Blue Short Term℠ Individual Enrollment Application

Anthem

Section A — Please print clearly in ink, or type

Last name of applicant	First name	Middle initial

Home address: Street	City	State	ZIP code

County	Home phone (include area code)	Social Security Number

Date of birth	Age	Sex	Height (Ft. / In.)	Weight	Marital status
/ /		☐ Male ☐ Female			☐ Single ☐ Married

Are all persons applying for coverage legal residents of the United States and residents of the state in which you are applying for coverage? ☐ Yes ☐ No (If no, attach a copy of your green card or visa.)

Name of employer	Work phone (include area code)

Section B — Coverage Desired

Deductible level desired: ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500

Type of coverage desired ☐ Single ☐ Children ☐ Parent/Children ☐ Couple ☐ Family

Term (months) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Check one: Coverage paid in full options:
- ☐ Premium Check Enclosed
- ☐ VISA
- ☐ MasterCard
- ☐ Discover
- ☐ American Express

Credit Card no.______________________

Expiration date: ____________

☐ Automatic Bank Draft (Complete section F.)

Monthly payment options: ($10 monthly fee)
- ☐ Automatic Bank Draft (Complete section F.) Premium will be deducted on the same day of the month as your assigned effective date.
- ☐ Bill me monthly (One month's premium must accompany this application.)

Total premium due: (Make check payable to **Anthem Blue Cross and Blue Shield**.)

$ ______________________

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 C — Dependent Information

Applicant information must be completed for all dependents (if any) for whom coverage is being requested. An eligible dependent may be your spouse, domestic partner, your unmarried children, or your spouse's 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.)

First name	Middle initial	Last name (if different from applicant)	Social Security Number	Height	Weight	Birthdate Mo.	Day	Year	Sex (M or F)	Relationship to applicant

If there are additional dependents, please attach a separate page with all requested information.

Section D — Other Coverage Information

Will this coverage replace a previous short-term or temporary plan? ☐ Yes ☐ No	If Yes, previous identification number	Policy expiration date
Do you or any person to be covered now have an active health coverage policy? ☐ Yes ☐ No	If Yes, expiration date (This coverage cannot be issued while any other coverage is in force.)	

Have you or any other person to be covered ever been denied health coverage for health reasons? ☐ Yes ☐ No **If yes, who was denied?**
Are you currently applying for any other coverage with us? ☐ Yes ☐ No

Did you or your eligible dependents have creditable coverage within the past 63 days? ☐ Yes ☐ No

Section E — Other Information

Are you, your spouse or domestic partner or any of your eligible dependents (whether or not named on this application) currently pregnant or an expectant parent (including adoptions)? **If Yes, who?** ☐ Yes ☐ No

Are you, your spouse or domestic partner or any of your eligible dependents an insulin dependent diabetic? ☐ Yes ☐ No

Is any person named on the application currently hospitalized or in a nursing home? ☐ Yes ☐ No
If Yes, provide the name of each person.

Within the last five years, have you, your spouse or domestic partner or any dependent to be covered, consulted with a health care provider for, been diagnosed with, or received treatment or medication for: heart or circulatory system disorder including heart attack or chest pain; stroke; diabetes; cancer or tumor; alcoholism or alcohol abuse; drug abuse or chemical dependency? ☐ Yes ☐ No
If Yes, who? **Specify condition(s):**

Within the last five years, has any person to be covered ever tested positive for Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) or other immune system disorder? ☐ Yes ☐ No
If Yes, who?

During the term of this plan, will you or any dependent turn age 65, or will any dependent turn age 25 or no longer be eligible for coverage? ☐ Yes ☐ No
If Yes, who? *(Dependents are eligible to the end of the calendar month in which they turn 25. When no longer eligible, dependents may apply for their own temporary coverage.)*

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Ohio: Community 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 the registered marks of the Blue Cross and Blue Shield Association.

Section F Automatic Bank Draft Authorization

If you completed Section B and selected Automatic Bank Draft, please complete this section.

Deduct premium from: ☐ Checking account ☐ Savings account (Premium will be deducted on the same day of the month as your assigned effective date.)

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

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

You **MUST** attach a **blank** voided check for checking account deduction and premium will be deducted on the same day of the month as your assigned effective date. **I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the 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	Applicant's Social Security Number

Account holder's signature (if other than the applicant)

Section G Significant Terms, Conditions and Authorizations (TERMS)

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 receives medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage approval date. I understand that in this situation the new information will not be considered as a pre-existing condition. However, Anthem has the right to review my application for coverage and, if approved, to determine the appropriate premium rate.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I am applying for the coverage selected on this application.
3. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application.
4. 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.
5. **I understand the pre-existing conditions in existence within 24 months immediately prior to my enrollment, for which medical advice, diagnosis, care or treatment was recommended or received, are not covered. Pregnancy is considered a pre-existing condition.**
6. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
7. I understand Anthem may convert my payments by check to an electronic Automated Clearinghouse (ACH) debit transaction. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem automatic debit process and will only occur each time I send a check to Anthem. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
8. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
9. I understand 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.
10. THIS PARAGRAPH APPLIES ONLY TO OHIO RESIDENTS, AND DOES NOT APPLY TO INDIANA OR KENTUCKY RESIDENTS: 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 Cod § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a 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.
11. 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.

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 omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

In Kentucky: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

In Ohio: Any person who, with the 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.

Your health coverage will be provided by one of the following companies based upon the state where you reside:

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.

In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.

In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

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.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Signature of Applicant *(for applicants age 18 or older)*	**Date**
Signature of Spouse or Domestic Partner *(if to be covered)*	**Date**

Do not cancel your present health coverage until you receive written notification from Anthem Blue Cross and Blue Shield that your new coverage is in force.

Section H Agent Certification

I hereby certify that I have asked the applicant all questions set forth above, and that I have accurately recorded the answers supplied by the applicant. Any reporting form that is required due to a positive response to this question has been completed and submitted with this application. I further certify that I have explained the exclusions and limitations of the policy.

Agent's Name (please print)	**Agent's Signature**	
Agent Number	**Agent Phone Number**	
Agent Fax Number	**Agent Email Address**	**Date**

IMPORTANT: No person, including an employee or agent of Anthem Blue- Cross and Blue Shield, has the authority to change or omit any of the questions or statements on this application.

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