Anthem

Your Individual Application Kit is enclosed

Here is a checklist to review before you return your application.

- ☐ Print clearly and complete the application in blue or black ink.
- ☐ If you make any changes while completing this form (for example, if you cross out something you wrote), be sure to **initial and date** those changes.
- ☐ If any **corrections** are needed or if the form is incomplete, the application may have to be returned to you, or we may try to call you, to obtain the necessary information. In that case, we will record your information on a form that will be attached to your application.
- ☐ You may request an effective date of any day of the month after the date we receive your application. Your application must be received by Anthem by the requested effective date in order to secure that date.
- ☐ **The primary applicant and spouse/domestic partner, if applicable, must sign and date the application in two places (top and bottom of page 11).**
- ☐ List the height and weight for each applicant.
- ☐ List the date of birth for each applicant.
- ☐ If you have had creditable health coverage in the past 63 days, please fill out Section I to apply for preexisting credit. Creditable Coverage is defined as prior coverage from a group plan, Medicare, Medicaid, health plan for active military personnel, including TRICARE, Indian Health Service, state risk pool, Federal Employees Health Benefits Program, state children's health insurance program, public health plan, U.S. Government plans, foreign health plans, individual insurance policy or Peace Corps service. Prior coverage does not count as Creditable Coverage if there was a break of more than 63 days prior to applying for this coverage.
- ☐ Select the plan, deductible amount and any applicable riders requested.
- ☐ Answer all health history questions in Section K. Failure to do so will delay the processing of your application.
- ☐ If you answered "yes" to any of the health history questions, give complete details on page 9.
- ☐ For Automatic Bank Draft, complete the Authorization located in Section H and include a **voided check.** We cannot accept deposit slips. (Your account will be drafted from the assigned effective date to the current billing date if your application is approved by Underwriting.)
- ☐ The initial premium is required with the application. Please provide your credit card authorization per the instructions in Section H. If you pay by check, please make the check payable to Anthem Blue Cross and Blue Shield, include your Social Security number on the front of the check, and affix the check to the front of the application.
- ☐ If you are eligible for Medicare, you are not eligible to apply for our individual products.

If you need assistance filling out the application, please contact your agent.

Ohio
Individual Enrollment Application

Anthem Anthem Life

Please complete in blue or black ink only. Do not write in shaded areas, these are for internal use only.

Section A – Coverage Information

Application Type (select one): ☐ New Coverage ☐ Change Anthem Individual policy coverage Policy No. _____ ☐ Add dependent(s) to current coverage Policy No. _____

Effective date requested: If your application is approved your coverage can start on any day of the month after the date we receive your application.

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

Section B – Applicant Information

Risk Tier	Last Name	First Name	MI	Social Security Number*

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

City	State	Zip	County

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

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

Tobacco Use: Have you used tobacco in the last 12 months? ☐ Yes ☐ No
If cigarettes, how many do you smoke per day? _____

Section C – Spouse or Domestic Partner Information

Risk Tier	Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner

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

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

Tobacco Use: Have you used tobacco in the last 12 months? ☐ Yes ☐ No
If cigarettes, how many do you smoke per day? _____

Section D – 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 unmarried children, or your spouse or domestic partner's unmarried children (to the end of the calendar month in which they turn 25). (List all dependents beginning with the eldest.)

Risk Tier	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			/	

Has any person listed on this application lived (not traveled) outside the U.S. for the past 3 consecutive months? ☐ Yes ☐ No

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

Section E – Medical Coverage

Select ONE Plan . . . ***then select ONE Deductible and any optional Riders***

Blue Access® Value

☐ Blue Access® Value . . . . . ☐ $2,000 ☐ $3,000 ☐ $5,000 ☐ $10,000

Blue Access® Economy

☐ Blue Access® Economy . . . . . ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,500

Blue Access® ☐ or Blue Traditional® ☐

☐ Plan 1 (20% coinsurance) . . . . . ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

☐ Plan 2 (20% coinsurance) . . . . . ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500

☐ Plan 3 (0% coinsurance) . . . . . ☐ $2,500 ☐ $5,000 ☐ $10,000 ($10,000 not available on Blue Traditional)

☐ **Maternity** rider (available with Plan 2 only)

Select ONE Plan then select ONE Deductible and any optional Riders

Lumenos® Health Savings Account

☐ Plan 1 (0% coinsurance)
☐ $1,500/$3,000 ☐ $3,000/$6,000 ☐ $5,000/$10,000

☐ Plan 2 (20% coinsurance)
☐ $1,500/$3,000 ☐ $3,000/$6,000

☐ Yes, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please forward my information to Anthem's banking partner. (Please fill in your social security number in section B.)

☐ 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.

Lumenos® Health Incentive Account Plus

☐ Plan 1 (0% coinsurance)
☐ $2,500/$5,000 ☐ $5,000/$10,000 ☐ $10,000/$20,000

☐ Plan 2 (20% coinsurance)
☐ $2,500/$5,000

Lumenos® Health Incentive Account

☐ Plan 1 (0% coinsurance)
☐ $1,000/$2,000 ☐ $2,500/$5,000 ☐ $5,000/$10,000

☐ Plan 2 (20% coinsurance)
☐ $1,000/$2,000 ☐ $2,500/$5,000

Optional riders: ☐ Maternity

Section F – Dental Coverage Selection

☐ **Dental Blue® Basic 100** ☐ **Dental Blue® Essential 100** ☐ **Dental Blue® Essential 200**

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

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

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

☐ Applicant & Spouse or Domestic Partner only ☐ Applicant & all dependent children listed

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

Section G – Term Life Insurance

Blue Preferred® Term Life

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

Do you, the applicant, own an existing life policy or annuity contract? ☐ Yes ☐ No (Answer by checking one)

If you answered "Yes" to the above question, inform the agent, who will provide you an "Important Notice: Replacement of Life Insurance or Annuities," which you must read and complete.

By applying for this proposed life policy, do you intend to replace, discontinue or change any existing life policy or annuity contract? ☐ Yes ☐ No (Answer by checking one)

Provide information below.

Applicants must meet Anthem'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 polices terminate at age 65.

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

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

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

Section H – Billing Options

Frequency (select one)

☐ Monthly ☐ Quarterly

☐ Semi-annually ☐ Annually

Initial Premium **Total amount enclosed/charged $** _____

☐ Bank Draft (see below)

☐ Check Enclosed (If paying by check, make the check payable to ABCBS.)

☐ Credit Card (see below)

☐ No Payment Enclosed

Method (select one)

☐ **HOME**—Bills will be sent to your home billing address unless a separate billing address is listed below.

Name Address (street and P.O. Box if applicable) City State Zip

☐ **AUTOMATIC BANK DRAFT** (automatic premium withdrawals)—your premium will be deducted on, or about the first of each month. (You **MUST** attach a **blank** voided check)

Deduct money from my/our account for (check one):

☐ My first payment only $_____ ☐ My first and ongoing payments

☐ My ongoing payments only (first payment made by other method)

I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. I understand that this authorization is in effect until I notify Anthem in writing that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals if they wish to do so.

Account holder's name (please print) **X**	Account holder's signature (if other than the applicant) **X**

Staple **blank, voided check** here

Staple **blank, voided check** here

☐ **IF PAYING BY CREDIT CARD:** A credit card can be used only for the initial premium payment.

Credit card information —

Cardholder's Name (as shown on the credit card): Cardholders' Address:

_____ _____

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

Type of Credit Card: ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Credit Card Number: _____

Expiration Date (month/year): _____ /_____

Authorization: *I authorize Anthem Blue Cross and Blue Shield to charge the credit card indicated for the amount specified in* ***Initial Premium****.*

Applicant's Signature:
X

☐ **NEW LIST BILL**—Billing through third-party (This option must have prior approval and requires separate List Bill forms to be completed and submitted with this application).

☐ **CHANGE TO EXISTING LIST BILL** List Bill Arrangement Number: _____

Section I – Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name. _____

Did you or your eligible dependents have creditable coverage within the past 63 days? ☐ YES ☐ NO (you may be eligible for preexisting credit).
The following information must be completed in order for credit to be given. Please provide the previous 18 months of coverage.

Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name and phone number of prior carrier(s)		Reason for cancellation
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	Cancellation Date of Coverage

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

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

Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name and phone number of prior carrier(s)		Reason for cancellation
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	Cancellation Date of Coverage

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

Section J – Healthy Lifestyle (optional)

You and your spouse or domestic partner may qualify for a better rate based on your lifestyle. Complete the section below if you would like to be considered for this special rate.

	Applicant		Spouse or Domestic Partner	
1. Have you been tobacco-free for the last 3 years?	☐ Yes	☐ No	☐ Yes	☐ No
2. Do you exercise regularly?	☐ Yes	☐ No	☐ Yes	☐ No
3. Are you in excellent health with no ongoing medical conditions?	☐ Yes	☐ No	☐ Yes	☐ No

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

STEP 1: Health history questions must be answered by each/every person applying for coverage.

Health History Questionnaire — All Questions Must Be Answered Or The Application Will Be Returned.

GIVE COMPLETE DETAILS IN STEP 2 (page 9) FOR ALL QUESTIONS ANSWERED "YES".

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 whether you are eligible for coverage. 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 later discover that you misrepresented or omitted information you knew in response to a question we may rescind your coverage, even after it has been issued. This means that you may lose your health benefits including coverage for treatment already received. Rescission may occur even if we review your medical records or seek medical confirmation of your health information as part of processing your application. 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.

Section K – Health History *(continued)*

	YES	NO
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	☐	☐
2. Have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	☐	☐
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Step 2)	☐	☐
4. Are you pregnant or an expectant father, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	☐	☐
5. Do you have implants, prosthesis or retained hardware?		
A. Breast implants	☐	☐
B. Eye/limb prosthesis	☐	☐
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	☐	☐
D. Joint replacement/internal fixations (i.e. pins, plates, rods etc.), neurostimulators	☐	☐
E. Any other prosthesis or implant (other than dental)	☐	☐
6. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following? *(all answers must be checked yes or no)*		
A. Headaches requiring prescription medication	☐	☐
B. Loss of consciousness	☐	☐
C. Sleep apnea/breathing difficulties while sleeping	☐	☐
D. Recurrent fainting, weakness or dizziness	☐	☐
E. Paralysis or numbness/tingling in limbs	☐	☐
F. Chest pain	☐	☐
G. Increased/irregular heart beat	☐	☐
H. Low or high blood pressure	☐	☐
I. High cholesterol	☐	☐
J. Shortness of breath	☐	☐
K. Heartburn (recurrent)	☐	☐
L. Abnormal and/or Recurrent bleeding (unrelated to menstruation)	☐	☐
M. Recurrent diarrhea and/or recurrent vomiting	☐	☐
N. Unexplained weight loss	☐	☐
O. Blood, sugar, and/or protein in urine	☐	☐
P. Recurrent pain (including back pain)	☐	☐
Q. Jaundice	☐	☐
R. Mass, cyst(s), or lump(s) in any body part including breast	☐	☐

	YES	NO
7. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?		
A. Abnormal Pap smear	☐	☐
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	☐	☐
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)?	☐	☐
D. Male infertility	☐	☐
E. Female fertility/infertility	☐	☐
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart, circulatory or blood disorder(s)	☐	☐
G. Kidney, bladder or prostate disorder(s)	☐	☐
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	☐	☐
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	☐	☐
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	☐	☐
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	☐	☐
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	☐	☐
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	☐	☐
N. Psoriasis, rosacea, acne or skin disorder(s)	☐	☐
O. Cataract, glaucoma, eye or ear disorder(s)	☐	☐
P. Diabetes, thyroid, endocrine glands	☐	☐
8. Within the last 5 years, have you experienced, suffered from, consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	☐	☐
9. Within the last 5 years, have you been advised by a health care professional to reduce alcohol intake?	☐	☐
10. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	☐	☐
11. Within the last five years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in Step 2.)		
A. Obsessive Compulsive Disorder	☐	☐
B. Minor depression	☐	☐
C. Anxiety/panic attacks	☐	☐
D. Attention Deficit Disorder (ADD/ADHD)	☐	☐
12. In the last 10 years have you had consultation, experienced symptoms, been diagnosed, had treatment or treatment recommended for any of the following:		
A. Schizophrenia, Major Depression/ BiPolar Disorder	☐	☐

Section K – Health History *(continued)*

B. Eating disorder (i.e. anorexia/bulimia) ☐ YES ☐ NO

13. Within the last 10 years, have you experienced (suffered from) or consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to drug abuse? ☐ YES ☐ NO

14. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor? ☐ YES ☐ NO

15. Have you ever been diagnosed with hepatitis? (check all types that apply)

A. Hepatitis A ☐ YES ☐ NO

B. Hepatitis B ☐ YES ☐ NO

C. Hepatitis C, D, E ☐ YES ☐ NO

16. Have you ever been diagnosed with, or treated for any of the following?

A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment ☐ YES ☐ NO

B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Diabetes, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma. ☐ YES ☐ NO

17. Are you a candidate for, or have you ever received an organ or bone marrow transplant? ☐ YES ☐ NO

18a. Within the last five years, have you had any illness, physical injury, persisting or new physical symptoms and/or health problems not mentioned elsewhere on this application that have not been evaluated or that you plan to have evaluated by a licensed health practitioner? ☐ YES ☐ NO

18b. Within the last two years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application? ☐ YES ☐ NO

19. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy? ☐ YES ☐ NO

20. Date last seen by a physician: _____
Reason: _____

Prescription Medications

List *all* medications taken within the last 12 months by any family member listed on this application (if not indicated in Step 2)

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name, Phone No. of Physician or Hospital
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____

Section K – Health History *(continued)*

STEP 2: If you answered "YES" to any of the health history questions, give complete details (see the example below)

Question Number of "YES"	Patient First Name	Physician Name & Telephone (with area code)	Specific Diagnosis & Treatment	Name & Dosage of Medication & Dates of Use		Duration of Condition		Was Surgery Performed?		Description of Surgery/ Procedures & Date(s)	Current Status
				Begin mm/yy	End mm/yy	Begin mm/yy	End mm/yy	YES	NO		
Example #17	Mary	Dr. John Doe 555-555-1000	Tonsillitis	Amoxicillin 250 mg. 4x day 8/2002	9/2002	8/2002	9/2002	☑	☐	Tonsillectomy 09/2002	Good
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		

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

Please read this section carefully before signing the application.

1. **I understand that it is mandatory that I notify Anthem, in writing, immediately if I (the applicant) or any other person for whom coverage is sought received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date. I understand that in this situation, Anthem has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be rescinded, or delayed, or reformed or benefits denied due to the illness, injury or condition being treated as a preexisting condition.**
2. I understand that sending my initial premium with this application, and the receipt of my payment by Anthem, does not mean that coverage has been approved. I may not assign any payment under my Anthem program. I am applying for the coverage selected on this application. I understand that any premium quote provided is preliminary and review of my application by medical underwriting may change the premium or result in a denial of coverage. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that if my application is denied, my bank account or credit card will not be charged.
3. **I understand that preexisting 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 preexisting condition.**
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. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
7. 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.
8. 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.
9. **I understand I am applying for individual health coverage (under Anthems' Group Trust) 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.**
10. If I purchase optional dental coverage for the Dental Blue® Essential, I understand that I will have a twelve month waiting period for coverage of Major Restorative Services. *(For a description of Preventive, Diagnostic and Major Restorative services please refer to your marketing materials.)*
11. By signing this application I certify that I understand that Anthem Life has the right to deny my 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 alone am responsible for reading and accurately completing this application, and I must communicate any changes to my status. I also understand that all other conditions of my medical application apply for the life application.
12. 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 material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

    If tobacco use question in Section B or Section C is answered "NO", I understand that the signature(s) shown on the following page will attest to non-tobacco usage for the past 12 months.

    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 (if to be covered) X	Date

Section M – Agent Certification

Agent Name (please print)		Date
Agent Email Address		
Agent No.	Agent Phone No.	Agent Fax No.
GA (if appicable)		GA code (if applicable)

Authorization for Use of Protected Health Information

The following authorization must be signed by the applicant and the applicant's spouse or domestic partner, if the spouse or domestic partner is to be covered. If the applicant and spouse or domestic partner, if applicable, does not sign this authorization, coverage, an addition to coverage, or an upgrade to coverage may be denied.

I hereby authorize that any provider of health services or supplies (e.g. physician, hospital, durable medical supplier, pharmacist), insurance company, organization, or person can release to Anthem Blue Cross and Blue Shield ("Anthem") and its agents, subsidiaries or affiliates medical and insurance information about health-related services and supplies provided to me, persons covered, or persons to be covered. This authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record. Anthem can use the information to review, investigate, or evaluate any application for an insurance policy, a policy reinstatement, or a request for change in policy benefits. Unless previously revoked, this authorization is valid for 30 months from the date I signed it.

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	Signature of Applicant or Legal Representative	Date of Birth	Date Signed

X

Printed name of Spouse or Domestic Partner	Signature of Spouse or Domestic Partner or Legal Representative	Date of Birth	Date Signed

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.