Anthem

Anthem Individual Enrollment/Change Application

3000 Goffs Falls Road
Manchester, NH 03111-0001
www.anthem.com

New Enrollment : 1-800-382-4832
Current Members : 1-800-807-2919

To Be Completed By Producer
Producer Name _____
Vendor Code # ___|___|___|___|___
Producer Signature _____
Producer Phone # _____
Effective Date ____/____/____
For Office Use Only
Firm Division No.
U/W Rate Decision

Remember to Complete All Sections of this Application

PLEASE USE BLACK OR BLUE INK ONLY

1. Applicant Information

Please check appropriate item: ☐ **New Enrollment** ☐ **Change** ☐ **Add/Remove Dependent**

Effective Date

If Anthem approves my application, please assign an effective date of ____/__/____. The effective date must be no earlier than the signature date and no greater than [60] days from the receipt of this application. **NOTE: REQUESTING AN EFFECTIVE DATE *DOES NOT GUARANTEE* COVERAGE OR ENROLLMENT *AS OF THE DATE REQUESTED.* Effective date will ultimately be assigned by Anthem Blue Cross and Blue Shield and communicated to you.**

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

2. Membership Choice

CHOOSE ONE MEMBERSHIP TYPE: ☐ SINGLE ☐ TWO PERSON ☐ FAMILY ☐ PARENT/CHILD(REN)

3. Plan Choice

(Please select one deductible option. The Two Person/Family Deductibles are greater than the Individual Deductible. Blue Direct deductibles are for in-network. There are additional deductibles for out-of-network.)

Blue Direct (PPO)

☐ Blue Direct $1,000/3,000
☐ Blue Direct $2,000/6,000
☐ Blue Direct $5,000/15,000

OR

Anthem Consumer-Driven Plan

Anthem Lumenos Health Savings Account (H.S.A.)
☐ $1,250/$2,500 deductible (100% In network)
☐ $2,500/$5,000 deductible (100% In network)
☐ $2,500/$5,000 deductible (80% In network)
☐ $5,000/$10,000 deductible (100% In network)

For Health Savings Accounts, complete the following:
☐ Yes, I would like to establish an H.S.A. with Anthem's banking partner. SSN required see Section 1.
☐ No, I do not want to establish an H.S.A. with Anthem's banking partner.

Anthem Lumenos Health Incentive Account Plus (H.I.A.)
☐ $2,500/$5,000 deductible (80% In network)
$200/$400 Funding (Individual/Family)

Anthem Lumenos Health Incentive Account (H.I.A.)
☐ $1,500/$3,000 deductible (80% In network)
☐ $2,500/$5,000 deductible (80% In network)

Would you like to add Maternity Coverage? ☐ Yes ☐ No

(Continued on back)

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

NOTE: IF ELECTING DEPENDENT COVERAGE, PLEASE LIST ALL ELIGIBLE CHILDREN UP TO AGE 26. You must complete a Certification for a Mentally or Physically Incapacitated Dependent Child form if your child is disabled, incapable of self-support, and over age 25. The form must also be completed by your physician.

Dependent 1			___ __ ____	☐M ☐F		
Dependent 2			___ __ ____	☐M ☐F		
Dependent 3			___ __ ____	☐M ☐F		

5. **Prior and *Other Insurance Information* — Please answer ALL of the following questions.**

(1) Anthem Blue Cross and Blue Shield (Anthem) credits prior coverage toward the preexisting period of applicants who apply within 63 days after termination of qualifying prior coverage as required by law. In order to ensure that appropriate credit toward the preexisting period is obtained, please complete the following:

(a) Have you had coverage within 63 days of the date of application? ☐ Yes ☐ No

If yes, Name and address of Insurer _____

Policy Number _____ Name of insured _____ Date of Birth _____

☐ Single ☐ Two Person ☐ Family

(b) Will medical coverage you are now electing replace another health insurance? ☐ Yes ☐ No

If yes, Name and address of Insurer _____

Group No. _____ Effective Date of Policy _____ End Date of Policy _____

(2) Are you or any of your dependents eligible for Medicare or Medicaid? ☐ Yes ☐ No

(3) (a) Are you or any family member on this application eligible for Anthem group coverage? ☐ Yes ☐ No

(b) If yes, does employer contribute towards premium of dependent coverage? ☐ Yes ☐ No

Please note: If you currently have coverage, do not cancel prior to your acceptance into our plan.

6. Billing Choice (Please Check One)	☐ Quarterly Paper Bill ☐ Monthly Paper Bill ☐ Electronic Fund Transfer - complete section 7 and attach a voided check or savings account deposit slip.

7. Electronic Fund Transfer Authorization (EFT) *(Complete if you want your payments deducted directly from your checking or savings account.)*

I hereby authorize Anthem to initiate a withdrawal (on or about the 5th business day of each month) from my bank account for payment of my premium. The bank account is with the bank named below, which is hereby authorized to withdraw this amount from my account each month.

BANK NAME	PHONE NUMBER
BANK ADDRESS	CITY/STATE/ZIP CODE
BANK INFORMATION: Routing #	Account #

TYPE OF ACCOUNT: (Check Only One) ☐ Checking Account (must attach voided check)

☐ Savings Account (must attach savings account deposit slip)

This authorization is to remain in effect until Anthem has received at least 30 days prior written notification from me of a termination date.

8. Statement Of Preferred / Standard Rate Acknowledgement

If preferred rates are not applicable but all eligibility requirements are met, Anthem will offer me, or any member to be covered under this policy a standard rate. If a standard rate is determined by underwriting, or if one or more of the individuals listed on my application do not meet the basic eligibility criteria, please indicate below how you would like us to proceed.

☐ Please continue with the enrollment process, subject to rate classification and eligible applicants. I understand that a lower rate may be available from the state's high-risk pool. If a lower rate is available, my producer or a representative from Anthem will contact me to discuss my options. Upon acceptance of the standard rate, I understand that I will receive a premium invoice from Anthem for the additional amount due.

If Anthem's standard rate is lower than the state's high-risk pool, I authorize Anthem to proceed with my enrollment and forward my membership materials to me.

☐ Before continuing the enrollment process, please contact me either through my producer or directly for authorization to continue at the standard rate.

☐ Do not continue the enrollment process at the standard rate.

9. Statement Of Premium Payment Acknowledgement

I understand that coverage most often becomes effective for eligible members on the first day of the month after submission of enrollment forms, provided that the Enrollment and Change Form and Health Statement form are completed accurately and in full, signed, dated and received by Anthem by the last day of the month prior to the effective date (unless the applicant requests a future effective date).

(Continued on back)

I understand that the submission of my enrollment forms are not a guarantee of coverage. Anthem will make the final determination about eligibility and rate classification by reviewing the information I submit.

Anthem may request further information about eligibility. If Anthem determines that I am not eligible for membership, I will be notified of the finding, coverage will not become effective.

If Anthem requests further information about eligibility and/or health status, my effective date of coverage may be delayed until Anthem receives all of the information requested. I will be notified of the effective date and any changes in premium offerings that may have occurred during the period of delay. If I do not respond to Anthem's request for further information within 24 days, coverage will not become effective.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

(Only applies if this is a replacement policy)

According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Anthem. For your own information and protection, certain facts should be pointed out to you, which could affect your rights to coverage under the new policy.

(a) 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 a claim for benefits being denied or reduced under the new policy, whereas the same claim might have been payable under your present policy. Or, even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

(b) 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 interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(c) 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.

(d) Finally, before you terminate your present policy, be certain that your application for the new policy has been accepted by the replacing company.

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.

I hereby authorize Anthem to institute the action indicated above. I understand that my Health Statement form is part of this application. To the best of my knowledge and belief, all of the information I provide is accurate and true. I will submit documentation of such to Anthem upon request. I understand that any significant misrepresentation or omission may cause Anthem to terminate or void my coverage, in accordance with New Hampshire law.

10. Applicant's Signature ***(If applicant is under 18, parent or guardian signature required.)*** _____ Date / /

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

Anthem Blue Cross and Blue Shield
Blue Direct®
Family Health Statement

This Family Health Statement is part of your Blue Direct® application. Please submit this with your Enrollment and Change Form.

Visit our Web site at anthem.com

Anthem®

2166 Rev. (11/07)

Blue Direct® Family Health Statement
Applicant and Family Information

PART A YES NO

HAS ANYONE HAD HEALTH OR LIFE INSURANCE MODIFIED, POSTPONED OR RATED? ☐ ☐

IF YES, PLEASE SUBMIT DETAILS _____

PART B Are you or any person to be insured – YES NO

1. currently disabled or unable to perform their normal activities? ☐ ☐
2. been hospitalized, had surgery or been advised to have surgery within the past five years for any reason? ☐ ☐
3. currently pregnant or an expectant parent? ☐ ☐
4. currently taking any medication? If yes, please specify medication and condition for which it is used: _____ ☐ ☐
5. have any conditions or symptoms for which a physician or other medical care provider has not been consulted? ☐ ☐
6. had medical expenses in excess of $5,000 in the last 12 months? ☐ ☐
7. been convicted of driving under the influence of drugs or alcohol within the last 36 months? ☐ ☐
8. smoked or used tobacco products in the last 12 months? ☐ ☐

PART C

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

1. Chest pain, heart attack, heart murmur, heart trouble, rapid, slow or irregular heart beat, other diseases of the heart, circulatory system or blood vessels, varicose veins, phlebitis, anemia or other disorder of the blood? ☐ ☐
2. Cancer, tumor or lymph node enlargement? (Indicate type of cancer and location _____) ☐ ☐
3. Sexually transmitted disease? ☐ ☐
4. Mental, emotional, behavioral or nervous condition or disorder of any kind? ☐ ☐
5. Brain disorder, neurologic problems, seizure disorder, any disorder of the central nervous system, stroke or paralysis? ☐ ☐
6. Alcohol or drug use, abuse and/or dependency? ☐ ☐
7. Medical diagnosis of AIDS (Acquired Immuno Deficiency Syndrome) or ARC (AIDS Related Complex)? ☐ ☐
8. Any disorder of the male/female reproductive organs including infertility and complications of pregnancy? ☐ ☐
9. Back, neck, bone, joint problems, Lupus, arthritis or autoimmune disorder? ☐ ☐
10. Diabetes? If so, specify date of diagnosis, type of treatment, amount of medications (if any): _____ _____ ☐ ☐
11. Any disorder of the stomach, intestines, gallbladder or esophagus? ☐ ☐
12. Any disorder of the lungs or respiratory system or Tuberculosis? ☐ ☐
13. Any disorder of the kidneys, bladder or urinary tract? ☐ ☐
14. Any disorder of the liver or pancreas? ☐ ☐
15. Any disorder of the endocrine system or glands? ☐ ☐

PART D

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

	YES	NO		YES	NO
1. Asthma	☐	☐	7. Lyme Disease	☐	☐
2. Bronchitis	☐	☐	8. Nose/Throat/Sinus problems	☐	☐
3. Chiropractic Care	☐	☐	9. Skin problems/Allergies	☐	☐
4. Ear problems	☐	☐	10. Blood Pressure or High Cholesterol	☐	☐
5. Eye problems	☐	☐	If yes, please provide blood pressure readings for the previous 12		
6. Headaches/Migraines	☐	☐	months and/or the results of the most recent lipid/cholesterol profile		

PART E Have you or any person to be insured – YES NO

1. had an examination or treatment for any illness or injury other than those stated above? ☐ ☐
2. engaged in or contemplated engaging in sports or hobbies such as racing, aviation, scuba diving, skydiving, etc? Specify who and what activities _____ ☐ ☐
3. currently have any claims open or under review through Worker's Compensation? ☐ ☐

GIVE DETAILS TO ABOVE QUESTIONS ON NEXT PAGE (Part G). Simply listing the name of a primary physician or referring to a physician's name will not be considered a substitute for listing fully detailed answers to the questions on this and the following page.

PART F
COMPLETE FOR ALL FAMILY MEMBERS APPLYING FOR COVERAGE:

FIRST NAME	INITIAL	LAST NAME		HEIGHT	WEIGHT	DATE OF BIRTH	SEX M/F
			APPLICANT	/		/ /	
				/		/ /	
				/		/ /	
				/		/ /	
				/		/ /	
				/		/ /	

PART G
DETAILS TO HEALTH HISTORY

GIVE DETAILS OF EACH ITEM CHECKED (✔) ON THE FIRST PAGE IN A "YES" COLUMN OF PARTS B, C, D and E.
(If more space is needed, attach separate page which must be signed and dated.)

Question Number	Person Affected	Condition/ Diagnosis	Treatment (Surgeries/Medications)	Treatment Dates From	Treatment Dates To	Date of Full Recovery or Last Treatment Date	Name, Address, Phone Number of Physician, Hospital/Institution

To the best of my knowledge and belief, all of the information I provide is accurate and true. I understand that any significant misrepresentation or omission may cause Anthem Blue Cross and Blue Shield to change my premium rate retroactive to my effective date or to terminate or void my coverage, in accordance with New Hampshire law.

Date_____

Applicant's Signature _____

Other Adult Signature (covered person 18 or older) _____