Anthem

1. Applicant Information For Each Person To Be Covered

☐ Check here if this is a change or an addition to an existing policy or a previously submitted application.

Last Name(s) First M.I.	Social Security Number	Sex M F	Birthdate (mm/dd/yyyy)	Current Age	Height FT. IN.	Weight LBS.
Primary Applicant		M ☐ F ☐	/ /			
Spouse or Domestic Partner		M ☐ F ☐	/ /			
Child		M ☐ F ☐	/ /			
Child		M ☐ F ☐	/ /			
Child		M ☐ F ☐	/ /			

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

Home Address *(Street or Rural Route required - do not use P. O. Box)*	City	State	Zip
Billing Address *(If different than above)*	City	State	Zip

☐ Check here if correspondence should be mailed to the billing address. | Email Address

Primary Applicant's Marital Status: ☐ Married ☐ Single ☐ Domestic Partner ☐ Other: _____

Telephone number(s) ( ) Day ( ) Evening ( ) Fax

2. Policy Selection

A. Choose Policy *(For more information, please refer to your sales brochure.)*

☐ **Individual Basic BlueCare**

B. Choose Deductible/Coinsurance

☐ $300/20% ☐ $750/20% ☐ $1,500/20% ☐ $2,500/0% ☐ $5,000/0%

C. Choose Optional Coverage

☐ Add Dental coverage

☐ Add Supplemental Accident coverage

☐ _____ Add Maternity coverage *
INITIAL HERE

* ***The primary applicant above must initial above and read the following to add Maternity Coverage:*** *My initials show that I understand the following: 1) conception must occur at least 6 months after the Maternity Coverage start date. If the female to be covered is an "Eligible Individual" as outlined in Section 5 of this application, and conception occurred prior to the effective date, I understand the 6 month waiting period is waived; and 2) this Maternity Coverage is only available to a female applicant or female spouse/domestic partner age 18 or older, or a female emancipated minor.*

D. Desired Start Date

*(mm/dd/yyyy)*_____ *NOTE: Your actual start date will be no earlier than the day after your application is received by Anthem or an Anthem representative, and no later than 70 days after the signature date on the application. We will notify you of your actual start date in writing.*

3. Insurance Coverage History

A. YES NO

☐ ☐ Is any person to be covered eligible for Medicare? *(Medicare is a health insurance program for people 65 years of age and older, certain younger disabled people, and people with permanent kidney failure.)*

If **YES**, list first name(s):

_____

B. YES NO

☐ ☐ Has any applicant been covered by Anthem Blue Cross and Blue Shield within the past 12 months?

If **YES**, list the complete policy numbers for all Anthem policies:

_____

C. YES NO

☐ ☐ Is employer provided health insurance coverage available to any person either as an employee or a dependent, even if they haven't taken it?

If **YES**, complete the chart below. *(If everyone listed on the application is eligible for the same coverage, simply write "All" on the first line.)*

First Name	Type of Coverage	Employer Offering Coverage Name & Phone Number
	☐ Active Employee ☐ COBRA ☐ Retiree	
	☐ Active Employee ☐ COBRA ☐ Retiree	

D. YES NO

☐ ☐ Has any person to be covered had any health insurance coverage within the past 90 days?

If YES, complete the chart below for each person to be covered who has had insurance coverage within the past 90 days. If any person has had more than one policy within the past two years, please complete a line for each policy. *(If everyone listed on the application had the same coverage, please write "All" on the first line.)*

If **NO**, skip to Section 4.

First Name(s)	Beginning Date of Coverage	Ending Date of Coverage	Type of Coverage	Insurance Company or HMO	Reason for Ending Coverage
	☐ More than 2 years ago OR ☐ ____ /____ /_____ MM DD YYYY	☐ Will end when this coverage begins ☐ Will keep current coverage OR ☐ ____ /____ /_____ MM DD YYYY	☐ Employer provided ☐ Individually purchased *(not through employer)* ☐ COBRA ☐ Other: _____	☐ Blue Cross Blue Shield ☐ Other: _____	☐ Cost/Benefits ☐ Left job/Retirement ☐ Coverage no longer offered ☐ Aging off parents/ guardian policy ☐ COBRA ended ☐ Other: _____
	☐ More than 2 years ago OR ☐ ____ /____ /_____ MM DD YYYY	☐ Will end when this coverage begins ☐ Will keep current coverage OR ☐ ____ /____ /_____ MM DD YYYY	☐ Employer provided ☐ Individually purchased *(not through employer)* ☐ COBRA ☐ Other: _____	☐ Blue Cross Blue Shield ☐ Other: _____	☐ Cost/Benefits ☐ Left job/Retirement ☐ Coverage no longer offered ☐ Aging off parents/ guardian policy ☐ COBRA ended ☐ Other: _____

4. Citizenship Information

YES NO

☐ ☐ Are all applicants to be covered by this policy citizens of the USA? If NO, please complete the following:

First Name(s)	How long has the individual(s) legally resided in the U.S.A.?

5. HIPAA Qualification Information

HIPAA is the Health Insurance Portability and Accountability Act. HIPAA enacted reforms in both the group and individual health insurance markets, in part, to help many individuals maintain insurance coverage if they lose or leave their jobs.

A. YES NO

☐ ☐ Would you like to enroll any individual on this application (including yourself) without underwriting?
Please note that any person not underwritten will receive our most expensive premium.

If NO, then skip to Section 6 and continue completing the application. If YES, please read section B below to determine if you are an *Eligible Individual* as defined by HIPAA. To qualify for this option, you (and/or the person(s) you select) must meet special criteria described below in this section.

B. In this section, when we say *Eligible Individual*, we mean someone who meets **ALL of the requirements (1 through 7)** listed below to qualify for special coverage availability privileges under the Health Insurance Portability and Accountability Act (HIPAA). **You may still apply for our coverage by answering the health questions and completing the remaining sections in this application, regardless of whether you qualify as a HIPAA "Eligible Individual."**

HIPAA Requirements: A *HIPAA Eligible Individual* is defined as someone who:

1. has had 18 months of prior creditable coverage (including group health plans, qualifying health insurance coverage, Medicare, Medicaid, CHAMPUS/TRICARE, or other publicly sponsored program)*;
2. was most recently covered under an employer group health plan, governmental plan or church plan*;
3. has elected and exhausted COBRA or similar state continuation of benefits coverage, if it was available;
4. is not eligible for any other group coverage, Medicare, or Medicaid;
5. does not have other health insurance;
6. has had no more than a 63 day break in coverage, unless waiting for a period of time to expire before group coverage was effective; and
7. has not had previous coverage terminated for fraud or non-payment of premium.

* *If the most recent creditable coverage is individual health insurance, and the insurer offering it exits the individual health insurance market and cancels the policyholder's coverage, then only 12 months, and not 18 months, of prior creditable coverage is required.*

If you meet all seven HIPAA requirements listed above, you are a *HIPAA Eligible Individual*, which means you are guaranteed coverage at our highest premium without having to answer health questions. Please list the first names of all qualifying *HIPAA Eligible Individuals* who wish to waive underwriting and be enrolled at our most expensive premium. If all persons to be covered are waiving medical underwriting, please skip to Section 9.

_____

First Name(s) of HIPAA Eligible Individual(s)

If you do NOT meet all the HIPAA requirements listed above, please proceed to Section 6 and continue completing the application.

IMPORTANT: Please attach copies of any certification or other documentation of prior creditable coverage furnished by previous carriers or employers, if available. This will help us process your application.

6. Medical Information

✍ *When you see this symbol and are answering YES to that question, an additional questionnaire is required. Please contact your sales agent.*

All applicants must answer all 43 questions.

Questions 1-18: In his/her lifetime, has any person to be covered been treated for, diagnosed by or consulted a physician, psychotherapist, counselor, or any other provider, or had indications of having any of the following illnesses, injuries, or conditions?

YES NO

☐ ☐ **1.** Acquired Immunodeficiency Syndrome or Human Immunodeficiency Virus (must have been diagnosed)

☐ ☐ **2.** Alcoholism

☐ ☐ **3.** Cancer, Kaposi's Sarcoma, or Leukemia

☐ ☐ **4.** Crohn's disease or Ulcerative Colitis

✍ ☐ ☐ **5.** Diabetes ☐ Treated with Insulin
☐ Other: _____

☐ ☐ **6.** Disorders of the spine or disc(s)

☐ ☐ **7.** Disease or disorders of the circulatory system

☐ ☐ **8.** Drug dependency/habit

✍ ☐ ☐ **9.** Epilepsy Date of last seizure: _____ *(mm/yyyy)*
Type:
☐ Grand Mal ☐ Petit Mal
☐ Other: _____

☐ ☐ **10.** Heart attack, angina, or stroke

YES NO

☐ ☐ **11.** Heart disease, disorders or heart surgery, pacemaker or valve replacements

☐ ☐ **12.** Hepatitis ☐ A ☐ B ☐ C
☐ Chronic ☐ Alcoholic
☐ Other: _____

☐ ☐ **13.** Kidney disease or disorders, including kidney stones

☐ ☐ **14.** Liver disorders or disease (including Cirrhosis), or disease or disorders of the pancreas

☐ ☐ **15.** Lung disorders or lung disease, including emphysema, tuberculosis, or chronic obstructive pulmonary disease (COPD). *(If Asthma, see question 22 below.)*

☐ ☐ **16.** Multiple Sclerosis, paralysis, or cerebral palsy

✍ ☐ ☐ **17.** Seizures (other than epilepsy)
Date of last seizure: _____ *(mm/yyyy)*
Type: _____

☐ ☐ **18.** Spina bifida, cleft palate or lip, or other congenital disorders

Questions 19-37: Within the past 10 years, has any person to be covered been treated for, diagnosed by, or consulted a physician, psychotherapist, counselor, or any other provider, or had indications of having any of the following illnesses, injuries, or conditions?

YES NO

☐ ☐ **19.** Allergies (hay fever, etc.)
☐ Immunotherapy
Date of last shot: _____ *(mm/yyyy)*
☐ Seasonal prescription medication
☐ Other: _____

✍ ☐ ☐ **20.** Anxiety/Depression

☐ ☐ **21.** Arthritis ☐ Rheumatoid
☐ Osteoarthritis
☐ Psoriatic
☐ Other: _____

✍ ☐ ☐ **22.** Asthma

☐ ☐ **23.** Back pain or other back disorders

☐ ☐ **24.** Bone diseases or disorders

☐ ☐ **25.** Disease or disorders of the ears, nose, or throat

☐ ☐ **26.** Disease or disorders of the eye (does not include corrective vision for near and farsightedness)

☐ ☐ **27.** Disease or disorders of the gallbladder, including gallstones

YES NO

☐ ☐ **28.** Disease or disorders of the joints (knees, shoulder, etc.)

☐ ☐ **29.** Disorders of the reproductive system (male or female)

☐ ☐ **30.** Disease or disorders of the stomach or intestines, including gastroesophageal reflux disease (GERD)

✍ ☐ ☐ **31.** Genital Warts, Herpes Simplex II, or other sexually transmitted disease(s)

☐ ☐ **32.** Hernia ☐ Hiatal ☐ Other (type and location):
_____

☐ ☐ **33.** Hyperlipidemia, including elevated cholesterol or triglycerides

✍ ☐ ☐ **34.** Hypertension or high blood pressure

☐ ☐ **35.** Hyperthyroidism, hypothyroidism, goiter, or other thyroid disease or disorders

☐ ☐ **36.** Implant(s), prosthetic device(s), internal fixation device(s), or retained hardware (i.e. pins, wires, screws, shunts, stents)

✍ ☐ ☐ **37.** Other nervous or mental conditions, including bipolar disorder, obsessive-compulsive disorder, or mental retardation

YES NO

☐ ☐ **38.** **Within the past 10 years,** has any person to be covered had any of the following **symptoms**: unexplained weight loss, night sweats, persistent fever or cough, prolonged fatigue, mouth infection (including oral thrush if an adult), tumors, chronic/recurrent skin rashes or lesions, recurrent episodes of diarrhea, lymph node enlargement, or unexplained recurrent headaches?

6. Medical Information *(continued)*

YES NO

☐ ☐ **39.** **Within the past 5 years and NOT already answered or described in Questions 1-38,** has any person to be covered been treated for, diagnosed by or consulted a physician, psychotherapist, counselor, or any other provider, or had indications of having any illness, injury, or medical abnormality?

☐ ☐ **40.** **Within the past 5 years and NOT already answered or described in this application,** has any person to be covered had **abnormal** results in any of the following tests: blood work, laboratory results, X-ray, EKG, blood flow studies, MRI scan, or CAT scan?

☐ ☐ **41.** **Within the past 5 years and NOT already answered or described in this application,** has any person to be covered had surgery, been confined in a hospital, or been treated in an emergency room?

☐ ☐ **42.** Has any person to be covered been advised of the need for **future** tests, procedures, surgery, or hospitalization?

☐ ☐ **43.** **Currently,** are you, your spouse/domestic partner, or any dependent child(ren), even if not named in this application, an expectant parent or the child of an expectant parent (includes son or male applicant)?

If YES, name of pregnant individual: _____ Relationship to Applicant: _____

7. Medical Charts

(Use an additional sheet of paper if necessary. All additional pages must be signed and dated by the primary applicant.)

A. Medical Details

Where "YES" was answered to any of the questions 1 through 42 in Section 6, list complete details in the chart below. Not providing complete details will delay the application process. *Completion of "Dates of Use" section is required if different than "Dates of Condition." (See example below as a guideline.)*

Question Number	Patient First Name *(and Jr./Sr. if applicable)*	Physician Name, Telephone No. *(with area code)* City & State	Specific Illness/Injury or Condition	Name of Medication and Dates of Use		Dates of Condition		Did Patient Have Surgery?	Surgery/ Procedures and Dates
				BEGIN *mm/yyyy*	END/ CURRENT *mm/yyyy*	BEGIN *mm/yyyy*	END/ CURRENT *mm/yyyy*	YES NO	*mm/yyyy*
EXAMPLE: #35	John Jr.	Dr. John Doe (804) 555-1000 Richmond VA	Underactive Thyroid	Synthroid		06/2005			Removed Goiter 06/2005
				07/2005	☒ CURRENT		CURRENT ☒	Y ☒ N ☐	
					☐ CURRENT		CURRENT ☐	Y ☐ N ☐	
					☐ CURRENT		CURRENT ☐	Y ☐ N ☐	
					☐ CURRENT		CURRENT ☐	Y ☐ N ☐	
					☐ CURRENT		CURRENT ☐	Y ☐ N ☐	
					☐ CURRENT		CURRENT ☐	Y ☐ N ☐	

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

7. Medical Charts *(continued)*

B. Prescription Drugs

YES NO

☐ ☐ For medication(s) **NOT already described in this application, within the past 12 months** has any physician or provider prescribed, dispensed or injected any medication for any person to be covered?

Patient First Name *(and Jr./Sr. if applicable)*	Physician Name, Telephone No. *(with area code)* City & State	Name of Medication and Dates of Use		Condition For Which Medication Was Given
		BEGIN *mm/yyyy*	END/ CURRENT *mm/yyyy*	
			☐ CURRENT	
			☐ CURRENT	
			☐ CURRENT	

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

C. Physician Information

If not already described in this application, please provide the following information about any physician(s) seen within the past 2 years for **ALL** applicants:

Patient First Name *(and Jr./Sr. if applicable)*	Name of Physician	Telephone Number *(with area code)*	Specialty

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

8. Lifestyle Information

A. Within the past 12 months, has any person to be covered used any tobacco product(s)?

YES NO

☐ ☐ If YES, please complete the following (even if you currently do not use a tobacco product):

First Name: _____ Tobacco Product: ☐ Cigarettes ☐ Other: _____

If cigarettes, number smoked per **day** during the past 12 months: ☐ 1-10 ☐ 11-20 ☐ 21-39 ☐ 40-49 ☐ 50 or more

First Name: _____ Tobacco Product: ☐ Cigarettes ☐ Other: _____

If cigarettes, number smoked per **day** during the past 12 months: ☐ 1-10 ☐ 11-20 ☐ 21-39 ☐ 40-49 ☐ 50 or more

If any person to be covered has used any tobacco product within the past 12 months but has stopped using all tobacco products, please provide the name of the person and the date he/she stopped.

First Name: _____ Date Stopped: _____

8. Lifestyle Information *(continued)*

B. Within the past 12 months, has any person to be covered consumed alcoholic beverages?

(Note: Even if you drink only on occasion, please provide the number of drinks you consume on such occasions.)

YES NO

☐ ☐ If YES, please complete the following *(One drink equals 12 oz. of beer, 4 oz. of wine, or 1 oz. of liquor.)*:

First Name: _____ Number of drinks consumed per **week**: ☐ 0-7 ☐ 8-14 ☐ 15-20 ☐ 21-26 ☐ 27-35 ☐ 36 or more
First Name: _____ Number of drinks consumed per **week**: ☐ 0-7 ☐ 8-14 ☐ 15-20 ☐ 21-26 ☐ 27-35 ☐ 36 or more

C. Within the past 12 months, has any person to be covered used marijuana?

YES NO

☐ ☐ If YES, please complete the following:

First Name: _____ Frequency of use per **month** during the past 12 months: _____

D. Within the past 5 years, has any person to be covered used cocaine, heroin, ecstasy, LSD or any other illicit drug(s)?

YES NO

☐ ☐ If YES, please complete the following:

First Name(s): _____

9. Certification and Authorization

This section must be signed and dated to avoid delays in processing.

A. Certification

I and my agent (if applicable) certify that I have read or have had read to me this completed application. I understand that any answer or statement made within this application that is untrue and is material to the risk assumed by Anthem Blue Cross and Blue Shield may prevent the recovery of benefits under the policy for that individual or individuals to be covered. Such answer or statement may also result in the termination or voiding of the policy back to its start date for the individual or individuals for whom the untrue and material information was provided.

I understand that:

1. no coverage will be in force until my application is approved by the Company and that the start date will be the date assigned by the Company;
2. the Anthem policy does not provide coverage for pre-existing health conditions for the first 12 months after the policy start date. I understand that if I have been covered by eligible health insurance before the Anthem policy, the 12 month waiting period may not apply to me, or the waiting period may be shorter than the entire 12 months;
3. if the Maternity Coverage was chosen, conception must occur at least six months after the Maternity Coverage start date. If you are an "Eligible Individual," as outlined in Section 5 of this application, and conception had occurred prior to the start date, the six month waiting period is waived;
4. my enclosed premium will be applied to coverage for approved person(s); the premium will be refunded if no persons are approved for the coverage selected and no other coverage is accepted; and
5. if any person for whom coverage is sought incurs a change in medical condition during the time period between the application date and the date Anthem underwriting approves the application, I must notify Anthem in writing of such change. I understand that failure to do so can result in the policy being revoked and no payment or coverage for any claim incurred.

I understand that the policy that I am applying for is an individual health insurance policy. As such, I understand that the policy, if issued, shall not be used as an employer-provided health care benefit plan. I certify that no employer of any person covered under this policy may pay any premium for this coverage, directly or indirectly, including through wage adjustment. I understand that "employer" does not include a trade or business wholly owned by an individual, or individual and spouse/domestic partner, that has no other employees or that does not offer health benefits to any other employees. Also, as it pertains to this provision, a church may purchase an individual policy if only purchasing it for one employee.

I understand that premiums not paid in accordance with this provision shall result in the non-renewal or discontinuance of the policy issued from this application.

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still 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/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 had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: _____(Date)

PLEASE NOTE: A copy of the "Notice to Applicant" was delivered to me upon signature.

X _____ / /
Signature of Applicant or *print and sign name* of Legal Representative — Date *(mm/dd/yyyy)*

X _____ / /
Signature of Spouse/Domestic Partner or *print and sign name* of Legal Representative — Date *(mm/dd/yyyy)*

X _____ / /
Signature of Other Adult Person to be covered or *print and sign name* of Legal Representative — Date *(mm/dd/yyyy)*

X _____ / /
Signature of Other Adult Person to be covered or *print and sign name* of Legal Representative — Date *(mm/dd/yyyy)*

X _____ / /
Signature of Agent if applicable — Date *(mm/dd/yyyy)*

___ ___ ___ ___ ___ ___ – ___ ___ ___ ___ _____
Agency Number — Agent Number — Receipt Date

( ) _____ ( ) _____ _____
Telephone Number — Fax Number — Email address

B. Authorization

This section must be signed and dated to avoid delays in processing.

The following authorization must be signed by the applicant and other adult persons, including adult dependents (e.g. age 18 or older in Virginia) to be covered. If the applicant does not sign this authorization, coverage may not be issued. If any other adult person to be covered refuses to sign the authorization, any coverage issued will not be extended to that person.

I hereby authorize that:

1. at the request of Anthem Blue Cross and Blue Shield, any provider of health services or supplies, insurance company, organization, institution, or person can release information to Anthem Blue Cross and Blue Shield about health-related services and supplies provided to me, persons covered, or persons to be covered. This authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record;
2. the Medical Review and Underwriting departments or agents of Anthem Blue Cross and Blue Shield, upon receiving this information, can use it to review, investigate, or evaluate any application for an insurance policy, a policy reinstatement, or a request for change in policy benefits;

9b. Authorization *(continued)*

3. unless previously revoked, this authorization is valid for 30 months from the date I signed it; and
4. a copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

X _____ / /

Signature of Applicant or *print and sign name* of Legal Representative — Date *(mm/dd/yyyy)*

X _____ / /

Signature of Spouse/Domestic Partner or *print and sign name* of Legal Representative — Date *(mm/dd/yyyy)*

X _____ / /

Signature of Other Adult Person to be covered or *print and sign name* of Legal Representative — Date *(mm/dd/yyyy)*

X _____ / /

Signature of Other Adult Person to be covered or *print and sign name* of Legal Representative — Date *(mm/dd/yyyy)*

If a legal representative signs on behalf of the applicant or any other adult person to be covered, a copy of the legal representative's authority must be attached to the application.

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

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Express Payment Authorization and Credit Card Payment

Take advantage of our easy payment methods!

You can choose to make your **initial premium payment** by check *(which will be cashed upon receipt but does not imply approval of your application)*, money order, or credit card. If choosing to pay by credit card, simply complete all of the credit card payment information in this section of the application.

For **future payments**, consider the convenience of our **free Express Payment service!** You'll find the Express Payment authorization form below. Express Payment saves you time, hassles, and the cost of checks and postage. And you can choose to have your premium deducted on the first or fifth day of the month

A. Express Payment Authorization *(Optional)*

It's convenient! You can authorize Anthem Blue Cross and Blue Shield to automatically deduct your premium payment from your checking account each month. Once your application is approved, we will work with your bank to initiate this service. Until the service is effective, you will receive a bill in the mail for your monthly premium. We will notify you when your Express Payment service is in effect.

Simply 1) complete the information below, 2) attach a voided check, and 3) remember to include your first month's premium when you return your completed application.

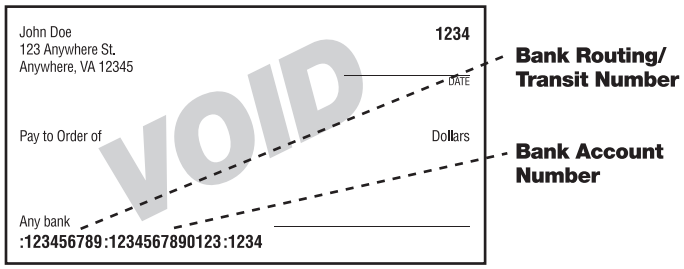
Applicant's Full Name: _____

Full Bank Name: _____

Routing #: _____

Account # (5-17 digits): _____

Date of Month for Express Payment to occur: ☐ **1st** ☐ **5th**



Be sure to attach a voided check.

I wish to take advantage of the Express Payment bank draft program to pay my Anthem Blue Cross and Blue Shield (Anthem) premiums every month. To do so, I authorize my bank as named above to deduct my Anthem health insurance premium every month directly from my bank account.

The appropriate bank account number and related bank routing number are shown on my enclosed blank, voided check. I understand that I am to pay my premiums directly to Anthem on schedule until my Express Payment bank draft becomes effective. If any premium is owed by me to Anthem when my Express Payment bank draft starts, I authorize my bank to draft both the past due premium along with the current premium. I agree that if my bank does not draft my account and pay my premium, I am responsible for making the correct premium payment to Anthem, no matter what the reason is for my bank's failure to draft and pay. I understand that failure to pay premiums when due can result in the termination of my Anthem health insurance coverage, and I understand my bank is not liable for that loss. This authorization is in effect until I notify Anthem by telephone or in writing delivered to Anthem by mail or by fax.

✗ _____ / /

Signature *(exactly as it appears on bank records)* Date *(mm/dd/yyyy)*

B. Credit Card Authorization for Initial Payment *(Optional)*

You may choose to make your initial premium payment by check, money order or credit card. Credit card payment is available for your initial premium payment only. If choosing to pay by credit card, you must complete ***all*** of the following information:

☐ **VISA** ☐ **MasterCard**

_____ /

Card Number Expiration Date *(mm/yyyy)*

I authorize Anthem Blue Cross and Blue Shield to bill my VISA or MasterCard account for the initial application payment. If the results of the health underwriting for my policy result in a different premium than my original premium quote, I also authorize Anthem Blue Cross and Blue Shield to bill my VISA or MasterCard for this difference if necessary.

_____

Applicant's Name *(Please print)*

✗ _____ / /

Cardholder's Signature Date *(mm/dd/yyyy)*

Anthem Blue Cross and Blue Shield
P. O. Box 14046
Roanoke, VA 24038-4046

Definition of Terms

These terms have been used in the application and have been defined here for your convenience.

1. **Primary applicant**
   The first person listed on the application. This person will be considered the policyholder if approved.
2. **Domestic partner**
   An individual with whom you have been living together six or more months and plan to continue living together, are financially interdependent, is at least 18 years old, not married to anyone else and not related by blood in a way that would prohibit marriage.
3. **Underwriting**
   Health underwriting is the assessment of the medical history and current health and lifestyle status of an applicant to determine the appropriate risk level and premium.
4. **Deductible**
   The amount you pay toward health care services each calendar year before receiving certain benefits.
5. **Coinsurance**
   The percentage of the allowable charge you pay for services covered by your policy after you meet your deductible.
6. **Supplemental Accident coverage**
   Coverage for services or supplies used to diagnose or treat an injury caused by an accident. Examples of accidents include: animal bites, choking on food or foreign objects, frostbite, and poisoning.
7. **Employer coverage**
   Insurance that is provided through an employer. The employer pays for some part of the premium for coverage.

Checklist

Please review this checklist before you return your application:

- ☐ Did you provide all requested information for each person to be covered? Failure to provide all requested information will cause a delay in the processing of your application.
- ☐ Did the Primary Applicant in **Section 1** initial and date any corrections to the application and sign and date any additional attachments?
- ☐ Individuals applying for coverage who are not U.S. citizens and who have resided in the USA less than two years will be required to complete a Medical Report of Application (MRA) form. ***The effective date of coverage will be after the receipt of this form.***
- ☐ Did you read **Section 9** carefully? All adults *(age 18 and over in the state of Virginia)* to be covered must sign and date both the **Certification** and the **Authorization** areas in **Section 9**. **The Authorization section applies to** Federal HIPAA regulations, which help us protect your privacy when handling your personal medical information. We cannot process your application without your signature in both areas. ***Please note: Anthem does not pay for medical records needed during the underwriting process.***
- ☐ Include the initial premium payment in the form of a check or money order made payable to Anthem, or use the convenient credit card payment option located behind the application. Please refer to the rate quote we mailed to you or that you obtained at **anthem.com** for the estimated initial premium. If you are approved and your actual premium differs from the estimate, we will notify you once your application has been processed. If your application is not approved, this initial payment will be refunded to you.
- ☐ Complete the Express Payment Authorization located behind the application to take advantage of our convenient monthly payment option *(beginning after your initial premium payment mentioned above)*.

If you need assistance, your Agent will be glad to help.

Underwriting Phone Number: 1-800-446-3948

Underwriting Fax Number: 1-800-336-2429