Colorado Individual Child-Only Enrollment Application

Anthem
Anthem Blue Cross and Blue Shield
P.O. Box 9041
Oxnard, CA 93031-9041

Please complete in blue or black ink only.

IMPORTANT NOTES:

- PREMIUM PAYMENT IS REQUIRED TO BE SUBMITTED WITH YOUR APPLICATION. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. Applications received with no premium payment will be returned which may impact your eligibility for coverage. If you have any questions, please call 1-877-373-9821.
- Key words (I, my, you, your, individual) are used throughout this application and refer to the child applicant.

Section A – Coverage Information

Child-Only Plan Qualifications

Qualified applicants under age 19 are accepted on a guarantee issue basis without any limitations or riders based on health status or pre-existing conditions. A carrier may deny coverage to an applicant for enrollment in a child-only plan if other creditable coverage is available, which can include current enrollment in a high-risk pool plan. Other eligibility requirements may also apply.

Open Enrollment

The initial open enrollment will be held in August of 2011, followed by a 30-day waiting period with a policy effective date of October 1, 2011. After the initial open enrollment period, open enrollment periods occur during the entire months of January and July, followed by a 30-day waiting period with a policy effective date of March 1st or August 31st. Applications must be received during the open enrollment month.

Qualifying Events

Outside the above open enrollment period the applicant may still enroll, if he/she has a qualifying event as defined below. Applications for a qualifying event must be received by Anthem within 30-days following the qualifying event.

Qualifying Events:

1. Within 30 days of Anthem's receipt of the application, has the applicant lost employer-sponsored health insurance coverage or lost eligibility under the Colorado Medical Assistance Act or the Children's Basic Health Plan? ☐ Yes ☐ No
2. Within 30 days prior of Anthem's receipt of the application, has the applicant involuntarily lost other existing coverage for any reason other than fraud, misrepresentation or failure to pay premium? ☐ Yes ☐ No
3. Within 30 days of Anthem's receipt of the application, has the applicant lost health insurance coverage due to dissolution of a marriage (divorce)? ☐ Yes ☐ No
4. Within 30 days of Anthem's receipt of the application, has the applicant been married? ☐ Yes ☐ No
5. Within 30 days of Anthem's receipt of the application, has there been an entry of a valid court or administrative order that requires that the applicant be covered under a policy of health insurance? ☐ Yes ☐ No
6. Is the date of the applicant's adoption within 30 days of Anthem's receipt of the application? ☐ Yes ☐ No
7. Is the applicant's date of birth within 30 days of Anthem's receipt of the application? ☐ Yes ☐ No

If the applicant has a qualifying event, coverage can start on any day of the month after the date we receive your application for a qualifying event. 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**

Section B – Applicant Information (Please print.)

Last Name	First Name	MI	Social Security Number*

Home Address (street and P.O. Box if applicable)	City	State	ZIP

Billing Address (street and P.O. Box if different from above)	City	State	ZIP

Marital Status ☐ Single ☐ Married ☐ Domestic Partner	Maiden Name (if applicable)	Height (Ft./In.) /	Weight (Lbs.)	Sex ☐ M ☐ F	Age	Date of Birth (mm/dd/yyyy) / /

Daytime Phone Number ( )	Evening Phone Number ( )	Fax Number ( )	Email*

** This information is used for internal purposes only.*

COCHOAPP (Rev. 8/11) Agent Name/TIN

Anthem Blue Cross and Blue Shield is the tradename of Rocky Mountain Hospital and Medical Service, Inc. Life and disability 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 B – Applicant Information (continued)

Provide your communication method of choice for all underwriting correspondence during the review of your application: ☐ Email ☐ Fax ☐ Mail

Language Choice (Optional) ☐ English ☐ Spanish

Do you read and write English? If NO, the translator must sign and submit a Statement of Accountability (Section L). ..... ☐ Yes ☐ No

Has the applicant lived (not traveled) outside the U.S. for the past three (3) consecutive months? ..... ☐ Yes ☐ No

Is the applicant a legal resident of the United States and resident of the state in which he/she is applying for coverage? ..... ☐ Yes ☐ No

Is the applicant a United States citizen? ..... ☐ Yes ☐ No

If NO, how many months/years have you resided in the United States? _____ years and _____ months

Section C – Medical Coverage

SmartSense Plus Child-Only..... ☐ 2500 - 70% w Standard (OH69)

Section D – Dental Coverage Selection

☐ YES, I wish to add dental coverage (at an extra cost).

PPO Plan ..... ☐ Anthem Blue Individual PPO Dental Plan (DE12)

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

☐ YES, in addition to my medical coverage, I wish to apply for term life insurance (at an extra cost).

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

If you answered "Yes" to the above question, inform the agent with whom you are working (if any), who will provide you an "Important Notice: Replacement of Life Insurance...."

By applying for this proposed life policy, do you intend to replace, discontinue or change any existing life policy? ..... ☐ Yes ☐ No

Provide information below.

Applicants must meet Anthem Life Insurance Company'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 on the month you turn age 65.

Applicant	Coverage Amount (select one)	Beneficiary*	Relationship	Beneficiary Street Address City/State/ZIP
☐ Applicant	☐ $15,000 (BV79) ☐ $25,000 (CV30)	Primary:		
		Contingent:		

DO NOT SUBMIT PREMIUM FOR ANY LIFE INSURANCE – IF ACCEPTED YOU WILL BE BILLED.

* **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 – The Health Insurance Portability and Accountability Act (HIPAA)

If you can answer YES to all of the following statements, you may meet the definition of a "federally eligible individual" and be considered HIPAA eligible.

1. I have had in the past 18 months, creditable coverage, the most recent of which was under a group health plan (including a government plan or church plan). ☐ Yes ☐ No

   If YES, please provide group name _____ and telephone number _____

2. I am NOT eligible for coverage under a group health benefit plan, Medicare or Medicaid and do NOT have other health benefit plan coverage. ☐ Yes ☐ No
3. My most recent coverage was NOT terminated as a result of nonpayment of premium or fraud. ☐ Yes ☐ No
4. If offered, I accepted continuation coverage and exhausted such benefits (i.e., State Continuation Coverage or COBRA). ☐ Yes ☐ No

   Date State Continuation or COBRA coverage ended: _____/_____/_____ MM/DD/YYYY

Can you answer YES to the statements above? ☐ Yes ☐ No

Do you qualify for HIPAA? ☐ Yes ☐ No

Section G – Employer Funded Insurance

1. Will an employer of fifty (50) or fewer eligible employees be paying for or reimbursing any applicant through wage adjustment, a health reimbursement arrangement or otherwise for any portion of the premium on the policy being applied for? ☐ Yes ☐ No

If you answered "No", you may stop and continue to Section H of this application.

2. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve months prior to the date of this application? ☐ Yes ☐ No

If the answer to question 1 is "Yes," the applicant cannot be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

Although the policy being applied for cannot be funded by an employer, the applicant may still be eligible for coverage paid for himself or herself. If the applicant wishes to apply for an individual policy of insurance where the applicant will pay the premiums, the applicant should continue completing the rest of the application and answer question 3.

3. Do you agree to apply for an individual policy of insurance and pay all the premiums without the financial assistance of your employer? ☐ Yes ☐ No

Section H – Other Health Coverage (Please answer ALL of the following questions.)

Anthem Blue Cross and Blue Shield may impose a surcharge for up to twelve months if the child was previously enrolled on a child-only plan, dropped the coverage and the lapse in coverage exceeds 63 days. The surcharge may be up to an additional 50% of the amount that would be charged for the same child who maintained coverage.

Have you had coverage in the last 63 days? ☐ Yes ☐ No

If you answered "YES" to the above, please provide the following information:

Certificate/Policyholder Number	Plan Name	State	Child-Only Policy? ☐ Yes ☐ No
Applicant Name	Most Recent Coverage Start Date / /	Date Of Policy Termination / /	

To determine eligibility for this plan, please indicate if other creditable coverage is available to the applicant under 19:

Do you have benefits or coverage provided under:

Colorado Medical Assistance Act, Medicare, Medicaid, or the children's basic health plan? ☐ Yes ☐ No

Employee welfare benefit plan or group health insurance or health benefit plan? ☐ Yes ☐ No

Individual health benefit plan? ☐ Yes ☐ No

State health benefits risk pool including but not limited to CoverColorado? ☐ Yes ☐ No

Chapter 55 of title 10 of the United States code, a medical care program of the federal Indian health service or of a tribal organization, a health plan offered under chapter 89 of title 5, United States code, a public health plan, or a health benefit plan under section 5 (e) of the federal "Peace Corps Act" (22 U.S. C. Sec. 2504 (e))? ☐ Yes ☐ No

NOTE: Please make a copy of the signed application for your records prior to submitting to Anthem Blue Cross and Blue Shield.

Section I – Health History (IMPORTANT: This section has two steps)

STEP 1 - ***All questions must be answered or the application will be returned.***

GIVE COMPLETE DETAILS IN STEP 2 FOR ALL SELECTED CHECK BOXES OTHER THAN THE "NO TO ALL" CHECK BOXES FOR QUESTIONS 1 - 14 BELOW.

When answering questions on this enrollment application the information provided 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.

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. We are relying on the information you provide to determine the appropriate rating tier for the policy. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician(s) to clarify your specific condition. We have the right to review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, do not assume we will review all of your medical records before approving your application. If we issue coverage to you and then discover an act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact, we may increase your premium to reflect the accurate health status. Even if you currently have health insurance coverage or had prior coverage with Anthem Blue Cross and Blue Shield, you must fully disclose and answer all health history questions.

PLEASE NOTE: The health history questions apply to ANY medical advice, diagnosis, care or treatment that you received or that a healthcare provider recommended that you receive for any of the conditions listed.

1. Bone, Joint and Muscle Problems

Within the last FIVE years, have you been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Arthritis (osteo-, rheumatoid or other)
- ☐ B. Back, neck, muscle, disc or tendon problems
- ☐ C. Bursitis
- ☐ D. Gout
- ☐ E. Fibromyalgia
- ☐ F. Osteopenia
- ☐ G. Ankylosing Spondylitis
- ☐ H. Osteoporosis
- ☐ I. TMJ (Temporomandibular Joint) disorder
- ☐ J. Other bone, joint or muscle problems
- ☐ K. **NO to all bone, joint and muscle problems**

2. Brain and Nerve Problems

Within the last FIVE years, have you been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Headaches requiring prescription medication
- ☐ B. Migraines
- ☐ C. MS (Multiple Sclerosis)
- ☐ D. Alzheimer's Disease or Dementia
- ☐ E. Muscular Dystrophy
- ☐ F. Parkinson's Disease
- ☐ G. Paralysis
- ☐ H. Seizures or convulsions
- ☐ I. Head Injury
- ☐ J. Stroke or Transient Ischemic Attack (TIA)
- ☐ K. Other brain or nerve problem
- ☐ L. **NO to all brain and nerve problems**

3. Breathing or Lung Problems

Within the last FIVE years, have you been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Asthma
- ☐ B. Bronchitis
- ☐ C. COPD (Chronic Obstructive Pulmonary Disorder)
- ☐ D. Cystic fibrosis
- ☐ E. Emphysema
- ☐ F. Pneumonia
- ☐ G. Sleep apnea
- ☐ H. Tuberculosis
- ☐ I. Other breathing or lung problems
- ☐ J. **NO to all breathing or lung problems**

4. Cancer, Cyst or Tumor

Have you ever been diagnosed with or received treatment for any of the following conditions :

- ☐ A. Cancer
- ☐ B. Basal cell
- ☐ C. Squamous cell
- ☐ D. Melanoma
- ☐ E. Polyp or Papilloma
- ☐ F. Cyst, growth, lump, mass or tumor
- ☐ G. Other cancer, cyst or tumor disorder
- ☐ H. **NO to all cancer, cyst or tumors**

Section I – Health History (IMPORTANT: This section has two steps) (continued)

5. Congenital (birth) or Developmental Disorders

Within the last FIVE years, have you been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Autism
- ☐ B. Cerebral Palsy
- ☐ C. Cleft palate and/or lip
- ☐ D. Mental retardation
- ☐ E. Other congenital or developmental disorders
- ☐ F. **NO to all congenital or developmental disorders**

6. Eyes, Ears, Nose and Throat Disorders

Within the last FIVE years, have you been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Allergies including hay fever and rhinitis
- ☐ B. Cataracts
- ☐ C. Detached retina
- ☐ D. Deviated nasal septum or polyps
- ☐ E. Ear infections (more than 2 in the last 12 months)
- ☐ F. Sinus infections (more than 2 in the last 12 months)
- ☐ G. Eye infections other than pink eye
- ☐ H. Glaucoma
- ☐ I. Hearing loss or cochlear implants
- ☐ J. Problems with tonsils or adenoids
- ☐ K. Other eyes, ears, nose or throat problems
- ☐ L. **NO to all eyes, ears, nose and throat problems**

7. Kidney or Bladder Problems

Within the last FIVE years, have you been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Bladder infections
- ☐ B. Pyelonephritis or Kidney infection
- ☐ C. Kidney failure
- ☐ D. Dialysis
- ☐ E. Kidney stones
- ☐ F. Urinary tract infections or problems
- ☐ G. Other kidney or bladder problems
- ☐ H. **NO to all kidney or bladder problems**

8. Nervous, Mental, Emotional or Behavioral Health Problems

Within the last FIVE years, have you been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Alcohol abuse
- ☐ B. Drug abuse
- ☐ C. Attention Deficit Disorder (ADD/ADHD)
- ☐ D. Bipolar Disorder
- ☐ E. Obsessive Compulsive Disorder
- ☐ F. Depression
- ☐ G. Anxiety
- ☐ H. Eating Disorder
- ☐ I. Panic Disorder
- ☐ J. Schizophrenia
- ☐ K. Other mental health problems
- ☐ L. **NO to all nervous, mental, emotional or behavioral health problems**

9. Male or Female Reproductive Problems

Within the last FIVE years, have you been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Cyst on ovary or problems with ovaries
- ☐ B. Uterine fibroids
- ☐ C. Endometriosis or Pelvic Inflammatory Disease
- ☐ D. Infertility (problems getting pregnant or in vitro fertilization)
- ☐ E. Abnormal pap smear or mammogram
- ☐ F. Sexually transmitted disease such as HPV (Human Papilloma Virus)
- ☐ G. Herpes or genital or anal warts
- ☐ H. Impotence or erectile dysfunction
- ☐ I. Disorders of the testicle
- ☐ J. Prostate problems
- ☐ K. Other female or male reproductive problems
- ☐ L. **NO to all male or female reproductive problems**

10. Heart, Blood and Blood Vessel Problems

Within the last FIVE years, have you been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Anemia
- ☐ B. Sickle cell anemia
- ☐ C. Hemophilia
- ☐ D. Leukemia
- ☐ E. Heart murmur or irregular heartbeat
- ☐ F. Aneurysm
- ☐ G. Angina (Chest Pain)
- ☐ H. Blood clots or phlebitis
- ☐ I. Heart disease or heart attack
- ☐ J. Heart valve disease or disorder
- ☐ K. High blood pressure (Hypertension)
- ☐ L. High cholesterol or triglycerides
- ☐ M. Raynaud's disease
- ☐ N. Varicose veins
- ☐ O. Pacemaker
- ☐ P. Other heart, blood or blood vessel problems
- ☐ Q. **NO to all heart, blood and blood vessel problems**

Section I – Health History (IMPORTANT: This section has two steps) (continued)

11. Metabolic, Immune System and Endocrine Problems

Within the last FIVE years, have you been diagnosed with or received treatment for any of the following conditions:

- ☐ A. HIV, AIDS or AIDS related complex
- ☐ B. Diabetes or high blood sugar
- ☐ C. Hormone or growth hormone disorders
- ☐ D. Lupus or SLE (Systemic Lupus)
- ☐ E. Thyroid or adrenal disorders
- ☐ F. Scleroderma
- ☐ G. Gaucher's disease
- ☐ H. Other metabolic, immune system and endocrine problems
- ☐ I. **NO to all metabolic, immune system and endocrine problems**

12. Skin Problems

Within the last FIVE years, have you been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Acne
- ☐ B. Psoriasis
- ☐ C. Rosacea
- ☐ D. Eczema or dermatitis
- ☐ E. Fungal infections
- ☐ F. Recurring or unresolved skin lesions (sores)
- ☐ G. Keratosis
- ☐ H. Severe burns
- ☐ I. Shingles
- ☐ J. Other skin disorders
- ☐ K. **NO to all skin problems**

13. Stomach, Intestinal and Liver Problems

Within the last FIVE years, have you been diagnosed with or received treatment for any of the following conditions:

- ☐ A. Colitis
- ☐ B. Chronic diarrhea
- ☐ C. Irritable bowel syndrome (IBS)
- ☐ D. Colon polyps
- ☐ E. Crohn's disease
- ☐ F. Gallstones or gallbladder disorder
- ☐ G. Diverticulitis or diverticulosis
- ☐ H. GERD (Gastroesophageal Reflux, or Acid Reflux)
- ☐ I. Hemorrhoids
- ☐ J. Hepatitis A
- ☐ K. Hepatitis B
- ☐ L. Hepatitis C, D, or E
- ☐ M. Hepatitis – type unknown
- ☐ N. Hernia
- ☐ O. Jaundice
- ☐ P. Liver disease/cirrhosis
- ☐ Q. Pancreatitis
- ☐ R. Ulcers
- ☐ S. Obesity surgery
- ☐ T. Constipation
- ☐ U. Other stomach, intestinal or liver problems
- ☐ V. **NO to all stomach, intestinal and liver problems**

14. Unexplained Problems or Symptoms in the last year

Within the last 12 MONTHS, have you had any of the following signs or symptoms for which you have NOT seen a doctor or other healthcare provider:

- ☐ A. Chest pain
- ☐ B. Dizziness
- ☐ C. Loss of consciousness/blackouts
- ☐ D. Pain in back, abdomen (stomach) or pelvis
- ☐ E. Numbness or tingling in the limbs
- ☐ F. Abnormal or recurrent bleeding (not related to menstruation)
- ☐ G. Shortness of breath or trouble breathing
- ☐ H. Lump or unexplained growth
- ☐ I. Tiredness that does not go away
- ☐ J. Weight loss of more than 10 pounds for reasons other than a weight loss program
- ☐ K. **NO to all unexplained problems or symptoms**

Section I – Health History (IMPORTANT: This section has two steps) (continued)

STEP 1 (continued) - ***All questions must be answered or the application will be returned.***

GIVE COMPLETE DETAILS IN STEP 2 FOR ANY LIFESTYLE OR OTHER QUESTIONS 15 - 24 ANSWERED "YES."

Lifestyle Questions

Tobacco Use

	YES	NO
15. a) Within the last **12 MONTHS**, have you used tobacco products or smoking cessation products?	☐	☐
b) If cigarettes, have you smoked 40 or more per day?	☐	☐

Alcohol and Drugs

	YES	NO
16. Have you ***ever*** used illegal drugs or been advised by a doctor or other healthcare provider to discontinue or decrease alcohol or drug use?	☐	☐

Other Questions

	YES	NO
17. Are you a candidate to receive or the recipient of an organ or bone marrow transplant?	☐	☐
18. Are you currently pregnant (includes positive pregnancy test), an expectant parent, or in the process of adoption or surrogate pregnancy?	☐	☐
19. Within the last **FIVE** years, have you had breast or other implants, internal fixation (pins, rods, screws, plates), joint replacement, prosthetic device, monitoring device, defibrillator, pacemaker, heart valve replacement, shunt, stent, or neuro stimulator?	☐	☐
20. Within the last **12 MONTHS**, have you been evaluated or treated in an emergency room or urgent care for any condition ***other than*** flu, sinus infection, pregnancy, bladder infection, hives, or for a sprain/strain that resolved in less than one month?	☐	☐
21. Within the last **FIVE** years, have you had treatment or surgery in a hospital or outpatient facility ***other than***: childbirth, fracture of a single bone in the hand, foot, arm or lower leg, hernia repair, hysterectomy, insertion of ear tubes in a child, tonsillectomy, tubal ligation, vasectomy, removal of appendix, or removal of gall bladder and was the procedure more than 3 months ago with no current treatment?	☐	☐
22. Have you been advised by a healthcare provider to have testing, examination, evaluation, treatment, therapy, or surgery that has not yet been completed?	☐	☐
23. Within the last **12 MONTHS**, have you received a prescription or taken any prescribed medication ***other than*** birth control for contraception, thyroid medication, or short term (10 days or less) antibiotics?	☐	☐
24 Within the last **THREE** years, have you been convicted of DUI two or more times?	☐	☐

Section I – Health History (IMPORTANT: This section has two steps) (continued)

STEP 2
Prescription Medications

List ***ALL*** medications taken within the last 12 MONTHS. Use an additional sheet of paper if necessary. All additional pages must be signed and dated by the applicant.

Applicant Name	Medication/Dosage/Frequency	Illness for which Medication is Prescribed	Date Prescribed (mm/dd/yyyy)	Date Discontinued (mm/dd/yyyy)	Name, Phone No. of Physician or Hospital
Example: Mary	Amoxicillin 250 mg 4x day	Tonsillitis	08/01/2008	09/01/2008	**Name:** Dr. John Doe **Phone:** 555-555-1000
					Name: **Phone:**
					Name: **Phone:**
					Name: **Phone:**
					Name: **Phone:**
					Name: **Phone:**

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

Health History

Give complete details below for all selected check boxes other than the 'no to all' check boxes for questions 1-14 and all Lifestyle or Other questions answered "YES" (see example below). Not providing complete details will delay the application process. Use an additional sheet of paper if necessary. All additional pages must be signed and dated by the applicant.

Question Number	Patient First Name	Name of Hospital, Clinic and/or Person Providing Care	Specific Diagnosis & Treatment	Name & Dosage of Medication & Dates of Use		Duration of Condition		Was Surgery Performed?		Description of Surgery/ Procedures & Date(s) (mm/yyyy)	Still Under Treatment
				Begin (mm/yyyy)	End (mm/yyyy)	Begin (mm/yyyy)	End (mm/yyyy)	YES	NO		
Example: #6	Mary	Dr. John Doe	Tonsillitis	Amoxicillin 250 mg 4x day 08/2008	09/2008	08/2008	09/2008	☑	☐	Tonsillectomy 09/2008	☐
								☐	☐		☐
								☐	☐		☐
								☐	☐		☐

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

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

Please read this section carefully before signing the application.

I, the undersigned, understand that under the Anthem Blue Cross and Blue Shield plan for which I am applying, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use an in-network hospital or physician.

AGREEMENT

By applying for coverage, I, the undersigned, agree to the following:

1. No coverage comes into effect until Anthem approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Anthem at its discretion.
2. Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. Cashing my check does not mean my application is approved.
3. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross and Blue Shield underwriting policy or the terms of any Anthem coverage.
4. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
5. I understand that coverage will not exist until this application is approved and effective date is assigned by Anthem.
6. I understand Anthem Blue Cross and Blue Shield may use any information prior to the effective date of coverage in considering my application, including medical conditions that occur after my signature and before the original effective date.
7. I understand that it is mandatory that I notify Anthem Blue Cross and Blue Shield, in writing, immediately if I (the applicant) 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 or the date underwriting approves, whichever is later. I understand that in this situation, Anthem Blue Cross and Blue Shield has the right to underwrite my application again, using the new information and that, as a result, my coverage might be delayed and premium rates adjusted.
8. By signing this application I understand that Anthem Life Insurance Company has the right to deny any application for term life 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 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.

I agree to update Anthem in writing with any additional medical history which relates to any of the preceding questions and of which I became aware after the date of this application, but before the effective date of coverage.

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

Rescission of Membership

I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered in this application, Anthem Blue Cross and Blue Shield may revoke my coverage. This means Anthem may cancel membership as if it never existed. Also, after approval for membership, if an act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact, is discovered by Anthem that was not provided to Anthem prior to the effective date of the policy, the plan may revoke coverage.

I understand that if my coverage is revoked, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for enrollment. I also understand that I may be required to pay for any claims that were paid while a member and that Anthem will refund all amounts paid by me except amounts owed to Anthem. I have personally read and completed this application. If I am accepted, this application will become part of the contract between Anthem Blue Cross and Blue Shield and me. I agree to abide by the terms of that contract.

REQUIREMENT FOR BINDING ARBITRATION:

I UNDERSTAND AND AGREE THAT ANY AND ALL DISPUTES BETWEEN ANTHEM AND ME MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT. UNDER THIS BINDING ARBITRATION REQUIREMENT, ANTHEM AND I ARE GIVING UP THE CONSTITUTIONAL RIGHT TO HAVE THE DISPUTE DECIDED IN A COURT OF LAW BY A JURY.

BEFORE COMMENCING ARBITRATION, THE PARTY SEEKING ARBITRATION MUST HAVE EXHAUSTED ALL LEVELS OF APPEAL AND REVIEW SET FORTH IN THE CERTIFICATE. ANY SUCH ARBITRATION WILL BE GOVERNED BY THE PROCEDURES AND RULES ESTABLISHED BY THE AMERICAN ARBITRATION ASSOCIATION. THE LAW OF THE STATE IN WHICH THE POLICY WAS ISSUED AND DELIVERED TO THE POLICYHOLDER SHALL GOVERN THE DISPUTE. THE DECISION IN ARBITRATION IS BINDING UPON BOTH ANTHEM AND ME. THE AWARD GIVEN IN ARBITRATION MAY BE ENFORCED OR REVIEWED IN ANY COURT THAT HAS PROPER JURISDICTION. IN THE EVENT ANY PERSON SUBJECT TO THIS ARBITRATION CLAUSE INITIATES LEGAL ACTION OF ANY KIND, THE OTHER PARTY MAY APPLY FOR A COURT OF COMPETENT JURISDICTION TO ENJOIN, STAY OR DISMISS ANY SUCH ACTION AND DIRECT THE PARTIES TO ARBITRATE IN ACCORDANCE WITH THIS PROVISION. THE QUESTION OF WHAT DISPUTES ARE SUBJECT TO THIS ARBITRATION CLAUSE SHALL BE DETERMINED BY THE ARBITRATOR.

If an Applicant does not read English, the translator must sign and submit a Statement of Accountability for translating this entire application (see Section L).

NOTICE:

By signing this contract you are agreeing to have ANY and ALL disputes against Anthem Blue Cross and Blue Shield decided by neutral arbitration and you are giving up your right to jury OR COURT trial for both medical malpractice claims and any other disputes. *Signatures Required.*

IMPORTANT: APPLICANTS OVER AGE 18 MUST PERSONALLY READ, AGREE TO, SIGN AND DATE THIS APPLICATION.

SIGN HERE

Printed name of Applicant	
Signature of Applicant ***(or Custodial Parent's or Legal Guardian's signature if applicant is under age 18)**** X	Date Signed / /

*** If the person signing the application has a different last name than the applicant, please indicate the reason:**

☐ **Custodial Parent or**

☐ **Legal Guardian** (NOTE: Court documents establishing legal guardianship must be submitted if the responsible adult is not the parent.)

Section K – Authorization for Use of Protected Health Information

The following authorization must be signed by the applicant applying for coverage or changing existing coverage.

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 acceptance of coverage, if not previously revoked.

By signing below:

I authorize Anthem Blue Cross and Blue Shield, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield, to obtain any medical records or other health history information concerning me 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 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 to Anthem Blue Cross and Blue Shield, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield. This information is needed to determine eligibility for coverage and Anthem Blue Cross and Blue Shield's acceptance of coverage requested for myself or so that a determination of coverage regarding a claim for specified benefits can be made.

I understand that I may revoke this Authorization at any time while Anthem Blue Cross and Blue Shield is determining eligibility for the coverage requested. To do so, I must submit a completed Authorization Revocation Form to Anthem Blue Cross and Blue Shield. An Authorization Revocation Form is available by calling 1-877-373-9821, going to our website, www.anthem.com/co, or writing to: Anthem Blue Cross and Blue Shield, P.O. Box 9041, Oxnard, CA 93031. If I revoke this Authorization after I initially apply for coverage, I understand that I will not be considered by Anthem Blue Cross and Blue Shield for enrollment in one of its medically underwritten health plans. If I revoke this Authorization after I ask to upgrade my coverage, I understand that the change will not be made. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by recipient and, in some circumstances, may no longer be protected by federal regulations governing the privacy of health information.

SIGN HERE

Printed name of Applicant	
Signature of Applicant ***(or Custodial Parent's or Legal Guardian's signature if applicant is under age 18)**** X	Date Signed / /

*** If the person signing the application has a different last name than the applicant, please indicate the reason:**

☐ **Custodial Parent or**

☐ **Legal Guardian** (NOTE: Court documents establishing legal guardianship must be submitted if the responsible adult is not the parent.)

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.

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. Life and disability products are underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Section L – Statement of Accountability

To be completed when the applicant cannot complete the application.

NOTE: Translator must be 18 years or older to translate the application on behalf of the applicant.

I, _____ , personally read and completed this Individual Enrollment Application for the applicant named below because:

☐ Agent assisted application ☐ Applicant does not read English ☐ Applicant does not speak English

☐ Applicant does not write English ☐ Other (explain): _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the: ☐ Applicant Or by _____

I also translated and fully explained the " Significant Terms, Conditions and Authorizations (TERMS)."

Translator Signature ***(Required)***:	Date ***(Required)***
X	/ /

I confirm that the application was translated on my behalf.

Printed name of Applicant	
Signature of Applicant ***(or Custodial Parent's or Legal Guardian's signature if applicant is under age 18)****	Date Signed
X	/ /

*** If the person signing the application has a different last name than the applicant, please indicate the reason:**

☐ **Custodial Parent or**

☐ **Legal Guardian** (NOTE: Court documents establishing legal guardianship must be submitted if the responsible adult is not the parent.)

Section M – Agent Certification

To be completed by your Anthem Blue Cross and Blue Shield-Appointed Agent.

1. 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

2. Did you see the proposed subscriber at the time this application was executed? ..... ☐ Yes ☐ No

If NO, please explain: _____

3. To the extent not already identified in Section H of this application, I have listed in an attachment to this application any other accident or sickness policies I have sold to the applicant in the past five years. With respect to those policies listed on the attachment, I will also identify those that are currently in force.

4. I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent Signature			Date
X			/ /
Agent Name (please print)		Agent Street Address / Suite No. / Personal Mail Box (PMB) No.	
Agent ID No. (TIN)	Sub-Agent ID Number	City/State/ZIP	
Agent Phone No.	Agent Fax No.	Agent Email Address	

Agent: Please mail this application to the following address:

Anthem Blue Cross and Blue Shield
P.O. Box 9041
Oxnard, CA 93031-9041

OR

Fax to: (800)327-9255

NOTE: Please make a copy of the signed application for your records prior to submitting to Anthem Blue Cross and Blue Shield.

Section N – Determination of Self-employed Business Group of One

An applicant who answers "Yes" to all four questions below and, if required by Anthem Blue Cross and Blue Shield, who can document their answers, meets the legal definition of a "self-employed business group of one" in Colorado:

1. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees?
2. Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?
3. Do you have gross income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue Service forms 1040, Schedule C, F or SE, or other forms recognized, by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years?

   Note: "Substantial part of your income "means income derived from business activities of the business group of one that are sufficient to pay for the annual premiums for the business group of one's health benefit plan.
4. Do you work a minimum of 24 hours a week on a permanent basis?

Can you answer "Yes" to the four questions above? ..... ☐ Yes ☐ No

Applicant's Statement

I (print name), _____, attest that the answers to the questions contained in this form are true and correct.

Printed name of Applicant	
Signature of Applicant ***(or Custodial Parent's or Legal Guardian's signature if applicant is under age 18)**** X	Date Signed / /

Applicant's Business

Business Group of One Disclosure

As required by Colorado law, please read the following disclosure, and if you qualify as a business group of one, print and sign your name in the spaces below.

I, (print name) _____, meet the definition of a self-employed business group of one as attested to on the Determination of Self-Employed Business Group of One above. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods, as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three-year period.

I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, the carrier's overall cost and utilization trends, the underwriting methodology used to evaluate individual coverage, my age, and a factor that reflects the cost of care where I live. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier's overall cost and utilization trends ("index rate,") my age, my family size, and a factor that reflects the cost of care where I live. I have been given a Colorado Health Plan Description Form showing the benefits under Colorado's small group Standard Health Benefit plans, I have also been given a Colorado Health Benefit Plan Description Form for the plan for which I am applying.

Printed name of Applicant	Applicant's Business Name	
Signature of Applicant ***(or Custodial Parent's or Legal Guardian's signature if applicant is under age 18)**** X		Date Signed / /

*** If the person signing the application has a different last name than the applicant, please indicate the reason:**

☐ **Custodial Parent or**

☐ **Legal Guardian** (NOTE: Court documents establishing legal guardianship must be submitted if the responsible adult is not the parent.)

NOTE: Please make a copy of the signed application for your records prior to submitting to Anthem Blue Cross and Blue Shield.

Anthem

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 policy to be issued by Anthem Blue Cross and Blue Shield. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

☐ **Additional benefits**

☐ **No change in benefits, but lower premiums**

☐ **Fewer benefits and lower premiums**

☐ **Other** (please specify) _____

1. Health conditions which you may presently have (preexisting conditions) are covered under the new policy for applicants under age nineteen (19).
2. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer or Other Representative ***(Signature not required for direct response sales.)***	Date Signed
X	/ /
Typed Name and Address of Issuer or Producer	
Printed name of Applicant	
Signature of Applicant ***(or Custodial Parent's or Legal Guardian's signature if applicant is under age 18)****	Date Signed
X	/ /

*** If the person signing the application has a different last name than the applicant, please indicate the reason:**

☐ **Custodial Parent or**

☐ **Legal Guardian** (NOTE: Court documents establishing legal guardianship must be submitted if the responsible adult is not the parent.)

Life products are underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks Blue Cross and Blue Shield Association.

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Anthem

Life products are underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks Blue Cross and Blue Shield Association.

Anthem

Access to the MIB

Information regarding your insurability will be treated as confidential. Anthem Blue Cross and Blue Shield or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act.

The address of MIB's Information Office is
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734

Information for consumers about MIB may be obtained on its website at *www.mib.com*.

Anthem Blue Cross and Blue Shield**,** or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

In Colorado: Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Nevada: Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc., dba HMO Nevada. 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 Applications – Colorado

Applicant / Member Name:	Primary Applicant's SSN:

(Premium Payment is required. Please choose from Option 1 or 2.)

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Checking Account Automatic Premium Payment (complete Section A)

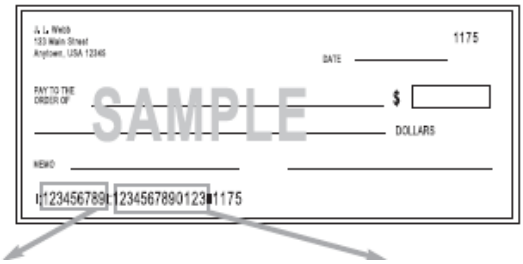
☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. If you choose one of these options, you will receive a bill every month thereafter.

☐ Paper Check* ☐ Electronic Check (complete Section B) ☐ Credit / Debit Card (complete Section C)

DO NOT SUBMIT PREMIUM FOR ANY LIFE INSURANCE – IF ACCEPTED, YOU WILL BE BILLED.

A. Monthly Checking Account Automatic Premium Payment – By providing your check information, you authorize us to electronically debit your bank account. If you have selected this option, your bank account will be debited one month's premium as soon as the day of approval. This will include all products selected, including dental and/or life. Subsequent premium amounts will be debited on the day you request below:

Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.



Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during underwriting, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross and Blue Shield to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross and Blue Shield premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and will be billed monthly. **You will incur a service charge for any withdrawal not honored.**

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

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Check Number	Amount
				$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield to charge my card for a one time initial debit upon approval. I understand that if this option is selected, my account will be debited one month of premium as soon as the day of approval. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **We accept Visa and MasterCard.**

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

Expiration Date: |__|__| / |__|__|

Cardholder Zip Code: |__|__|__|__|__|__| – |__|__|__|__|

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize us either to use 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.

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