



Anthem Individual Enrollment/Change Application

P.O. Box 1014 North Haven, CT 06473
www.anthem.com
1-866-279-9911

| To Be Completed By Agency / Producer | |
|--------------------------------------|-------|
| Agency Name | _____ |
| Vendor Code # | _____ |
| Producer Signature | _____ |
| Producer Phone # | _____ |
| For Office Use Only | |
| Effective Date | _____ |
| Firm Division No. | _____ |

Contact your Producer to enroll online, or complete all sections of this application.

PLEASE USE BLACK OR BLUE INK ONLY AND PRINT CLEARLY

Please check appropriate item:

- New Enrollment Plan Change Add/Remove Dependent

| | | |
|---|------------------------------------|--|
| 1. Applicant Information | | Email Address |
| Name (Last/First/Middle initial) | | Home Address (Number and Street) |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth MO. DAY YR. | Social Security Number |
| Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership | | City/State/Zip Code |
| Telephone Numbers Daytime: _____ Evening: _____ | | Billing Address (If different from Home Address) |
| | | City/State/Zip Code |

2. Membership Choice Choose one membership type: INDIVIDUAL TWO PERSON FAMILY

3. Plan Choice (Please select one deductible option. The Two Person/Family Deductibles are two times the Individual Deductible. All deductible options are calculated per calendar year.)

| | | |
|---|---|---|
| <p>BlueCare Direct (HMO)</p> <p><input type="checkbox"/> \$1,500/\$3,000 (Individual/Two Person or Family Deductible) (Select ONE Drug Maximum)</p> <p><input type="checkbox"/> \$ 500 Drug Maximum</p> <p><input type="checkbox"/> \$2,000 Drug Maximum</p> | <p>Century Preferred Direct (PPO)</p> <p>Check One Deductible Option:</p> <p><input type="checkbox"/> \$250/\$500 (Individual / Two Person or Family Deductible)</p> <p><input type="checkbox"/> \$1,500/\$3,000 (Individual / Two Person or Family Deductible)</p> <p><input type="checkbox"/> \$1,500/\$3,000 (Individual / Two Person or Family Deductible, 80% In network)</p> <p><input type="checkbox"/> \$3,000/\$6,000 (Individual / Two Person or Family Deductible)</p> <p><input type="checkbox"/> \$5,000/\$10,000 (Individual / Two Person or Family Deductible)</p> <p><input type="checkbox"/> \$10,000/\$20,000 (Individual / Two Person or Family Deductible)</p> <p>Prescription Drug Coverage: YES NO <input type="checkbox"/> <input type="checkbox"/></p> | <p>Lumenos (PPO)</p> <p>Lumenos Health Savings Account*</p> <p><input type="checkbox"/> \$2,000/\$4,000 deductible (80% In network)</p> <p><input type="checkbox"/> \$2,500/\$5,000 deductible (100% In network)</p> <p><input type="checkbox"/> \$2,500/\$5,000 deductible (80% In network)</p> <p><input type="checkbox"/> \$3,500/\$7,000 deductible (100% In network)</p> <p><input type="checkbox"/> \$5,000/\$10,000 deductible (100% In network)</p> <p><input type="checkbox"/> \$5,950/\$11,900 deductible (100% In network)</p> <p>*For Health Savings Accounts, complete the following:</p> <p><input type="checkbox"/> Yes, I would like to establish an H.S.A. with Anthem's banking partner. (SSN required see Section 1)</p> <p><input type="checkbox"/> No, I do not want to establish an H.S.A. with Anthem's banking partner.</p> <p>Lumenos Health Incentive Account Plus</p> <p><input type="checkbox"/> \$2,500/\$5,000 deductible (80% In network)</p> <p>\$200/\$400 Funding (Individual/Family)</p> <p>Lumenos Health Incentive Account</p> <p><input type="checkbox"/> \$1,500/\$3,000 deductible (80% In network)</p> <p><input type="checkbox"/> \$2,500/\$5,000 deductible (80% In network)</p> |
|---|---|---|

Recommended for HMO Plan Only. Name of Applicant's Primary Care Physician (PCP) (Refer to www.anthem.com)

| | | | |
|-----------|------|------------------|--|
| First | Last | City | Existing Patient |
| PCP Name: | | PCP Provider No. | YES NO <input type="checkbox"/> <input type="checkbox"/> |

| 4a. Dependent Information | Add | Delete | Social Security Number | Sex | Date of Birth (mm/dd/yy) | (Recommended for the HMO only) Primary Care Physician | (Recommended for the HMO only) PCP ID Number (10 digits) | Existing Patient | Below please indicate name of recognized institution for full time students |
|---------------------------|-----|--------|------------------------|--|--------------------------|---|--|---|---|
| | | | | | | | | | |
| Spouse / Domestic Partner | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Dependent 1 | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Dependent 2 | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Dependent 3 | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Dependent 4 | | | | <input type="checkbox"/> M <input type="checkbox"/> F | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | |

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4b. 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

5. 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

6. Billing Choice (Please Check One) Electronic Fund Transfer - complete section 7 and Monthly Paper Bill
attach a voided check or savings account deposit slip.

7. Electronic Fund Transfer Authorization (EFT) (Complete if you want your payments deducted directly from your checking or savings account.)

I hereby authorize Anthem Blue Cross and Blue Shield to initiate a withdrawal (on or about the 5th business day of each month) from my bank account for payment of my premium. The bank account is with the bank named below, which is hereby authorized to withdraw this amount from my account each month.

Bank Name _____ Phone Number _____

Bank Address _____ City/State/Zip Code _____

Bank Information: Routing # _____ Account # _____

Type of Account: (Check Only One): Checking Account (must attach voided check)
 Savings Account (must attach saving account deposit slip)

This authorization is to remain in effect until Anthem Blue Cross and Blue Shield has received at least 30 days prior written notification from me of a termination date.

8. Effective Date

If Anthem approves my application, please assign an effective date of _____. The effective date must be no earlier than the signature date and no greater than 60 days from the receipt by Anthem of this application. **(NOTE: REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE COVERAGE OR ENROLLMENT AS OF THE DATE REQUESTED. Effective date will ultimately be assigned by Anthem Blue Cross and Blue Shield and communicated to you.)**

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 false and/or incomplete responses or statements 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.

| | |
|--|------|
| 9. Applicant's Signature (If applicant is under 18, parent or guardian signature required.) | Date |
| | / / |

| | |
|---------------------------|------|
| Spouse's Signature | Date |
| | / / |