Ohio Open Enrollment Options Application for CMM Plans

Anthem

ASSIGNED EFFECTIVE DATE (DO NOT WRITE IN THIS AREA.)

Please complete in blue or black ink only.

Section A – Applicant Information

Last Name	First Name	MI	Social Security Number*

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

City	State	Zip	County

Marital Status	Height (Ft. / In.)	Weight (Lbs.)	Sex	Age	Date of Birth
☐ Single ☐ Married	/		☐ M ☐ F		/ /

Daytime Phone Number	Evening Phone Number	E-mail* If possible, do you want E-mail notification? ☐ Yes ☐ No
( )	( )	

Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? . . . . . ☐ Yes ☐ No

Are all applicants listed on this 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 – Spouse or Domestic Partner Information

Last Name	First Name	MI	Relationship
			☐ Spouse ☐ Domestic Partner

Social Security Number*	Height (Ft. / In.)	Weight (Lbs.)	Sex	Age	Date of Birth
	/		☐ M ☐ F		/ /

Is your spouse or domestic partner a legal resident of the United States and a resident of the state in which you are applying for coverage? . . . . . ☐ Yes ☐ No

Section C – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary.)

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 28). (List all dependents beginning with the eldest.)

First, MI (last name if different)	Relationship to Applicant	Social Security Number*	Sex	Age	Date of Birth mm/dd/yyyy	Height Ft. / In.	Weight Lbs.
	Child		M ☐ F ☐			/	
	Child		M ☐ F ☐			/	
	Child		M ☐ F ☐			/	
	Child		M ☐ F ☐			/	
	Child		M ☐ F ☐			/	

**This information is used for internal purposes only and will not be disclosed.*

Anthem Blue Cross and Blue Shield is the trade name of Community 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 D – Medical Coverage

Comprehensive Major Medical (CMM)	Select Type of health coverage:
☐ **Basic** ☐ **Standard**	☐ Single ☐ Parent/Child(ren) ☐ Family ☐ Child(ren) ☐ Couple

Section E – Eligibility and Prior Coverage Information (This section must be fully completed.)

Was your last coverage through an employer? . . . . . ☐ Yes ☐ No

If yes, please complete the following:

Contract Holder's Name		Identification Number	
Employer's Name		Telephone number (include area code) ( )	
Employer's Address (street and P.O. Box if applicable)	City	State	Zip
Effective Date of Coverage	Cancellation Date of Coverage		

Were you/are you eligible for COBRA/State Continuation benefits? . . . . . ☐ Yes ☐ No

If yes, please complete the following:

COBRA/State Continuation Effective Date	COBRA/State Continuation Expiration Date

Have you elected and exhausted COBRA or state continuation benefits? . . . . . ☐ Yes ☐ No

Are you eligible for Medicare or Medicaid? . . . . . ☐ Yes ☐ No

Are you currently covered under any other health plan or are you eligible to be covered under any other health plan? . . . . . ☐ Yes ☐ No

If yes, please complete the following:

Contract Holder's Name		Identification Number	
Name of Current Coverage		Telephone number (include area code) ( )	
Address of Current Coverage (street and P.O. Box if applicable)	City	State	Zip

If family, list all persons covered under the plan.

Type of Coverage and Policy Number	Effective Date of Coverage	Cancellation Date of Coverage

Was your most recent health coverage terminated for non-payment of premium or due to fraud? . . . . . ☐ Yes ☐ No

Are you or any person to be covered currently confined to a health care facility? . . . . . ☐ Yes ☐ No

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

Please read this section carefully before signing the application. For the purposes of this application, a Non-Federally Eligible Individual is a person who does not have any other health coverage and is not eligible to be covered under any private or government sponsored program, including but not limited to state continuation coverage, COBRA, Medicare and Medicaid.

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 is or becomes eligible for any other health coverage including any private or government sponsored program, such as state continuation coverage, COBRA, Medicare or Medicaid or I or any other person for whom coverage is sought becomes confined to a health care facility because of chronic illness, permanent injury or other infirmity after the date I sign this application but before my coverage effective date. I understand that in these situations, Anthem has the right to review 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, benefits denied due to the other coverage, 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 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 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. I understand that if my application is denied, my bank account or credit card will not be charged.

3. **If I am a Non-Federally Eligible Individual, I understand that I have a 90 day waiting period before my coverage begins. I also understand that, for applicants age nineteen (19) and older, pre-existing conditions are limited to 12 months after enrollment for conditions in existence within 6 months immediately prior to my enrollment for which medical advice, diagnosis, care or treatment was recommended or received. Pregnancy is considered a pre-existing condition for Non-Federally Eligible Individuals and I understand if I select the Comprehensive Major Medical standard plan I have a 270 day waiting period before any maternity benefits are covered.**

4. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.

5. 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.

6. I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 C.F.R. Parts 160 and 164) and the Ohio Revised Code § 3904.13. I also understand that under the HIPAA Privacy Regulation and Ohio law, I have the right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

7. 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; and he or she does not have any other health coverage and is not eligible to be covered under any private or government sponsored program, including but not limited to state continuation coverage, COBRA, Medicare and Medicaid.

Anthem Blue Cross and Blue Shield is the trade name of Community 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 F – Significant Terms, Conditions and Authorizations (TERMS) *(continued)*

8. **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.**

9. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.

10. I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem in accepting this application. Any 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).

    Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

    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.

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 (if to be covered) X	Date

Section G – Agent Certification

To be completed by your Anthem-appointed agent:

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

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	
GA (if applicable)		GA code (if applicable)	

Anthem Blue Cross and Blue Shield is the trade name of Community 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.

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 Community Insurance Company acceptance of coverage, if not previously revoked.

By signing below: I authorize Community Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Community 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, and/or insurance support organizations.

I also authorize any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations to furnish any medical records or health history information concerning me and any family member listed on my Application to Community Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Community Insurance Company. This information is needed to determine eligibility for coverage and Community 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 or domestic partner, a copy of the legal representative's authority must be attached to the application.*

A photocopy of this form will be as valid as the original.
You or 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 Community 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.

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

Anthem Blue Cross and Blue Shield is the trade name of Community 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
Ohio

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

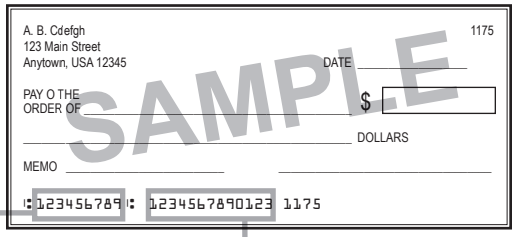
Method of payment (you must select one):

- ☐ 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 Anthem 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)	Account Holder Name (Please PRINT)	Date
X		

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.

☐ **NEW LIST BILL –** Billing through third-party ☐ **CHANGE TO EXISTING LIST BILL** **List Bill Arrangement Number:** _____

(This option must have prior approval and requires separate List Bill forms to be completed and submitted with the application.)

Life and Disability products underwritten by Anthem Insurance Company, Inc. Anthem Blue Cross and Blue Shield is the trade name of Community 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.