Anthem
Anthem Health Plans of Virginia, Inc.

Anthem Life
Anthem Life Insurance Company

This is an application for medical coverage insured by Anthem Health Plans of Virginia, Inc., and if you choose, can also be used to apply for term life coverage insured by Anthem Life Insurance Company.

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.)*

☐ **Premier**	☐ **SmartSense**	☐ **CoreShare**
B. Choose Deductible/Coinsurance		
☐ $500/20% ☐ $1,500/20% ☐ $2,500/20% ☐ $2,500/0% ☐ $3,500/0% ☐ $5,000/0% ☐ $7,500/0% ☐ $10,000/0%	☐ $750/30% ☐ $1,500/30% ☐ $2,500/30% ☐ $3,500/30% ☐ $5,000/30% ☐ $7,500/30% ☐ $10,000/0%	☐ $750/50% ☐ $1,500/50% ☐ $2,500/50% ☐ $3,500/50% ☐ $5,000/50% ☐ $7,500/50%
C. Choose Optional Coverage		
☐ Add Dental coverage ☐ Add Supplemental Accident coverage ☐ _____ (INITIAL HERE) Add Maternity coverage* *(Maternity coverage only available for deductible options of $2,500 and higher.)*	☐ Add Dental coverage ☐ Add Supplemental Accident coverage	☐ Add Dental coverage ☐ Add Supplemental Accident coverage

* ***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. In addition, this Maternity Coverage is only available for deductible options of $2,500 or higher.*

D. Desired Start Date

If your application is approved your coverage can start on any day of the month after the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.

Please choose the date you would like your coverage to start: ____/____/_____ MM/DD/YYYY

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. An independent licensee of the Blue Cross and Blue Shield Association.
®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. Anthem Life Insurance Company is an affiliate of Anthem Blue Cross and Blue Shield.

E. Choose Optional Term Life Insurance

Add Term Life Insurance

☐ $25,000 coverage for you and $25,000 coverage for your spouse; and $15,000 coverage per dependent child

☐ $50,000 coverage for you and $50,000 coverage for your spouse; and $15,000 coverage per dependent child

YES NO

☐ ☐ Do you, the primary applicant by applying for the proposed policy or contract intend to replace, discontinue or change an existing life insurance policy or annuity contract?

***If you selected any of the renewable term life insurance options above**, this coverage will be issued as a separate policy from your health insurance policy. Your life policy will be insured by Anthem Life Insurance Company (Anthem Life), an affiliate of Anthem Health Plans of Virginia, Inc. Eligibility for this term life coverage is dependent upon the underwritten approval of **all** applicants for the health policy applied for in Section 2A with the exception of those applicants listed in Section 5 as HIPAA Eligible Individuals. Anthem Life is an independent licensee of the Blue Cross and Blue Shield Association.*

Definitions

The **Primary Beneficiary** is the person designated to receive the proceeds of a life insurance policy following the death of the insured.

The **Contingent Beneficiary** is the person who will receive the death benefit if the primary beneficiary should die before the person whose life is insured.

The **Percentage of Allocation** is the percentage amount of the term life insurance death benefit that an applicant designates to his/her beneficiary(ies). For example, a 50% allocation to a beneficiary would leave half of the death benefit proceeds to that individual.

Please complete the information below for each person on this application. Each applicant can have multiple beneficiaries. Use an additional sheet of paper if necessary. All additional pages must be signed and dated by the primary applicant.

First Name of Applicant	Beneficiary Name	Beneficiary Social Security Number	Relationship to Applicant	Allocation		Percentage of Allocation *(must add up to 100% for each applicant)*
				PRIMARY	CONTINGENT	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	
				☐	☐	

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

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/ Replacing Coverage
	☐ More than 2 years ago OR ☐ ____ /____ /_____ MM DD YYYY	☐ Will replace current coverage 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 replace current coverage 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 Medicaid, 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 answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

✍ *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

6. Medical Information *(continued)*

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?

☐ ☐ 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		06/2006			Removed Goiter 06/2006
				07/2006	☒ 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: _____

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 and Anthem Life (if applicable) may prevent the recovery of benefits under the policy for that individual or individuals to be covered. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found on an application 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 Anthem Blue Cross and Blue Shield and that the start date will be the date assigned by Anthem Blue Cross and Blue Shield;**
2. **for applicants age nineteen (19) and older, the Anthem Blue Cross and Blue Shield 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 Blue Cross and Blue Shield 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;**
5. **it is mandatory that I notify Anthem, in writing, immediately if I (the applicant) or any other person for whom coverage is sought received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage 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 delayed or reformed or, for applicants nineteen (19) and older, benefits denied due to the illness, injury or condition being treated as a preexisting condition;**
6. **the Anthem Blue Cross and Blue Shield 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 the Anthem Blue Cross and Blue Shield policy may pay any premium for 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 health policy if only purchasing it for one employee. Premiums not paid in accordance with this provision shall result in the non-renewal or discontinuance of the Anthem Blue Cross and Blue Shield policy issued from this application;**
7. **benefits provided by Anthem Blue Cross and Blue Shield combined with benefits payable under any other health care policy or HMO program will not exceed the allowable charge; and**
8. **my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 6 months or more; he or she is mentally competent; he or she, is at least 18 years old; 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.**

X _____ / /

Signature of Primary 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)*

B. Authorization for Use of Protected Health Information

The following authorization must be signed by all of the following persons if they are applying for coverage or changing existing coverage:

- the applicant;
- the applicant's spouse or domestic partner; and
- any Dependent Child age 18 or over.

If the authorization is not signed by all of the persons listed above who are seeking coverage, the application may be returned to you as incomplete or acted upon without regard to any person whose required signature was not included.

By signing below:

I authorize Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company (if applicable), or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company (if applicable), to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations.

I also authorize any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans, medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations to furnish any medical records or health history information concerning me and any family member listed on my Application to Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company (if applicable), or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company (if applicable). This information is needed to determine eligibility for coverage and Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company (if applicable) 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.

This authorization is for the term of the coverage of the health insurance policy in connection with a determination of coverage regarding a claim for health insurance benefits. This authorization is for the duration of the claim in connection with a determination of coverage regarding a claim for life insurance benefits under any life insurance policy issued. However, this authorization will expire 24 months from the date I sign it for purposes of determining my eligibility or continued eligibility for coverage under any health insurance or life insurance policy issued.

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

Printed name of Applicant/Member	Signature of Applicant/Member or his/her Legal Representative	Date *(mm/dd/yyyy)*
Printed name of Spouse or Domestic Partner or Dependent Child age 18 or over listed on Application	Signature of Spouse or Domestic Partner or Dependent Child* or his/her Legal Representative	Date *(mm/dd/yyyy)*
Printed name of Dependent Child age 18 or over listed on Application	Signature of Dependent Child* or his/her Legal Representative	Date *(mm/dd/yyyy)*

** If listed on your application or change form, your spouse/domestic partner and each dependent child age 18 or over must sign above.*

If a legal representative signs on behalf of the applicant or spouse or domestic partner, a copy of the legal representative's authority must be attached to the application.

A photocopy of this form will be as valid as the original. You or your authorized representative has the right to receive a copy of this Authorization upon request.

Express Payment Authorization and Credit Card Payment

Take advantage of our easy payment methods!

You can choose to make your **first 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.

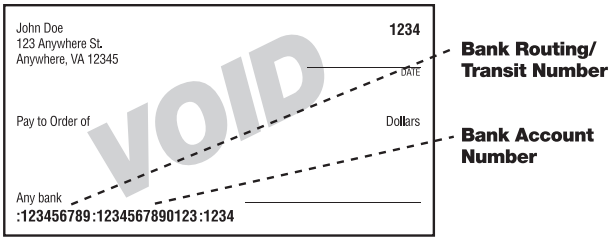
Applicant's Full Name: _____

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. I understand that a service charge will be incurred for any withdrawal not honored. 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 First Payment *(Optional)*

If paying by credit card: A credit card can be used only for the **initial premium payment**.

Credit card information

_____

Cardholder Name (as shown on the credit card) Cardholder Address

If applicant is using the credit card of another cardholder: By signing this form, applicant represents and warrants that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for this payment and any charges accruing to it.

Type of credit card: ☐ VISA ☐ Mastercard

_____ /

Credit card number Expiration Date *(month/year)*

Authorization: I authorize Anthem Blue Cross and Blue Shield to charge my VISA or MasterCard credit card account for the initial premium 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 charge my VISA or MasterCard credit card for this difference if necessary.

I agree that Anthem Blue Cross and Blue Shield is fully protected in honoring any credit card payments. I further agree that if any credit card payment is dishonored, with or without cause, intentionally or inadvertently, Anthem Blue Cross and Blue Shield is under no liability whatsoever, including any fees imposed by my bank, if my credit card is rejected even though such dishonor results in termination of coverage.

✗ _____

Cardholder's Signature

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. **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.
3. **Deductible**
   The amount you pay toward health care services each calendar year before receiving certain benefits.
4. **Coinsurance**
   The percentage of the allowable charge you pay for services covered by your policy after you meet your deductible.
5. **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.
6. **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 three months 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 first premium payment mentioned above)*.

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

Direct Sales Phone Number: 1-800-334-7676

Direct Sales Fax Number: 540-853-5148

If you have questions while your application is in the underwriting process you may contact the Underwriting Department at 1-800-446-3948.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. An independent licensee of the Blue Cross and Blue Shield Association.
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ANTHEM BLUE CROSS AND BLUE SHIELD

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An independent licensee of the Blue Cross and Blue Shield Association.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente.

(If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the customer service number.)

NOTICE – PLEASE READ CAREFULLY

This is an update to the Health Insurance Portability and Accountability Act (HIPAA) *eligible individual* definition. Medicaid is being added to the definition as indicated in #2 below.

Please note that 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 Medicaid, 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.*