s. Ins 3.33,
Appendix 1

INDIVIDUAL UNIFORM APPLICATION FOR INDIVIDUAL MAJOR MEDICAL HEALTH INSURANCE FORM

Ref: Section Ins 3.33, Wis. Adm. Code, and s. 601.41 (10), Wis. Stat.

State of Wisconsin
Office of the Commissioner of Insurance
P.O. Box 7873
Madison, WI 53707-7873
(608) 266-3585
Web Address: oci.wi.gov

This form is designed for an individual's initial application for coverage. Please contact the insurer with questions regarding this form.

Instructions: Please complete the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application, please attach, sign and date each page.

I. INFORMATION

Primary Applicant/Insured Information:

First, Middle and Last Name				
Social Security No.*	Place of Birth	Birth Date	Gender	Height _____ Weight _____
Residential Address				
City	County	State	Zip Code	
Mailing Address, if different from residential address				
City	County	State	Zip Code	
Home Phone	Alternative Phone		Email (Optional)	
*If you have a Social Security Number.				
The Primary Applicant is: [ ] Single [ ] Married [ ] Under the age of 18** **If primary applicant is under the age of 18, please complete sections – II. C. and V.				
Employment Information: Primary job duties: Self-Employed: [ ] Yes [ ] No				

II. ADDITIONAL APPLICANTS

A. Please complete ONLY if your spouse and/or children under the age of 27 are applying for coverage. If there is not enough space provided, please attach additional family information. **Please sign and date the additional sheet.**

Spouse Name (First; M.I.; Last)	Gender	Social Security Number*/ Place of Birth	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

* If you have a Social Security number.

Child Name (First; M.I.; Last)	Gender	Social Security Number*	Birth Date (Mo/Day/Yr)	Height Weight	Primary Job Duties (if applicable)

* If you have a Social Security number.

B. Does the child(ren) named within this application live with you at the address shown above?

[ ] Yes [ ] No If "No," please list the child(ren)'s name and mailing address(es):

Mailing Address Named Applicant			
City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child.			

C. If the primary applicant is under the age of 18, provide the name and mailing address of the legal guardian or custodial parent:

Mailing Address Legal Guardian or Custodial Parent			
City	County	State	Zip Code
Home Phone		Alternative Phone	
Name of the Legal Guardian or Parent responsible for carrying health insurance for the minor child			

III. CURRENT AND PREVIOUS COVERAGE

Please provide information about you or your dependent's individual or group health insurance coverage or other health coverage (either prior or current). It will help us determine whether you will have any waiting periods for preexisting conditions for the health insurance you are applying for. By providing this information you are not reducing your health insurance.

Does anyone applying for coverage have current health coverage?

[ ] Yes [ ] No If "Yes," please indicate insurer and applicant _____.

Has any applicant had health insurance coverage within the last 18 months?
[ ] Yes [ ] No If "Yes," please indicate insurer and applicant_____.

If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted?
[ ] Yes [ ] No

Is any applicant enrolled in Medicare?
[ ] Yes [ ] No If "Yes," name of applicant _____. For this applicant, please stop here – this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid or other governmental health programs (i.e. BadgerCare, TRICARE, Veterans services)?
[ ] Yes [ ] No If "Yes," name of applicant _____. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

IV. MEDICAL INFORMATION

NOTICE TO APPLICANT:

The insurance company does not use or collect genetic information for any Underwriting purpose. Genetic information includes information related to genetic tests, genetic counseling, and any family history of a disease or disorder. Any such information should not be included on an application or communicated to the insurance company in any manner. For the purpose of these questions, *chronic* means persistent, continuous, or periodic, or a combination of any of these terms.

You are required to disclose information regarding any disease or condition for which:

- Any applicant has been diagnosed or treated by any healthcare provider.
- Any applicant has had testing with abnormal results.
- Any applicant is awaiting test results.
- Any applicant has been recommended or scheduled for diagnostic testing, consultation, treatment, follow-up, or surgery.
- Any applicant has taken or has been advised to take any prescription medication.
- Any change in health status for which any applicant has not sought medical care or treatment.

Within the last FIVE (5) YEARS has anyone, including you or any family member requesting coverage, received counseling, care or treatment, medication, medical advice or been told a diagnosis for any of the conditions or illnesses listed below? (Please check all conditions that apply.)

Please mark "Yes" or "No" for each item, for you and any family members requesting coverage. Provide additional information for each question you answer "Yes" to on the Additional Medical Details page that follows the health questions.

Answers to the medical questions should be complete, true and correct to the best of your knowledge. You are required to promptly notify us if there is a change in your or your family's health prior to the effective date of coverage and provide updated information. If at any time during the underwriting process prior to the effective date of coverage, you or your health history changes, please notify us immediately as this may impact your coverage.

WITHIN THE LAST FIVE (5) YEARS:

1. Infectious and Parasitic Diseases

a. AIDS (acquired immunodeficiency syndrome), ARC (AIDS-related complex), HIV positive [The reporting of HIV test results is limited to FDA-licensed tests, and	[ ] Yes [ ] No

you need not report results of tests conducted at an anonymous counseling and testing site or through the use of a home test kit.]	
b. Lyme's Disease	[ ] Yes [ ] No
c. Sexually transmitted disease(s)	[ ] Yes [ ] No

2. Blood, Gland, Endocrine, Metabolic and Immune Disorders (other than HIV, ARC, AIDS)

a. Anemia/blood disorder	[ ] Yes [ ] No
b. Thyroid disease	[ ] Yes [ ] No
c. Diabetes/high or low blood sugar. ..... (If "Yes," record last HGA1C reading and date on the Additional Medical Details page.)	[ ] Yes [ ] No
d. Adrenal disorder	[ ] Yes [ ] No
e. Enlargement of lymph nodes	[ ] Yes [ ] No
f. Endocrine/gland/hormone system	[ ] Yes [ ] No

3. Cancer, Cyst and Tumors

c. Cancer. ..... (If "Yes," include the stage, type and location of the tumor on the Additional Medical Details page.)	[ ] Yes [ ] No
b. Tumors, cyst, lump, polyp	[ ] Yes [ ] No

4. Mental/Nervous/Behavioral Disorders

a. Alcohol/chemical/drug abuse/dependency	[ ] Yes [ ] No
b. Has any applicant used sedatives; tranquilizers; cocaine or other hallucinogenic or narcotic drugs?	[ ] Yes [ ] No
c. Eating disorders such as, but not limited to, anorexia or bulimia	[ ] Yes [ ] No
d. Mental/emotional condition/depression	[ ] Yes [ ] No
e. Autism	[ ] Yes [ ] No
f. Suicide attempt	[ ] Yes [ ] No
g. Alcohol, chemical, drug abuse therapy, treatment or counseling within last 5 years ..... (if "Yes," record date of last session in on the Additional Medical Details page)	[ ] Yes [ ] No

5. Brain and Nervous System

a. Brain disease or injury/concussion	[ ] Yes [ ] No
b. Convulsion/seizures/epilepsy	[ ] Yes [ ] No
c. Chronic headaches/migraines	[ ] Yes [ ] No
d. Neurological condition/disease/injury	[ ] Yes [ ] No
e. Sleep apnea/chronic sleep disorder	[ ] Yes [ ] No
f. Stroke	[ ] Yes [ ] No
g. Multiple Sclerosis	[ ] Yes [ ] No
h. Paralysis	[ ] Yes [ ] No

6. Skin Disorders

a. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer	[ ] Yes [ ] No

7. Eyes, Ears, Nose

a. Chronic ear/nose condition/disease	[ ] Yes [ ] No
b. Chronic eye condition/disease	[ ] Yes [ ] No
c. Cataracts/glaucoma	[ ] Yes [ ] No

8. Mouth, Throat or Jaw

a. Chronic throat/tonsil/adenoid/disease/disorder	[ ] Yes [ ] No
b. TMJ/jaw joint	[ ] Yes [ ] No

9. Heart or Circulatory System

a. Blood/circulatory disorder	[ ] Yes [ ] No
b. Heart attack/chest pain/murmur/angina	[ ] Yes [ ] No
c. Elevated/High cholesterol (if "Yes," record last reading and the date on the Additional Medical Details page)	[ ] Yes [ ] No
d. Elevated/High or low blood pressure (if "Yes," record last 3 readings and dates in past 12 months on the Additional Medical Details page)	[ ] Yes [ ] No
e. Phlebitis/blood clot	[ ] Yes [ ] No
f. Heart disease/disorder	[ ] Yes [ ] No

10. Respiratory System

a. Asthma	[ ] Yes [ ] No
b. Emphysema/Chronic obstructive pulmonary disease (COPD)	[ ] Yes [ ] No
c. Chronic respiratory/lung condition	[ ] Yes [ ] No
d. Pneumonia/bronchitis	[ ] Yes [ ] No

11. Digestive System

a. Appendicitis/chronic abdominal pain	[ ] Yes [ ] No
b. Blood in stool	[ ] Yes [ ] No
c. Colon/rectum/intestine/bowel/Crohn's disease	[ ] Yes [ ] No
d. Ulcer/esophageal reflux	[ ] Yes [ ] No
e. Gallbladder	[ ] Yes [ ] No
f. Liver condition/hepatitis/pancreas	[ ] Yes [ ] No

12. Urinary System

a. Bladder/urinary tract	[ ] Yes [ ] No
b. Kidney/kidney stones	[ ] Yes [ ] No

13. Male or Female Reproductive Systems

a. Breast (lumps or masses)	[ ] Yes [ ] No
b. Prostate/elevated PSA/prostatitis	[ ] Yes [ ] No
c. Reproductive system disorder/infertility/dysfunction	[ ] Yes [ ] No
d. Abnormal pap smear or mammography	[ ] Yes [ ] No

14. Pregnancy, Birth or Congenital Abnormalities

a. Birth defect/congenital deformities	[ ] Yes [ ] No

b. Pregnancy complications	[ ] Yes [ ] No
c. Are you, your spouse or any dependent child(ren) (even if not listed on the application) currently pregnant or an expectant parent? (If "Yes," due date _____.)	[ ] Yes [ ] No

15. Muscular or Skeletal System

a. Back/neck/spine disorder	[ ] Yes [ ] No
b. Bone/orthopedic disorder	[ ] Yes [ ] No
c. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia.....	[ ] Yes [ ] No
d. Osteoarthritis/osteoporosis/osteopenia	[ ] Yes [ ] No
e. Rheumatoid arthritis.....	[ ] Yes [ ] No
f. Knee/shoulder/hip/joint surgery/disorder	[ ] Yes [ ] No
g. Hernia	[ ] Yes [ ] No

16. Miscellaneous

a. Cosmetic surgery/implants	[ ] Yes [ ] No
b. Use of prosthetic devices/limbs	[ ] Yes [ ] No
c. Had chronic fatigue	[ ] Yes [ ] No
d. Is any person to be insured now disabled, on disability, or unable to perform normal work or age-related activities	[ ] Yes [ ] No
e. Any fluctuations in weight (+/- 20lbs) in the past 12 months	[ ] Yes [ ] No
f. Implantable devices/stents/shunts/pace maker.....	[ ] Yes [ ] No
g. Allergies	[ ] Yes [ ] No
h. Transplants	[ ] Yes [ ] No

17. Other Injury, Illness, Treatment or Condition

a. Within the last 5 years, has any applicant had any other injury, illness, treatment, or condition not already listed; been hospitalized or scheduled to be hospitalized; had surgery or had surgery scheduled; had a test or a test scheduled; been recommended to have a test or surgery that was not performed for any reason not already mentioned; been prescribed medication for a condition or injury not already mentioned? (We are NOT seeking the results of HIV Antibody test.)	[ ] Yes [ ] No

18. Tobacco Use

a. Has any applicant used tobacco products in any form within the last 12 months?..	[ ] Yes [ ] No
If "Yes", provide the name of applicant(s), amount of tobacco used and frequency:	

19. Other Activities

a. Has any applicant been involved in or participated in organized motorized racing or other extreme activities?	[ ] Yes [ ] No
If "Yes", provide the name of applicant(s), activity and frequency of the activity:	

ONLY complete this section if you need assistance with completing the medical information portion of this Application. Please note that this may require additional time to process your application.

Please contact me at this phone number during business hours:

I am unavailable during business hours, please contact me at this number during evenings or weekends:

Additional Medical Details Page

For any "Yes" responses in the medical information questions, please provide complete details below. Not providing complete details will delay the application process. Within the last five years has anyone been prescribed medications that were recommended or received from a licensed health care professional? Use an additional sheet(s) of paper if necessary.

All additional pages must be signed and dated by the primary applicant.

Question # or additional information								
Applicant Name								
Specific Diagnosis & Type of Treatment								
Duration of Condition	**Began mm/yy**		**Began mm/yy**		**Began mm/yy**		**Began mm/yy**	
	End mm/yy		**End mm/yy**		**End mm/yy**		**End mm/yy**	
Name/ Dosage/ Frequency of medication & Dates of Medication Use	**Name of Rx**		**Name of Rx**		**Name of Rx**		**Name of Rx**	
	Dose		**Dose**		**Dose**		**Dose**	
	Began mm/yy	**End mm/yy**	**Began mm/yy**	**End mm/yy**	**Began mm/yy**	**End mm/yy**	**Began mm/yy**	**End mm/yy**
Was surgery performed								
Description of surgery/ Procedures/ Tests/Result & Dates								
Current Status/ O-Ongoing/ R-Resolved								
Readings for Blood Pressure, Cholesterol & Diabetes	**Date**	**Reading**	**Date**	**Reading**	**Date**	**Reading**	**Date**	**Reading**
Physician/ Hospital Name, City, State								

V. TERMS AND CONDITIONS

I acknowledge that I have read and completed the entire Application. If I received assistance in reading or completing this Application, I have identified the person(s) who assisted me. I agree that the answers are, to the best of my knowledge and ability, complete and true.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the insurance company on the certificate or policy.

I understand that any intentional misrepresentation relied upon by the insurer may be used to deny a claim. I further understand that this contract can be voided if within the first 24 months from the date of the policy or certificate it is determined that I or a family member made an intentional misrepresentation in the application.

I understand that it may be a crime to submit an application or file a claim based on a false or deceptive statement. I further understand it may be a crime to submit an application that is intended to mislead an insurer or conceal significant information about the applicant.

I understand that I may request a copy of this Application and the notice of the company's privacy practices. I agree that a photocopy is as valid as an original. A legible facsimile or electronic signature shall have the same force as the original.

Signature (or e-signature) of Primary Applicant (If Primary Applicant is under the age of 18, Signature of legal guardian or custodial parent)	**Date Signed**
Signature (or e-signature) of Spouse	**Date Signed**

Signature (or e-signature) of each listed child who has attained the age of 18

Signature (or e-signature) of an Adult Child Applicant	**Date Signed**
Signature (or e-signature) of an Adult Child Applicant	**Date Signed**
Signature (or e-signature) of an Adult Child Applicant	**Date Signed**

Complete this section if someone assisted you in the completion of this Application

The following person assisted me in completing the Application:
Please explain the assistant's relationship to you and your family:

Wisconsin Individual Enrollment Supplemental Form

Anthem | Anthem Life

Please complete in blue or black ink only.

Section A – Coverage Information

Primary Applicant: First Name	MI	Last Name	Date of Birth / /

Application Type (select one):

☐ New Coverage

☐ Change Anthem Individual policy coverage Policy No. _____

☐ Add dependent(s) to current coverage Policy No. _____

Effective date requested: 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**

Are all applicants listed on the Individual Uniform Application legal residents of the United States and residents of the state in which you are applying for coverage? ☐ Yes ☐ No

If NO, who? _____

Are all applicants listed on the Individual Uniform Application United States citizens? ☐ Yes ☐ No

If NO, who? _____

and how many years/months have they resided in the United States? _____ years and _____ months

Section B – Other Health Coverage

Did you or your eligible dependents have creditable coverage within the past 63 days, including any Anthem coverage? (You may be eligible for preexisting credit. Preexisting condition limitations do not apply to applicants under the age of nineteen (19), if applying for non-grandfathered coverage.) ☐ Yes ☐ No

The following information must be completed in order for credit to be given. Please provide the previous 18 months of coverage.

Name(s) of covered persons. If the whole family, simply write ALL in space below.			Identification Number(s)
Name and phone number of prior carrier(s)			Reason for cancellation
Type of coverage: ☐ Group ☐ Individual	Is this Blue Cross and Blue Shield coverage? ☐ Yes ☐ No	Effective Date of Coverage / /	Cancellation Date of Coverage / /

Will you be canceling this coverage if approved for Anthem coverage? ☐ Yes ☐ No

Complete this section if you've had more than one carrier in the last 18 months (attach a separate sheet if necessary).

Name(s) of covered persons. If the whole family, simply write ALL in space below.			Identification Number(s)
Name and phone number of prior carrier(s)			Reason for cancellation
Type of coverage: ☐ Group ☐ Individual	Is this Blue Cross and Blue Shield coverage? ☐ Yes ☐ No	Effective Date of Coverage / /	Cancellation Date of Coverage / /

Will you be canceling this coverage if approved for Anthem coverage? ☐ Yes ☐ No

Blue Cross Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWi collectively underwrite or administer the POS policies. Life products underwritten by Anthem Life Insurance Company. Independent licensees 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.

Section C – Medical Coverage

Select one network option, then select your plan option and any optional benefits available for your selected plan:

☐ **BLUE ACCESS® PPO Network**

☐ **BLUE Preferred Plus® POS Network**

Plan Name, In Network Coinsurance, Deductible Options					Optional Benefits
Select ONE Plan...then select ONE Individual Deductible and any optional benefits. *Total Family Deductible is two (2) times the amount shown.*					
☐ **SmartSense® Plus**					
(50% coinsurance)	☐ $500	☐ $1,000	☐ $1,500	☐ $2,500	☐ **Upgrade Drug Coverage**
(30% coinsurance)	☐ $500	☐ $1,000	☐ $1,500	☐ $2,500	
	☐ $3,500	☐ $5,000	☐ $10,000		
☐ **Premier Plus**					
(20% coinsurance)	☐ $500	☐ $1,000	☐ $1,500	☐ $2,500	☐ **Upgrade Drug Coverage**
	☐ $1,500 - no office visit copay				☐ **Add Maternity coverage** (available on $2,500 or higher deductible options)
(0% coinsurance)	☐ $2,500	☐ $3,500	☐ $5,000	☐ $10,000	
	☐ $2,500 - no office visit copay				
☐ **CoreShare**					
(50% coinsurance)	☐ $750	☐ $1,500	☐ $2,500		
	☐ $3,500	☐ $5,000			
(0% coinsurance)	☐ $7,500	☐ $10,000	☐ $15,000	☐ $25,000	

HSA Compatible Plans

Select ONE Plan...then select ONE Deductible (Individual/Family).

☐ **Lumenos® HSA Plus**		
(50% coinsurance)	☐ $1,500/3,000	
(20% coinsurance)	☐ $1,750/3,500	
(0% coinsurance)	☐ $1,500/3,000	☐ $2,500/5,000
	☐ $3,500/7,000	☐ $5,500/11,000

☐ **YES**, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Anthem's banking partner. (Please fill in your social security number on the Individual Uniform Application.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Anthem's banking partner.

Section D – Dental Coverage Selection

☐ **Dental Blue® Basic 100**

☐ **Dental Blue® Essential 100**

☐ **Dental Blue® Essential 200**

☐ Yes, I wish to add dental coverage (at an extra cost per individual)

If Yes, select ONE coverage type (applies to individuals listed on this application only):

☐ Applicant only

☐ Applicant & Spouse or Domestic Partner only

☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

☐ Applicant & all dependent children listed

☐ Yes, if myself or any listed family member are declined for medical coverage, still enroll **all members selected above, if eligible.**

Section E – Anthem Life Insurance Company's Term Life Insurance

Blue Preferred® Term Life

☐ Yes, in addition to my medical coverage, I wish to apply for Term Life Insurance (at an extra cost per individual).

Do you, the applicant, own an existing life policy or annuity contract? ..... ☐ Yes ☐ No

If you answered "Yes" to the above question, inform the agent (if any), who will provide you a notice regarding replacement, which you must read and sign.

Do you intend to replace existing life insurance or an existing annuity on the same life? ..... ☐ Yes ☐ No

Provide information below.

Applicants must meet Anthem Life's Underwriting Guidelines to qualify for Term Life Insurance Coverage. Applicants under the age of one year are not eligible for Life Insurance. All Term Life policies terminate at age 65.

Applicants	Coverage Amount (select one)	Beneficiary**	Relationship	Beneficiary Street Address City/State/ZIP code
☐ Applicant	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		
☐ Spouse ☐ Domestic Partner	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		
☐ Child(ren)	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		

* The $50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to $25,000.

** **If a beneficiary is not listed** and a policy is issued, death benefits will be paid in accordance with the Beneficiary Provision of the Policy.

Section F – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

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 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 age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, benefits denied due to the illness, injury or condition being treated as a preexisting 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. I am applying for the coverage selected on this application. 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. 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.
4. **For applicants age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, I understand that benefits are not payable for any undisclosed preexisting conditions for the first 12 months after my effective date. Pregnancy is also a preexisting condition.**
5. If the plan I purchase offers a maternity rider, and I purchase that maternity rider, I understand that 1) these benefits apply only to me or my covered spouse and not to any dependent child and 2) these benefits will not begin until after my membership has been in effect for 18 months.
6. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
7. 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.
8. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
9. 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.
10. 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.
11. If I purchase optional dental coverage for the Dental Blue® Essential, I understand that I will have a twelve month waiting period for coverage of Major Restorative Services. *(For a description of Preventive, Diagnostic and Major Restorative services please refer to your contract.)*
12. By signing this application I certify that I understand that Anthem Life has the right to deny my application for Term Life Insurance Coverage, and if it does, I will be notified in writing. I understand that if Anthem Life declines this coverage, no benefits will be payable. I understand that I alone am responsible for reading and accurately completing this application, and I must communicate any changes to my status. I also understand that all other conditions of my medical application apply for the life application.
13. I represent that the answers given to all questions on this application, together with any supplemental or additional pages, 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 act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, 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.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate your present policy and replace it with a Contract to be issued by Anthem. For your own information and protection, certain facts should be pointed out which should be considered before you make this change.

1. Health conditions that you may presently have may not be covered under the new Contract. This could result in a claim for benefits being denied that may have been payable under your present policy.
2. Even though some of your present health conditions may be covered under the new Contract, these conditions may be subject to certain waiting periods, for applicants age nineteen (19) and older applying for non-grandfathered coverage, under the new Contract before coverage is effective.
3. Questions in the application for the new Contract must be answered truthfully and completely; otherwise, the validity of the Contract and the payment of any benefits thereunder may be voided.
4. The new Contract will be issued at a higher age than that used for the issuance of your present policy; therefore the cost of the new Contract, depending upon the benefits, may be higher than you are paying for your present policy.

Section F – Significant Terms, Conditions and Authorizations (TERMS) *(continued)*

5. The renewal provisions of the new Contract should be reviewed so as to make sure of your rights to periodically renew the policy.
6. It may be to your advantage to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. You should be certain that you understand all the relevant factors involved in replacing your present coverage.

SIGN HERE

Signature of Applicant (or Custodial Parent's or Guardian's signature if applicant is under age 18) X	Date
Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) X	Date
Signature of Dependent Child(ren) age 18 or over X	Date

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. This Authorization will expire 24 months following Anthem Blue Cross and Blue Shield's or Anthem Life Insurance Company's acceptance of coverage, if not previously revoked.

By signing below: I authorize Anthem Blue Cross and Blue Shield or Anthem Life Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield or Anthem Life Insurance Company, 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, MIB, Inc., formerly Medical Information Bureau (MIB), and/or insurance support organizations. I further authorize Anthem Blue Cross and Blue Shield or Anthem Life Insurance Company to disclose protected health information it may collect about me to MIB, which may re-disclose such information to other insurance companies pursuant to the MIB information exchange.

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 or Anthem Life Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield or Anthem Life Insurance Company. This information is needed to determine eligibility for coverage and Anthem Blue Cross and Blue Shield's or Anthem Life Insurance Company's 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 subject to revocation at any time by written notice to Anthem except to the extent that Anthem has already taken action in reliance on this authorization. If I revoke this authorization after I initially apply for coverage, I understand that I/we will not be considered for coverage. If I revoke this authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that if my and/or my family's information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans governed by federal privacy regulations, my/our information might be re-disclosed by any of those recipients and will not be protected by federal privacy regulations. A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

SIGN HERE

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

* *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/domestic partner or dependent child age 18 or over, a copy of the legal representative's authority must be attached to the application.*

Section G – Agent Certification

To be completed by your Anthem-appointed agent:

Risk Tier	Applicants	Last Name	First	MI
	☐ Primary Applicant			
	☐ Spouse/Domestic Partner			
	☐ Dependent 1			
	☐ Dependent 2			
	☐ Dependent 3			
	☐ Dependent 4			

☐ Please check box if any additional sheets of paper have been completed for this section. If so, please attach and return the additional sheets with this application.

1. Does the applicant intend to replace, discontinue or change any existing life policy or annuity contract? ..... ☐ Yes ☐ No
2. Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting? ..... ☐ Yes ☐ No
3. I certify to the best of my knowledge and belief, the responses herein are accurate. ..... ☐ Yes ☐ No

Agent Signature X			Date
Agent Name (please print)	Agent Street Address/Suite No./Personal Mail Box(PMB)No.		
Agent ID No.	City/State/Zip	County Code	Area
Agent Phone No.	Agent Fax No.	Agent Email Address	

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

THIS PAGE IS INTENTIONALLY BLANK.

If you have an Anthem agent, please mail directly to:
your Anthem agent.

If you do NOT have an Anthem agent, please mail to:

Anthem Blue Cross and Blue Shield
P. O. Box 659806
San Antonio, TX 78265-9106

Blue Cross Blue Shield of Wisconsin ("BCBSWi") underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare") underwrites or administers the HMO policies; and Compcare and BCBSWi collectively underwrite or administer the POS policies. Life products underwritten by Anthem Life Insurance Company. Independent licensees 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.

Payment Methods for Individual Coverage
Wisconsin

Anthem

Anthem Life

Please complete in blue or black ink.

Applicant / Member Name (Please Print):	**Primary Applicant's Social Security Number:**

INITIAL PREMIUM PAYMENT IS REQUIRED WITH APPLICATION. PLEASE CHOOSE ONE:

- ☐ Automatic Bank Payment (complete Section A). **If you choose this option, you must also select the Automatic Bank Payment option for future premiums.**
- ☐ Credit/Debit Card (complete Section B)
- ☐ One-time Electronic Bank Payment (complete Section C)
- ☐ Check or Money Order attached (make payable to Anthem)*

*When you provide a check as payment, you authorize us to either use the information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic fund transfer, funds will be withdrawn from your account as soon as the day of approval, and you will not receive your check back from your financial institution.

FUTURE PREMIUM PAYMENTS (MAKE ONE SELECTION OUT OF EACH COLUMN):

Frequency (you must select one):

- ☐ Monthly
- ☐ Quarterly
- ☐ Semi-annually
- ☐ Annually

Method of payment (you must select one):

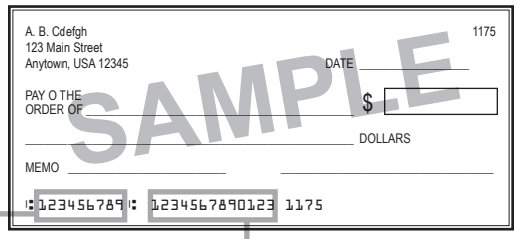
- ☐ Automatic Bank Payment (You must complete Section A)
- ☐ Bill me for future premiums.(Bills will be sent to address on application, unless a different address is listed below.)

Name _____ Address _____

City _____ State _____ ZIP _____

A. Automatic Bank Payment – If you select this option for your initial payment, <u>your bank account may be debited one month's premium as soon as the day of approval</u>. This will include all products selected, including dental and/or life. I hereby authorize Anthem to initiate a withdrawal on the same day of each month as my assigned effective date from the bank account named below.

- ☐ Checking Account
- ☐ Savings Account **(account number will be different than that of checking account)**. Check with your financial institution to be sure automatic recurring deductions are allowed against this account.



Provide your Bank Account Information here:

9-Digit Bank Routing Number	Bank Account Number
|__|__|__|__|__|__|__|__|__|	

I authorize to initiate premium deductions (and corrections to premium deductions) from the bank account indicated, and the designated financial institution to debit the same account. **I understand that the initial premium amount may vary as a result of change(s) during the underwriting process and that following premium amounts may vary as a result of change(s) I make once enrolled.** These may include, but are not limited to, adding and deleting dependents or moving my residence. I understand that Anthem's rights with each premium deduction are the same as if I submit a check signed by me. This authorization is in effect until I provide Anthem thirty (30) days written notice that I no longer desire this service, and Anthem and the designated financial institution have the right to discontinue the premium deductions if they wish to do so. **I also understand that a service charge may be incurred for any withdrawal not honored.**

Authorized Signature (as it appears on the financial institution's records) **X**	Account Holder Name (Please PRINT)	Date

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

B. Credit/Debit Card – As a convenience to me, I request and authorize Anthem to charge the credit/debit card indicated one time for the initial premium payment amount upon approval. I understand that if this option is selected, the credit/debit card indicated may be charged for the initial premium payment amount as early as the date of approval. **If the initial premium payment amount varies from the quote generated by the system or due to changes during the underwriting process, I also authorize Anthem to charge the credit/debit card indicated for the different amount.**
I agree that Anthem is fully protected in honoring any credit/debit card payments. I further agree that if any credit/debit card payment is dishonored, with or without cause, intentionally or inadvertently, Anthem is under no liability whatsoever, including any fees imposed by credit/debit card company or my bank, if my credit/debit card is rejected even though such dishonor results in termination of coverage. **We accept Visa and MasterCard.**

Type Of Card: ☐ Visa ☐ MasterCard

Card Number: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Expiration Date: |___|___|/|___|___|

Authorized Signature (as it appears on the credit/debit card) **X**	Cardholder Name (as it appears on the credit/debit card – Please PRINT)		Date
Cardholder Billing Address	City	State	ZIP

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

C. One-time Electronic Bank Payment – Please complete the information below.

Account Holder Name (Please PRINT)	9-Digit Bank Routing Number |___|___|___|___|___|___|___|___|___|	Account Number
Authorized Signature (as it appears on the financial institution's records) **X**		Date

☐ Checking Account

☐ Savings Account **(account number will be different than that of checking account).** Check with your financial institution to be sure automatic deductions are allowed against this account.

I authorize Anthem to initiate a one-time deduction from the bank account indicated and the designated financial institution to debit the same account.

I understand that the initial premium amount may vary as a result of change(s) during the underwriting process, and I authorize Anthem to debit the bank account for the different amount. If this option is selected, I understand my account may be debited the initial premium payment amount as early as the date of approval.

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

Life and Disability products underwritten by Anthem Life Insurance Company. Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin ("BCBSWi"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWi, which collectively underwrite or administer the POS policies. Independent licensees 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.