

**Section A** Please print clearly in ink, or type.

Last name of applicant		First name		Middle initial
Home address: Street		City	State	ZIP code
County		Home phone (include area code)		Social Security Number
Date of birth / /	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height (Ft. / In.)	Weight
Are all persons applying for coverage legal residents of the United States and residents of the state in which you are applying for coverage?				<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, attach a copy of your green card or visa.)
Name of employer		Work phone (include area code)		

**Section B** Coverage Desired

Deductible level desired: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	Type of coverage desired <input type="checkbox"/> Single <input type="checkbox"/> Children <input type="checkbox"/> Parent/Children <input type="checkbox"/> Couple <input type="checkbox"/> Family	Term (days) _____ (30–180 days)
<b>Check one:</b> Coverage paid in full options: <input type="checkbox"/> Premium Check Enclosed <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express Credit Card no. _____ Expiration date: _____ <input type="checkbox"/> Automatic Bank Draft (Complete section F.)	Monthly payment options: (\$10 monthly fee) <input type="checkbox"/> Automatic Bank Draft (Complete section F.) Premium will be deducted on the same day of the month as your assigned effective date. <input type="checkbox"/> Bill me monthly (One month's premium must accompany this application.)	<b>Requested future effective date:</b>  Total premium due: (Make check payable to <b>Anthem Blue Cross and Blue Shield.</b> ) \$ _____

**Section C** Dependent Information

Applicant information must be completed for all dependents (if any) for whom coverage is being requested. An eligible dependent may be your spouse, domestic partner, your unmarried children, or your spouse's or domestic partner's unmarried children (to the end of the calendar month in which they turn 25). (List all dependents beginning with the eldest.)

First name	Middle initial	Last name (if different from applicant)	Social Security Number	Height	Weight	Birthdate			Sex (M or F)	Relationship to applicant
						Mo.	Day	Year		

If there are additional dependents, please attach a separate page with all requested information.

**Section D** Other Coverage Information

Will this coverage replace a previous short-term or temporary plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, previous identification number	Policy expiration date
Do you or any person to be covered now have an active health coverage policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, expiration date (This coverage cannot be issued while any other coverage is in force.)	
Have you or any other person to be covered ever been denied health coverage for health reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, who was denied?</b>		
Are you currently applying for any other coverage with us? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did you or your eligible dependents have creditable coverage within the past 63 days? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Section E** Other Information

Are you, your spouse or domestic partner or any of your eligible dependents (whether or not named on this application) currently pregnant or an expectant parent (including adoptions)? <b>If Yes, who?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you, your spouse or domestic partner or any of your eligible dependents an insulin dependent diabetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person named on the application currently hospitalized or in a nursing home? <b>If Yes, provide the name of each person.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last five years, have you, your spouse or domestic partner or any dependent to be covered, received any medical or surgical consultation, advice, or treatment including medication for: heart or circulatory system disorder including heart attack or chest pain; stroke; diabetes; cancer or tumor; alcoholism or alcohol abuse; drug abuse or chemical dependency? <b>If Yes, who? Specify condition(s):</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last five years, has any person to be covered ever tested positive for Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) or other immune system disorder? <b>If Yes, who?</b> (NOTE: HIV or AIDS tests are limited to FDA-licensed blood tests. You do not have to disclose a positive test result obtained at an anonymous counseling or testing site, or a home test kit.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
During the term of this plan, will you or any dependent turn age 65, or will any dependent turn age 25 or no longer be eligible for coverage? <b>If Yes, who?</b> (Dependents are eligible to the end of the calendar month in which they turn 25. When no longer eligible, dependents may apply for their own temporary coverage.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Section F Automatic Bank Draft Authorization

If you completed Section B and selected Automatic Bank Draft, please complete this section.

Deduct premium from:  Checking account  Savings account (Premium will be deducted on the same day of the month as your assigned effective date.)

Deduct money from my/our account for (check one):

My first and ongoing payments  My ongoing payments only (first payment made by other method)

You **MUST** attach a **blank** voided check for checking account deduction and premium will be deducted on the same day of the month as your assigned effective date. **I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the account indicated and the designated financial institution to debit the same account. I understand that this authorization is in effect until I notify Anthem in writing that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals if they wish to do so.**

Account holder's name

Applicant's Social Security Number

Account holder's signature (if other than the applicant)

## Section G Significant Terms, Conditions and Authorizations (TERMS)

1. I understand that it is mandatory that I notify Anthem, in writing, immediately if I (the applicant) or any other person for whom coverage is sought has been advised of, diagnosed with or treated for any illness, injury or condition or has symptoms that would cause a prudent person to seek care, after the date I sign this application but before my effective date. I understand that in this situation, Anthem has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be rescinded or delayed or benefits denied due to the illness, injury or condition being treated as a pre-existing condition.
2. I understand that sending my initial premium with this application, and the receipt of my payment by Anthem, does not mean that coverage has been approved. I understand that if my application is denied, my bank account or credit card will not be charged.
3. I may not assign any payment under my Anthem program.
4. I am applying for the coverage selected on this application.
5. I understand that any premium quote provided is preliminary and review of my application by medical underwriting may change the premium or result in a denial of coverage.
6. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application, and that no right whatsoever is created by this application.
7. I understand that any pre-existing conditions in existence within 24 months immediately prior to my enrollment, for which medical advice, diagnosis, care or treatment was recommended or received or for symptoms that arose that would cause a prudent person to seek care, are not covered. Pregnancy is considered a pre-existing condition.
8. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
9. I understand Anthem may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed.

The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem automatic debit process and will only occur each time I send a check to Anthem. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.

10. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
11. I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is mentally competent; he or she is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
12. I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
13. I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem in accepting this application. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative.

Signature of Applicant (for applicants age 18 or older)

Date

Signature of Spouse or Domestic Partner (if to be covered)

Date

**Do not cancel your present health coverage until you receive written notification from Anthem Blue Cross and Blue Shield that your new coverage is in force.**

## Section H Agent Certification

I hereby certify that I have asked the applicant all questions set forth above, and that I have accurately recorded the answers supplied by the applicant. Any reporting form that is required due to a positive response to this question has been completed and submitted with this application. I further certify that I have explained the exclusions and limitations of the policy.

Agent's Name (please print)

Agent's Signature

Agent Number

Agent Phone Number

Agent Fax Number

Agent Email Address

Date

**IMPORTANT: No person, including an employee or agent of Anthem Blue Cross and Blue Shield, has the authority to change or omit any of the questions or statements on this application.**