Tonik Individual Enrollment Application

The Tonik plan is offered by Anthem Blue Cross and Blue Shield (Anthem).
In Connecticut, Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans, Inc., an independent licensee of the Blue Cross and Blue Shield Association.
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Agency/Producer USE ONLY			
Agency Name	Vendor Code	E-MAIL ADDRESS:	Phone No:

ALL INFORMATION YOU PROVIDE MUST BE ACCURATE.

1. *Applicant Information*

Applicant's Last Name	First Name	M.I.
Home Address (Must be complete: P.O. Box not acceptable)		
City	State	Zip Code
County home address is located in:		

Reason for Application

☐ New Enrollment ☐ Change of Coverage

Specify Change ____________________

Applicant's Social Security No.			Daytime Phone No.	Evening Phone No.
Billing Address *(if different from above)* or P.O. Box				Personal Mail Box (PMB) No.
City	State	Zip Code	Marital Status	
E-mail Address			If possible, do you want e-mail notification? ☐ Yes ☐ No	
Are you a current resident of Connecticut? ☐ Yes ☐ No				

☐ Male ☐ Female	Birth Date	Age	Height	Weight

2. *Plan Selection*

☐ $1,500 Deductible ☐ $3,000 Deductible ☐ $5,000 Deductible

3. *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 date of application? ☐ Yes ☐ No

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

Name of Other Insurance Company	Policy No.	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 this policy? ☐ Yes ☐ No			

C. Have you had a policy with Anthem in the past five years? ☐ Yes ☐ No

If the answer to question (C) is yes, please enter your previous policy number (if known):____________________

4. *Health Statement* – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.
Give COMPLETE details of any "yes" answers in this section.

1. Have you consumed alcoholic beverages within the past 12 months?
   ☐ Yes ☐ No

2. Have you had a physical exam, any diagnostic test or screening test such as blood test, x-ray, CAT scan, MRI, EKG, mammogram etc. within the past 2 years?
   ☐ Yes ☐ No

3. Do you intend to or have you discussed or been advised by a medical professional to have testing, treatment, therapy or surgery that has not yet been completed?
   ☐ Yes ☐ No

4. For Females - Date of your last menstrual period:
   Month________Day________Year________
   Was it more than 40 days ago?
   ☐ Yes ☐ No

5. Do you have any internal fixations, implants, prostheses, retained hardware (i.e. pins, screw, shunts, stents) or had joint replacement surgery?
   ☐ Yes ☐ No

6. Have you ever had indications of, been diagnosed, treated or hospitalized for any mental, emotional, behavioral, depressive or anxiety disorder/ condition (including eating disorders and attention deficit disorders)?
   ☐ Yes ☐ No

7. Have you ever had any counseling or psychotherapy of any kind?
   ☐ Yes ☐ No

8. Have you ever had indications of, been diagnosed or treated for cancer, skin cancer, malignant tumor or lymph node enlargement?
   ☐ Yes ☐ No

9. Have you ever had indications of, been diagnosed or treated for any of the following?

A. AIDS/ARC or HIV (must be diagnosed)	☐ Yes	☐ No
B. Diabetes	☐ Yes	☐ No
C. Hepatitis (A, B, C, Chronic, Other)	☐ Yes	☐ No
D. Multiple sclerosis or paralysis	☐ Yes	☐ No
E. Heart Attack	☐ Yes	☐ No
F. Coronary Artery Disease or Bypass Surgery, or Angioplasty?	☐ Yes	☐ No
G. Stroke or TIA (Transient Ischemic Attack)	☐ Yes	☐ No
H. COPD (Chronic Obstructive Pulmonary Disease)	☐ Yes	☐ No
I. Renal Failure	☐ Yes	☐ No
J. Ulcerative Colitis / Crohn's Disease	☐ Yes	☐ No

10. Have you ever had indications of, been diagnosed or treated for any disease or disorder related to the following?

A. Heart / Circulatory / Blood Disorders	☐ Yes	☐ No
B. Endocrine / Metabolic / Immunity Disorder	☐ Yes	☐ No
C. Kidney / Liver / Digestive Disorders	☐ Yes	☐ No
D. Brain / Neurological Disorders	☐ Yes	☐ No
E. Birth Defects / Congenital Disorders	☐ Yes	☐ No
F. Respiratory Disorders	☐ Yes	☐ No

11. Have you ever had indications of, been diagnosed or treated for any conditions or disorders of the back, neck, joints or bones?
    ☐ Yes ☐ No

12. In the past 5 years have you had two or more of the following: Unexplained weight loss, rash /skin lesions or recurrent headaches, persistent fever or cough, prolonged fatigue, mouth infections, recurrent diarrhea, excessive vomiting, night sweats, lymph node enlargement?
    ☐ Yes ☐ No

13. In the past 5 years have you had indications of, been diagnosed or treated for any of the following?

A. Arthritis	☐ Yes	☐ No
B. Epilepsy or seizure disorder	☐ Yes	☐ No
C. Disorders of the spine, disc(s) or back	☐ Yes	☐ No
D. Eating disorders	☐ Yes	☐ No
E. Alcoholism or alcohol abuse	☐ Yes	☐ No
F. Drug dependency or drug abuse	☐ Yes	☐ No

14. In the past 2 years have you had indications of, been diagnosed or treated for any of the following?

A. Allergy injections	☐ Yes	☐ No
B. Asthma	☐ Yes	☐ No
C. Eye disorders (excluding glasses/contact lenses)	☐ Yes	☐ No
D. Ear, nose or throat disorders	☐ Yes	☐ No
E. Skin conditions, growths, moles or cysts	☐ Yes	☐ No
F. Abnormal lab tests or results, including Pap tests	☐ Yes	☐ No
G. Migraines	☐ Yes	☐ No

15. In the past 2 years have you had indications of, been diagnosed or treated for any of the following?

A. Increased or irregular heart rate	☐ Yes	☐ No
B. High blood pressure	☐ Yes	☐ No
C. High Cholesterol	☐ Yes	☐ No
D. Thyroid disorder	☐ Yes	☐ No
E. GERD (Gastro Esophageal Reflux Disease)	☐ Yes	☐ No
F. Reproductive System problems (male/female) – including infertility?	☐ Yes	☐ No
G. Abnormal bleeding	☐ Yes	☐ No
H. Sexually transmitted disease (STD)	☐ Yes	☐ No

16. Within the past 12 months have you been prescribed or taken any prescribed medications (other than birth control or short term (10 day) antibiotics)?
    ☐ Yes ☐ No

17. Within the past 12 months have you been hospitalized or treated in the emergency room?
    ☐ Yes ☐ No

18. Have you been diagnosed, had symptoms or received treatment for any condition(s) not listed elsewhere on this application?
    ☐ Yes ☐ No

19. Have you been refused medical coverage by Anthem for health reasons within the last 2 years?
    ☐ Yes ☐ No

20. Are you currently disabled or do you currently have an open Worker's Compensation claim or case under review?
    ☐ Yes ☐ No

4B. *Professional Services* – Give COMPLETE details of any "yes" answers in this section.

Question No.	Name of Hospital, Clinic and/or Person Providing	Phone No.
Date of Treatment *(Month/Year)*	Date Ended	☐ Still Under Treatment
Name of Condition/Illness	Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)*/Results	City / State / Zip	Fax No. *(Optional)*

Question No.	Name of Hospital, Clinic and/or Person Providing	Phone No.
Date of Treatment *(Month/Year)*	Date Ended	☐ Still Under Treatment
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Date of Treatment *(Month/Year)*	Date Ended	☐ Still Under Treatment
Name of Condition/Illness	Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)*/Results	City / State / Zip	Fax No. *(Optional)*

4C. *Prescription Medications* – List all medications taken within the last 12 months

Medication/Dosage Frequency *(i.e., Ritalin/10mg/daily)*	**Illness for which Medication is Prescribed**	**Date Prescribed** *(Month/Day/Year)*	**Date Discontinued** *(Month/Day/Year)*	**Name, Phone No. of Physician or Hospital**
				Name:
				Name:
				Name:
				Name:

5. *Requested Effective Date*

If Anthem approves my application, I request that I receive an effective date of ______________________________. The date you request must be no earlier than the day after the day the application is submitted and no greater than 60 days from the electronic submission 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.

6. *Credit/Debit Card Authorization for Ongoing Monthly Payments*

In order to process your application you will need to provide your first month's payment. Applications will not be processed without this payment. Your ongoing monthly payments will also be charged to the credit or debit card you use to pay your first month's payment. If you wish to elect an alternative payment method for your ongoing payments (i.e. check, electronic funds transfer), you can do so in our Tonik VIP Lounge for members only after you have submitted your application and received notice that you have been accepted into the plan.

Payment Amount:

No charges will be made to your credit/debit card until your application is approved and you are enrolled for coverage. If your coverage or age changes from the time of quote, the first month's premium may be different from the quoted amount. Your second month's billing invoice will reflect the credit or debit to offset any changes due to coverage or age.

IMPORTANT: Your credit/debit card will NOT be charged until you are approved.

Choose a card type:	✹ VISA®	✹ MASTERCARD®
Name as it appears on card:		
Account Number (16 digits):		
3-digit Security Code:		
Expiration Date:	Month:	Year:

Cardholder's billing address

Street:		
City:		
State:		Zip:

7. *Certification*

Certification

I acknowledge receipt of an outline of coverage for Tonik. I certify that I am not eligible for Medicare.

I understand the following:

a. 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.

b. that I will be responsible for notifying Anthem of any 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.

c. that the purpose of the statement of health is to provide Anthem with information for determining the qualifications of myself for the health coverage applied for and I agree that this statement of health shall become part of the contract between Anthem and myself.

I represent that the information I have provided is true and complete to the best of my knowledge and belief.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder, or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Connecticut Division of Insurance.

I authorize release of any information regarding this application to my broker of record.

8. *Conditioned Authorization*

(Applicant Name) Electronic Signature

BY CHECKING THE BOXES AND ENTERING MY NAME BELOW I AM INDICATING MY INTENT TO ELECTRONICALLY SIGN THIS APPLICATION AND REPRESENT THAT ALL OF THE INFORMATION I HAVE PROVIDED IS TRUE, COMPLETE, AND ACCURATE.

☐ I consent to filling out this application electronically and I understand that by applying for coverage I am agreeing to the items under the section titled Certification above and to electronically sign this section on the application.

☐ I agree to provide an original (non-electronic) signature if necessary to authorize the release of medical information should it be required in the future.

☐ I authorize Anthem Blue Cross and Blue Shield to bill by VISA or Mastercard for my monthly premiums.

☐ Check here if this form is signed by a legal representative on behalf of the covered individual and the legal representative is responsible for the payment of the premium for the policy, hereunder (does not apply to a parent or guardian). A copy of a Health Care Power of Attorney, a court order or other documentation establishing custody or other legal documentation demonstrating the ability of the legal representative to act on the covered individual's behalf, **must be received by Anthem within 60 days of submitting the application**. If you do not submit legal documentation within 60 days, coverage will not become effective, your initial premium payment will be refunded to you and you may be asked to reapply.

Please type your name in the spaces below to electronically sign your application:

First Name:		Middle Initial:
Last Name:		Date of Birth:

Please re-type your name in the spaces below to confirm your electronic signature:

First Name:			Middle Initial:
Last Name:			
City:		State:	Signed On:

9. *Conditional Receipt*

THIS RECEIPT DOES NOT PROVIDE ANY COVERAGE UNTIL ALL THE TERMS AND CONDITIONS LISTED BELOW ARE MET.

Anthem has received from the named Applicant an advance deposit equal to the first required premium payment together with an application for designated health insurance coverage. Such payment is accepted subject to the following conditions:

> Subject to provisions of the contract, the coverage applied for will be effective from, and the contract date as of, the day following acceptance by Anthem, unless otherwise specifically stated, provided that the payment evidenced by this receipt is the full required premium payment and provided that Anthem determines that as of the date of the application the proposed covered person is acceptable for coverage and for the benefits applied for. If the application is not approved by Anthem said Plan shall incur no liability and the payment evidenced by this receipt will be refunded to the applicant. No one has the authority to waiver or modify any of the terms or conditions of this receipt.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

Protecting Your Privacy

This notice reviews our policies and practices regarding our disclosure of your Nonpublic Personal Financial Information (NPFI) that we collect and maintain as described here.

How we protect information

We restrict access to your Nonpublic Personal Financial Information (NPFI) and make sure your records are accessed only by employees whose specific jobs require them to do so. We maintain physical, electronic, and procedural safeguards to protect NPFI against unauthorized access and use. If we share your NPFI with affiliated or nonaffiliated entities as provided in this notice, we take steps to ensure the protection of your NPFI against unauthorized access and use. These safeguards that protect against unauthorized access and use apply regardless of whether you are a current or former customer. We only disclose NPFI we collect and maintain about our customers and former customers as set forth here.

Information we collect

We collect NPFI about you and your dependents in order to provide you with the products and services you have requested.

Examples of the sources we use to collect NPFI include:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates or others; and
- Information we receive from a consumer reporting agency.

Nonpublic Personal Financial Information (NPFI)

- NPFI which we may disclose about our customers and former customers includes: information such as name, address, Social Security Number, date of birth, dependent information, employment information, and income; information we receive from consumer reporting agencies such as credit history and creditworthiness; and information relating to transactions, such as balances, payment history and parties to the transaction.
- Companies to whom we may disclose NPFI: As permitted by law, we may disclose the NPFI that we collect about you and your dependents to our affiliates and to nonaffiliated third parties to perform insurance functions, such as parties involved in the following types of businesses or relationships:
  - Insurance and other financial service providers, such as workers' compensation insurers, automobile liability insurers, other insurers, third-party administrators, insurance agents and brokers;
  - Non-financial companies, such as health care providers (doctors, dentists, pharmacies, hospitals), vendors, contractors, subcontractors, consultants and government authorities.
- Companies that provide services for us: We may also disclose your NPFI, as described above, to the following categories of nonaffiliated third parties with which we contract to perform functions or services on our behalf:
  - Insurance brokers and agents;
  - Vendors, contractors and subcontractors, e.g., mailing vendors, case management vendors, pharmacy benefit managers, dental benefit managers and provider network managers. If we contract with a nonaffiliated third party to perform functions or services on our behalf, the contract will limit the scope and use of your NPFI and provide safeguards against unauthorized use or disclosure of your NPFI by the nonaffiliated third party.

Opt-out notice

We are required to offer you the right to let us know (opt-out) that you do not want your NPFI shared with nonaffiliated third parties if we use your NPFI in a manner that is not permitted by federal or Connecticut law to perform insurance functions. Because we only share your NPFI as permitted by law for activities that are part of our normal insurance functions, we are not required to offer an opt-out right at this time. If in the future we decide to change our business practices, we would then provide you with an opportunity to opt-out of the disclosure.

Changes to Anthem's Notice of Information Privacy Policies and Practices

We reserve the right to modify or supplement this Notice of Information Privacy Policies and Practices at any time. If we make material changes, we will provide current customers with a revised notice. This notice is provided on behalf of Anthem Health Plans, Inc. doing business as Anthem Blue Cross and Blue Shield.

CT Eligibility Requirements

Please read the following section carefully as it outlines our basic eligibility requirements for Anthem's individual health plan coverage. Other eligibility requirements may apply.

When you submit your electronic application, you will receive an immediate notification if you fail to meet one or more of these basic criteria. The notice will inform you of the requirement that is not met. If applicable, you will also be notified your option to apply for health coverage through the Connecticut Health Reinsurance Association (HRA).

If you wish to withdraw the application entirely, you must notify us within 10 business days of receiving our notice of ineligibility. Notice to withdraw the application should be emailed to individualsalesCT@anthem.com.

State Residency:

The applicant must reside in Connecticut.

Age/Medicare:

You are not eligible for Anthem's Individual Health coverage if you are age 65 or older and/or entitled to Medicare benefits.

Height and Weight:

If any applicants are not within our guidelines, you will receive an immediate notification upon electronic submission to Anthem.

Disclaimer

Anthem has 30 days to process your application. If the entire application is not approved, Anthem will disclose in writing, the reason(s) for non-acceptance and what needs to be done for reconsideration, if applicable.

Anthem must receive a 30-day advance notification to cancel your coverage.

In no event shall Anthem incur any liability before an application is approved or with respect to an application that has been declined.

No coverage shall exist for which the application is made until approved by Anthem.