

Anthem. Supplement to Individual Enrollment Application

This form provides additional space, if needed, to list applicants and information for medical and/or term life insurance coverage.

Primary Applicant's Social Security or ID No. Primary Applicant's Last Name							M.I.							
Annlinanta	far Oarrana	_											20	
Applicants for Coverage Please list ALL applicants (youngest to oldest) applying for coverage. If a family member's last name is different than yours, please explain: MUST BE ACCURATE							3A. For HMO Use Only Choose a physician for each family member from the Provider Directory.			3B. FamilyElect Medical Coverage Choose Medical				
Relation	Last Name	e First	M.I.		I Security ID No.	Birthdate	Age	Height	Weight	PMG/ IPA	Primary Care Physician (PCP)		Plan code number(s) from Section 2	
☐ Son ☐ Daughter					/ /						☐ Yes ☐ No			
☐ Son ☐ Daughter						/ /						☐ Yes ☐ No		
Anthem Blue	e Cross Life	and He	alth Insu	ırance Co										
						LIFE COVER		***		I.C. C. A.	U DI 0	1.10		
Insurance Co		Coverage	e at an add	ditional ch							nthem Blue Cro le for life insura		i Health	
Family Member Name \$15,00		✓ Amou \$15,000 (30)	unt of Coverage \$30,000 \$50,000 (31) (32)		Beneficiary Name Relati			ionship Beneficiary Address City / State / ZIP Code						
				• •	(/									
Last Doctor	Visit (for an	y reaso	n includ	ing chec	kup) – Prov	vide inform			family		rs you wish to			
Family Member Date of			Reason for Visit		Normal	Results Normal Abnormal Findings			Name, Phone No. & Fax No. (Fax # optional) of Physician or Hospital					
, monizo		Visit				√ /	(Explain)		uiiigs	Compl	e / Zip Code			
										Name:				
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								Applicant's So	cial Secur	ity or II	D No.
							L				
Prescriptio	on Medicatio	ons – List all m	edications tak	ken within the	last 12 r	nonths by an	y family mo	ember listed or	ո this apլ	olicatio	on.
Family Member			Dosage/Frequer sor/100mg/daily	" ANTIICII IAIG	ss for edication scribed	Date Prescribed (Mo/Day/Yr)	Date Discontinu (Mo/Day/Y	ed ∣ of Dby	me, Phone No. sician or Hospital		
								Name:			
								Phone:			
								Name:			
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								Phone:			
	on Medicatio		- L # #5/	.!! 4 - 44			. .				
Question #			elow of any "Yes ntified on Physicia			ns in Section lospital, Clinic a		Providing Care	Phone	No.	
									()	
Date of Onset/Treatment (Month/Year) Date Ended				Still under treatment	Physician Intern		☐ Pediatric ☐ Family	☐ Cardiac ☐ Other			
Name of Cor	ndition/Illness				Address				S	Suite No.	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) / Results						te / ZIP Code			Fax No.	. (Optiona	al)
Question #	Name of Famil	y Member (As ide	ntified on Physicia	n's Record)	Name of I	Hospital, Clinic a	nd/or Person	Providing Care	Phone	No.	
, , , , ,									()	
Date of Onset/Treatment (Month/Year) Date Ended				☐ Still under treatment		Physician Specialty ☐ Pediatric ☐ Cardiac ☐ Internal Medicine ☐ Family ☐ Other					
Name of Cor	ndition/Illness				Address				S	Suite No.	
Treatment Re	endered (i.e., X-r	ay, lab, surgical p	rocedure, etc.)	/ Results	City / Sta	te / ZIP Code			Fax No.	. (Optiona	al)
Question # Name of Family Member (As identified on Physician's Record)						Hospital, Clinic a	nd/or Person	Providing Care	Phone (No.	
Date of Onse	ate of Onset/Treatment (Month/Year) Date Ended			Still under	Physician Intern		☐ Pediatric☐ Family	☐ Cardiac ☐ Other		,	
Name of Condition/Illness						ar weaterne	<u> Ганніу</u>	Other	S	Suite No.	
Treatment R	andered (i.e. X-r	ay, lab, surgical p	rocedure etc)	/ Results	City / Sta	te / ZIP Code			Fay No	. (Optiona	al)
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Question # Name of Family Member (As identified on Physician's Record)					Name of I	Phone No.					
Date of Opent/Treatment (Month / Year) Date Ended					Dhysiolan	Chaoialtu			(
Date of Onset/Treatment (Month/Year) Date Ended				☐ Still under treatment	Physician Intern			☐ Cardiac ☐ Other			
Name of Cor	ndition/Illness				Address				S	Suite No.	
Treatment Rendered (i.e., X-ray, lab, surgical procedure, etc.) / Results					City / Sta	te / ZIP Code			Fax No.	. (Optiona	al)
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	S (Required) arent or Legal G		All applicants ov	ver age 18 mus Today's Dat		date. cant's Spouse				Today's	Date
Applicant/Parent or Legal Guardian Today's Da					e Applio	cant's Spouse				Today's	Date

Today's Date

Applicant's Spouse



Today's Date

Applicant/Parent or Legal Guardian