ☐ | ☐ |
| E. Any other prosthesis or implant (other than dental) | ☐ | ☐ |
| **7.** Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following? ***(All answers must be checked Yes or No.)*** | | |
| A. Headaches requiring prescription medication | ☐ | ☐ |
| B. Loss of consciousness | ☐ | ☐ |
| C. Sleep apnea/breathing difficulties while sleeping | ☐ | ☐ |
| D. Recurrent fainting, weakness or dizziness | ☐ | ☐ |
| E. Paralysis or numbness/tingling in limbs | ☐ | ☐ |
| F. Chest pain | ☐ | ☐ |
| G. Increased/irregular heart beat | ☐ | ☐ |
| H. Low or high blood pressure | ☐ | ☐ |
| I. High cholesterol | ☐ | ☐ |
| J. Shortness of breath | ☐ | ☐ |
| K. Heartburn (recurrent) | ☐ | ☐ |
| L. Abnormal and/or Recurrent bleeding (unrelated to menstruation) | ☐ | ☐ |
| M. Recurrent diarrhea and/or recurrent vomiting | ☐ | ☐ |
| N. Unexplained weight loss | ☐ | ☐ |
| O. Blood, sugar, and/or protein in urine | ☐ | ☐ |
| P. Recurrent pain (including back pain) | ☐ | ☐ |
| Q. Jaundice | ☐ | ☐ |
| R. Mass, cyst(s), or lump(s) in any body part including breast | ☐ | ☐ |
| **8.** Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following? | | |
| A. Abnormal Pap smear | ☐ | ☐ |
| B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease) | ☐ | ☐ |
| C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)? | ☐ | ☐ |
| D. Male infertility | ☐ | ☐ |
| E. Female fertility/infertility | ☐ | ☐ |
| F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart, circulatory or blood disorder(s) | ☐ | ☐ |
| G. Kidney, bladder or prostate disorder(s) | ☐ | ☐ |
| H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s) | ☐ | ☐ |
| I. Hernia; hemorrhoid; rectal, or intestinal disorder(s) | ☐ | ☐ |
| J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s) | ☐ | ☐ |
| K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s) | ☐ | ☐ |
| L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay | ☐ | ☐ |
| M. Asthma, allergies, tuberculosis, any lung or sinus or breathing problems | ☐ | ☐ |
| N. Psoriasis, rosacea, acne or skin disorder(s) | ☐ | ☐ |
| O. Cataract, glaucoma, eye or ear disorder(s) | ☐ | ☐ |
| P. Diabetes, thyroid, endocrine glands | ☐ | ☐ |

## Section J – Health History (continued)

| | YES | NO |
|---|---|---|
| **9.** Within the last 5 years, have you experienced (suffered from) or consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol? | ☐ | ☐ |
| **10.** Within the last 5 years, have you been advised by a health care professional to reduce alcohol intake? | ☐ | ☐ |
| **11.** Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder? | ☐ | ☐ |
| **12.** Within the last 5 years have you had counseling or treatment for any mental, emotional, or behavioral disorder? (If you answered Yes, please check any that apply below.) | ☐ | ☐ |
| A. Obsessive Compulsive Disorder | ☐ | ☐ |
| B. Minor depression | ☐ | ☐ |
| C. Anxiety/panic attacks | ☐ | ☐ |
| D. Attention Deficit Disorder (ADD/ADHD) | ☐ | ☐ |
| **13.** Within the last 5 years, have you experienced (suffered from) or consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to drug abuse? | ☐ | ☐ |
| **14.** In the past 10 years have you had consultation, been diagnosed, had treatment or treatment recommended for any of the following: | | |
| A. Schizophrenia, Major Depression/BiPolar Disorder | ☐ | ☐ |
| B. Eating disorder (i.e. anorexia/bulimia) | ☐ | ☐ |
| C. Down's Syndrome | ☐ | ☐ |
| D. Autism | ☐ | ☐ |
| E. Cerebral Palsy | ☐ | ☐ |
| **15.** Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor? | ☐ | ☐ |
| **16.** Have you ever been diagnosed with hepatitis? (Check all types that apply.) | | |
| A. Hepatitis A | ☐ | ☐ |
| B. Hepatitis B | ☐ | ☐ |
| C. Hepatitis C, D, E | ☐ | ☐ |

| | YES | NO |
|---|---|---|
| **17.** Have you ever been diagnosed with, or treated for any of the following? | | |
| A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment | ☐ | ☐ |
| B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Diabetes, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma. | ☐ | ☐ |
| **18.** Are you a candidate for, or have you ever received an organ or bone marrow transplant? | ☐ | ☐ |
| **19a.** Within the last 5 years, have you had any illness, physical injury, persisting or new physical symptoms and/or health problems not mentioned elsewhere on this application that have not been evaluated or that you plan to have evaluated by a licensed health practitioner? | ☐ | ☐ |
| **19b.** Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application? | ☐ | ☐ |
| **20.** Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy? | ☐ | ☐ |
| **21.** Date last seen by a physician: _____ | | |
| Reason: _____ | | |

## Other Health Questions

| | YES | NO |
|---|---|---|
| **1.** During the past 12 months, have you or any applicants regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco? | ☐ | ☐ |
| **2.** Have you or any applicants used marijuana within the last 2 years? (If yes, check the appropriate box.) | ☐ | ☐ |
| ☐ less than 4 times per month | | |
| ☐ 5 - 7 times per month | | |
| ☐ 8 or more times per month | | |

| | YES | NO |
|---|---|---|
| **3.** Have you or any applicants used any illegal or controlled substances (i.e. cocaine, heroin, methamphetamines, LSD), or abused prescription medications within the last 10 years? | ☐ | ☐ |
| **4.** Have you or any applicants ever used illegal intravenous (IV) drugs? | ☐ | ☐ |
| **5.** Please check the appropriate box below based on your average weekly consumption of alcoholic beverages over the past year. (One beverage equals 12 oz beer, 4 oz wine or 1 oz liquor.) | ☐ | ☐ |
| ☐ 0-14 per week | | |
| ☐ 15-26 per week | | |
| ☐ 27 or more per week | | |

## Section J – Health History (continued)

**STEP 2: If you answered "YES" to any of the health history questions, give complete details (see the example below)**

| Question Number of "YES" | Patient First Name | Physician Name & Telephone (with area code) | Specific Diagnosis & Treatment | Name & Dosage of Medication & Dates of Use | | Duration of Condition | | Was Surgery Performed? | | Description of Surgery/ Procedures & Date(s) (mm/yyyy) | Current Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Begin (mm/yyyy) | End (mm/yyyy) | Begin (mm/yyyy) | End (mm/yyyy) | YES | NO | | |
| Example: #8F | Mary | Dr. John Doe 555-555-1000 | Hypertension | Lopressor 100mg/daily 01/2007 | 02/2008 | 01/2007 | 02/2008 | ☐ | ☑ | | Good |
| | | | | | | | | ☐ | ☐ | | |
| | | | | | | | | ☐ | ☐ | | |
| | | | | | | | | ☐ | ☐ | | |
| | | | | | | | | ☐ | ☐ | | |

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

### Prescription Medications

List ***ALL*** medications taken within the last 12 months by any family member listed on this application (if not indicated in Step 2).

| Family Member | 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 | Lopressor 100mg/daily | Hypertension | 01/01/2007 | 02/09/2008 | **Name:** Dr. John Doe<br>**Phone:** 555-555-1000 |
| | | | | | **Name:** _____<br>**Phone:** _____ |
| | | | | | **Name:** _____<br>**Phone:** _____ |
| | | | | | **Name:** _____<br>**Phone:** _____ |
| | | | | | **Name:** _____<br>**Phone:** _____ |

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

## Section K – Billing Options (Please choose from option 1 or 2 below. Premium payment required.)

Would you like multiple family policies on one bill? ☐ Yes ☐ No

☐ **OPTION 1:**

**If you choose one of the following options for initial payment and future payments, you are not required to send in a check for initial payment.**

☐ **Monthly Checking Account Automatic Premium Payment** (complete Section 3)

☐ **Credit/Debit Card** (complete Section 5)

If you chose Credit/Debit Card, please select the frequency you would like your premiums pulled: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly
If no selection is made, this option will default to monthly.

☐ **OPTION 2:**

**If you did not select an option in Option 1, please choose from the options below for your initial premium payment:**

☐ **Paper Check***

☐ **Electronic Check** (complete Section 4)

☐ **Credit/Debit Card** (complete Section 5)

If you chose Credit/Debit Card, please select the number of months for your initial premium payment debit: ☐ One Month ☐ Three Months
If no selection is made, the default debit will be one month's premium for initial payment.

If you choose one of these three options for your initial payment you will receive a bill every month thereafter. An administrative fee may be added to paper billings.

* 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 information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.

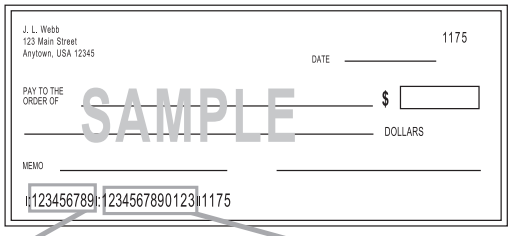
**DO NOT SUBMIT PREMIUM FOR ANY LIFE INSURANCE – IF ACCEPTED YOU WILL BE BILLED.**

### 3. Monthly Checking Account Automatic Premium Payment

By providing your check information to the right, you authorize us to electronically debit your bank account. If you have not sent in an initial premium payment from Option 2, your bank account will be debited one month's premium the day after 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 28th 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.**




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 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 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 $25.00 service charge for any withdrawal not honored.**

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

### 4. Electronic Check

In lieu of sending a Paper Check, we can submit this same information electronically. You will need 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 |
|---|---|---|---|---|
| | | | | $ |

## Section K – Billing Options (continued)

**5. Credit/Debit Card**

As a convenience to me, I request and authorize you to charge my card for recurring premiums on each due date. 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. The amount may also change as outlined in my policy. 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 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, MasterCard, Discover and Star.***

* ***For Star, we accept 16 digit card numbers only.***

| Card No. (16 digits only) | Expiration Date (mm/yyyy) / | Cardholder ZIP Code - |
|---|---|---|

| Authorized Signature (as it appears on the credit card) | Cardholder Name (as it appears on the credit card - PRINT) | Date |
|---|---|---|

## 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 60-75 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. If I, or any person for whom coverage is sought, incurs an illness or a change in medical condition during the period of time between the application date and the date underwriting approves the application, or during the period of time between the date underwriting approves the application and effective date, notification to Anthem, in writing, of such illness or change is mandatory and a condition precedent to the coverage being effective.
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.

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 I provided incomplete or false material information, 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 incomplete or false material information 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.**

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**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).**

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**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<br>X | Date of Birth<br>/ / | Date Signed<br>/ / |
|---|---|---|---|
| Printed name of Spouse or Domestic Partner | Signature of Spouse or Domestic Partner or Legal Representative<br>X | Date of Birth<br>/ / | Date Signed<br>/ / |
| Printed name of Dependent Child over 18 | Signature of Dependent Child over 18<br>X | Date of Birth<br>/ / | Date Signed<br>/ / |
| Printed name of Dependent Child over 18 | Signature of Dependent Child over 18<br>X | Date of Birth<br>/ / | Date Signed<br>/ / |

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

## Section M – Authorization for Use of Protected Health Information

**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 from any physicians, hospitals, pharmacies, pharmacy benefits managers, health benefits plans, and/or other health care providers or medical or pharmacy benefit administrators concerning my care and the care of any family member listed on my Application.

I also authorize any physicians, hospitals, pharmacies, pharmacy benefits managers, health benefit plans, and/or other health care providers or medical or pharmacy benefit administrators to furnish any medical records concerning my care and the care of 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 my application will not be considered if this form is not signed and returned with my completed Application if I am initially applying for enrollment in a medically underwritten health plan offered by Anthem Blue Cross and Blue Shield, or signed and returned with my completed Change of Coverage Form if I wish to add a family member or upgrade my coverage in the future. This Authorization will expire 24 months following when determination is completed regarding my/our eligibility for coverage and Anthem Blue Cross and Blue Shield's acceptance of coverage, if not previously revoked.

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.

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

SIGN HERE

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

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

### Designated Legal Representative

If this form is signed by a legal representative on behalf of the individual, please complete the following.

| Legal Representative (please print full name) | Legal Relationship to Individual |
|---|---|
| Signature<br>X | Date |

## 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 I 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

| | | YES | NO |
|---|---|---|---|
| **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? | Self | ☐ | ☐ |
| | Spouse/Domestic Partner | ☐ | ☐ |
| **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? | Self | ☐ | ☐ |
| | Spouse/Domestic Partner | ☐ | ☐ |
| **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 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. | Self | ☐ | ☐ |
| | Spouse/Domestic Partner | ☐ | ☐ |
| **4.** Do you work a minimum of 24 hours a week on a permanent basis? | Self | ☐ | ☐ |
| | Spouse/Domestic Partner | ☐ | ☐ |

**Applicant's Statement:** I (print name), _____, attest that the answers to the questions about self-employed business group of one in the above section are true and correct.

| Applicant Signature: X | Date |
|---|---|

**Spouse/Domestic Partner's Statement:** I (print name), _____, attest that the answers to the questions about self-employed business group of one in the above section are true and correct.

| Spouse/Domestic Partner Signature (if applying for coverage): X | Date |
|---|---|

I, (print name) _____, meet the definition for a self-employed business group of one as attested to in the Determination of Self-employed Business Group of One, as indicated above on this application. **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 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, my family size, 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 Plan Description Form for the plan for which I am applying. Applicant's Statement.

**If you or your spouse answered "YES," to ALL four questions above, please complete the following section.** If you waive coverage for a family member who will not be covered under this policy, you must list the other coverage for the dependent and when it became effective.

| **Full Name** | **Name of Other Coverage** | **Effective Date of Other Coverage** (mm/dd/yyyy) |
|---|---|---|
| Spouse/Domestic Partner | | |
| Dependent | | |
| Dependent | | |

Anthem

# 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. 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. Failure to include all material medical information 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*<br>**X** | Date |
|---|---|
| Typed Name and Address of Issuer or Producer | |
| Applicants Signature<br>**X** | Date |

*Signature not required for direct response sales.

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COINDAPP (Rev. 8/08)



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