

Anthem Individual Enrollment/Change Application



P.O. Box 14024
 Roanoke, VA 24038-4024
 www.anthem.com
 Fax No. : 1-888-449-4807

To Be Completed By Agent/Producer	
Producer Name	Preferred Insurance
Vendor Code #	0 0 5 2 2
Producer Signature	James Gulalo
Producer Phone #	203-994-0759
Effective Date	/ /
For Office Use Only	
Firm Division No.	
U/W Rate Decision	

Remember to Complete All Sections of this Application

PLEASE USE BLACK OR BLUE INK ONLY

1. Applicant Information	Please check appropriate item: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change – Policy No. _____ <input type="checkbox"/> Add/Remove Dependent – Policy No. _____
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Effective Date If your application is approved, your coverage can start on any day of the month after the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.

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

NAME (LAST/FIRST/MIDDLE INITIAL)			HOME ADDRESS (NUMBER AND STREET)
Male	DATE OF BIRTH	SOCIAL SECURITY NUMBER	CITY/STATE/ZIP CODE
Female	MO. DAY YR.		
TELEPHONE NUMBERS		BILLING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)	
HOME:	WORK:		
EMAIL ADDRESS		CITY/STATE/ZIP CODE	

2. Medical Coverage

Anthem will enroll all eligible family members unless otherwise instructed below.

I, the Applicant, request that Anthem not enroll any eligible applicants unless ALL family members qualify.

Plan Name, In Network Coinsurance, Deductible Options

Optional Benefits

Select ONE Plan...then select ONE Deductible and any optional benefits.

<input type="checkbox"/> Anthem Premier PPO	(20% coinsurance) <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500	<input type="checkbox"/> Enhanced Drug Benefit Rider
(0% coinsurance) <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000		
<input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000		
<input type="checkbox"/> Anthem SmartSense PPO	(50% coinsurance) <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500	
(30% coinsurance) <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500		
<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500		
(0% coinsurance) <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$12,000		

HSA Compatible Plans

Select ONE Plan...then select ONE Deductible and any optional benefits.

<input type="checkbox"/> Lumenos Health Savings Account Plus PPO
Single
(20% coinsurance) <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$4,000
(0% coinsurance) <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,950
Family (more than one applicant)
(20% coinsurance) <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$8,000
(0% coinsurance) <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$8,000 <input type="checkbox"/> \$11,900
<input type="checkbox"/> 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 in Section 1.)
<input type="checkbox"/> 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.

3. Dependent Information

NAME (LAST/FIRST/MIDDLE INITIAL)	Add	Delete	Social Security Number	Sex	Date of Birth (mm/dd/yy)	Relationship to Applicant
Additional Adult (Spouse, Domestic Partner)			_____	<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 1			_____	<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 2			_____	<input type="checkbox"/> M <input type="checkbox"/> F		
Dependent 3			_____	<input type="checkbox"/> M <input type="checkbox"/> F		

Yes No Are all applicants listed on this application legal residents of the United States and residents of the state in which you are applying for coverage?

If NO, who? _____

Yes No Are all applicants listed on this application United States citizens?

If NO, who? _____

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

4. Prior and Other Insurance Information - Please answer ALL of the following questions.

(A) Do you have any other health insurance policy or certificate in force? Yes No

(B) Have you had coverage within 120 days of the application? Yes No

If you answered "Yes" to A or B, please provide the following information:

Name of Other Insurance Company _____

Policy Number _____ Type of Coverage Group Individual Last Date of Coverage _____

If the answer to question (A) is yes, do you intend to replace your current medical or health policy with the policy? Yes No

A completed, signed Health Statement must be enclosed with this completed, signed application. Important: Please attach copies of any certification or other documentation of prior creditable coverage furnished by previous carriers or employers, if available. This will help us process your application.

ANTHEM INDIVIDUAL PRODUCTS ARE ISSUED ON AN INDIVIDUAL BASIS AND ARE REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN.

I acknowledge receipt of an outline of coverage provided by the policy checked above. I certify that neither I nor any family member listed is eligible for Medicare. I understand the following: (a) that all coverage and services are subject to the Exclusions, Limitations and Conditions of the Subscriber Agreement or other Evidence of Coverage document; (b) that no benefits will apply until I receive written approval and confirmation of effective date, and my first month's paid premium has been processed by, Anthem Blue Cross and Blue Shield and; (c) that I will be responsible for notifying the Company of any change in dependent status or change of address. I understand that any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact may result in rescission of coverage and/or nonpayment of claims for myself or my dependents. I certify that my statements in this form and the attached Health Statement are true and complete to the best of my knowledge and belief.

5. Applicant's Signature

(if applicant is under 18, parent or guardian signature required.) _____

Date: ____ / ____ / ____

Other Adult's Signature

(covered person 18 or older) _____

Date: ____ / ____ / ____

6. 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 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 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 to disclose protected health information it may collect about me to MIB, for the MIB information exchange. MIB 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 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 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 Blue Cross and Blue Shield, except to the extent that Anthem Blue Cross and Blue Shield has already taken action in reliance on this authorization. Any information received by Anthem Blue Cross and Blue Shield, pursuant to this authorization is subject to restrictions on disclosure to others as set forth under Federal and state laws.

IF LISTED ON YOUR APPLICATION, YOUR SPOUSE/DOMESTIC PARTNER AND EACH DEPENDENT CHILD OVER AGE 18 MUST SIGN BELOW.

SIGN HERE	Printed name of Applicant	Signature of Applicant* or Legal Representative X	Date of Birth ____ / ____ / ____	Date Signed ____ / ____ / ____
	Printed name of Spouse or Domestic Partner	Signature of Spouse or Domestic Partner or Legal Representative X	Date of Birth ____ / ____ / ____	Date Signed ____ / ____ / ____
	Printed name of Dependent Child over 18	Signature of Dependent Child over 18 X	Date of Birth ____ / ____ / ____	Date Signed ____ / ____ / ____
	Printed name of Dependent Child over 18	Signature of Dependent Child over 18 X	Date of Birth ____ / ____ / ____	Date Signed ____ / ____ / ____

****(or Custodial Parent's or Guardian's signature if applicant is under age 18)***

***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.***



**CONNECTICUT
INDIVIDUAL MARKETS HEALTH
STATEMENT**

APPLICANT AND FAMILY INFORMATION

PLEASE USE BLACK OR BLUE INK ONLY

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

**PART A
COMPLETE FOR YOU AND ANY FAMILY MEMBERS APPLYING FOR COVERAGE**

	FIRST NAME	INITIAL	LAST NAME	HEIGHT	WEIGHT	DATE OF BIRTH	SEX M/F	SOCIAL SECURITY #
APPLICANT				/		/ /		
SPOUSE				/		/ /		
DEPENDENT				/		/ /		
DEPENDENT				/		/ /		
DEPENDENT				/		/ /		
DEPENDENT				/		/ /		

PART B

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. IS ANY PERSON TO BE INSURED ELIGIBLE FOR MEDICARE? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. HAS ANYONE HAD HEALTH OR LIFE INSURANCE MODIFIED, POSTPONED OR RATED? PLEASE SUBMIT DETAILS _____ | <input type="checkbox"/> | <input type="checkbox"/> |

PART C

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Are you or your spouse or any dependent to be insured currently disabled or unable to perform their normal activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you or any dependent to be insured been hospitalized, had surgery or been advised to have surgery within the past 5 years for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you or any dependent to be insured currently pregnant, or an expectant parent? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you or any dependents currently taking any medication?
If yes, please specify medication and condition for which it is used: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you or any dependents have any conditions or symptoms for which a physician or other medical care provider has not been consulted? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you or any dependent had medical expense in excess of \$5,000 in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you, your spouse or any dependent used tobacco products within the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |

If cigarettes, please list the name of each applicant and how many cigarettes they smoke per day.

PART D

1. Have you or any dependent to be insured ever had or been told they had, or been medically counseled, consulted or treated for any of the following? (Check **yes** or **no** and **circle the disorder**)

	YES	NO
A. Chest pain, heart attack, heart murmur, heart trouble, rapid slow or irregular heartbeat, other diseases of the heart, circulatory system or blood vessels, varicose veins, phlebitis, anemia or other disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
B. Cancer, tumor or lymph node enlargement? Indicate type of cancer and location _____	<input type="checkbox"/>	<input type="checkbox"/>
C. Sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
D. Mental, emotional, nervous disorder, depression, anxiety, psychotherapy or counseling of any kind?	<input type="checkbox"/>	<input type="checkbox"/>
E. Brain disorder, neurologic problems, seizure disorder, any disorder of the central nervous system, stroke or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
F. Alcohol or drug use, abuse and/or dependency?	<input type="checkbox"/>	<input type="checkbox"/>
G. Medical diagnosis of AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS Related Complex)?	<input type="checkbox"/>	<input type="checkbox"/>
H. Any disorder of the male/female reproductive organs including infertility and complications of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
I. Back, neck, bone, joint problems, Lupus, arthritis or autoimmune disorder?	<input type="checkbox"/>	<input type="checkbox"/>
J. Diabetes? If so, specify date of diagnosis, type of treatment, amount of medications (if any): _____	<input type="checkbox"/>	<input type="checkbox"/>
K. Any disorder of the stomach, intestines, gallbladder or esophagus?	<input type="checkbox"/>	<input type="checkbox"/>
L. Any disorder of the lungs or respiratory system or Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
M. Any disorder of the kidneys, bladder or urinary tract?	<input type="checkbox"/>	<input type="checkbox"/>
N. Any disorder of the liver or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>
O. Any disorder of the endocrine system or glands?	<input type="checkbox"/>	<input type="checkbox"/>

PART E

Within the last two years have you or any dependent to be insured ever had, been told they had, consulted or treated for any of the following:

a. Asthma	YES/NO <input type="checkbox"/> <input type="checkbox"/>	d. Ear problems	YES/NO <input type="checkbox"/> <input type="checkbox"/>	g. Lyme Disease	YES/NO <input type="checkbox"/> <input type="checkbox"/>
b. Bronchitis	<input type="checkbox"/> <input type="checkbox"/>	e. Eye problems	<input type="checkbox"/> <input type="checkbox"/>	h. Nose/Throat/Sinus problems	<input type="checkbox"/> <input type="checkbox"/>
c. Chiropractic Care	<input type="checkbox"/> <input type="checkbox"/>	f. Headaches/Migraines	<input type="checkbox"/> <input type="checkbox"/>	i. Skin problems/Allergies	<input type="checkbox"/> <input type="checkbox"/>

PART F

Have you or any dependent had an examination or treatment for any illness or injury other than those stated above? YES NO

GIVE DETAILS ON THE FOLLOWING QUESTIONS BELOW.

Simply listing the name of a primary physician or referring to a physician's name will not be considered a substitute for listing full detailed answers to the questions on this and the previous page.

If you checked (✓) yes to any question, please provide a complete explanation in Part G below.

PART G

DETAILS TO HEALTH HISTORY

If more space is needed, attach separate page which must be signed and dated.						
Question Number	Person Affected	Condition/Diagnosis	Treatment (Surgeries/Medications)	Treatment Dates from/to	Date of Full Recovery	Name, Address, Phone Number of Physician, Hospital/Institution

I hereby represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief, and understand these said answers and statements form the basis upon which insurance will be made effective. I understand that any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact about medical history could result in the denial of an otherwise valid claim and rescission, voiding or reformation of insurance.

Date _____ Applicant Signature _____
 (If applicant is under 18, parent or guardian signature is required.)

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