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

Anthem Individual Enrollment/Change Application

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

Name (Last/First/Middle initial)	Email Address
☐ Male ☐ Female / Date of Birth (MO. DAY YR.) / Social Security Number	Home Address (Number and Street)
Marital Status ☐ Single ☐ Married ☐ Domestic Partnership (Include "Statement of 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.)

BlueCare Direct (HMO)

☐ **$1,500/$3,000** (Individual/Two Person or Family Deductible)
(Select ONE Drug Maximum)
☐ **$ 500** Drug Maximum
☐ **$2,000** Drug Maximum

Century Preferred Direct (PPO)

Check One Deductible Option:
☐ **$250/$500** (Individual / Two Person or Family Deductible)
☐ **$1,500/$3,000** (Individual / Two Person or Family Deductible)
☐ **$5,000/$10,000** (Individual / Two Person or Family Deductible)
☐ **$10,000/$20,000** (Individual / Two Person or Family Deductible)

Prescription Drug Coverage: YES ☐ NO ☐

Lumenos (PPO)

Lumenos Health Savings Account*
☐ **$1,250/$2,500** deductible (100% In network)
☐ **$2,500/$5,000** deductible (100% In network)
☐ **$2,500/$5,000** deductible (80% In network)
☐ **$5,000/$10,000** deductible (100% In network)
*For Health Savings Accounts, complete the following:
☐ Yes, I would like to establish an H.S.A. with Anthem's banking partner. **(SSN required see Section 1)**
☐ No, I do not want to establish an H.S.A. with Anthem's banking partner.

Lumenos Health Incentive Account Plus
☐ **$2,500/$5,000** deductible (80% In network)
$200/$400 Funding (Individual/Family)

Lumenos Health Incentive Account
☐ **$1,500/$3,000** deductible (80% In network)
☐ **$2,500/$5,000** deductible (80% In network)

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

PCP Name: First Last City PCP Provider No. Existing Patient YES ☐ NO ☐

4. Dependent Information

Name (Last/First/Middle initial)	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 (Age 19-23)
Spouse / Domestic Partner				☐M ☐F				☐Yes ☐No	
Dependent 1				☐M ☐F				☐Yes ☐No	
Dependent 2				☐M ☐F				☐Yes ☐No	
Dependent 3				☐M ☐F				☐Yes ☐No	
Dependent 4				☐M ☐F				☐Yes ☐No	

(Continued on back)

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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 63 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 **attach a voided check or savings account deposit slip.**	☐ Monthly Paper Bill

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 / /

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CONNECTICUT
INDIVIDUAL MARKETS HEALTH STATEMENT

APPLICANT AND FAMILY INFORMATION

PLEASE USE BLACK OR BLUE INK ONLY

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 CURRENTLY ON MEDICARE? ☐ ☐
2. HAS ANYONE HAD HEALTH OR LIFE INSURANCE MODIFIED, POSTPONED OR RATED? PLEASE SUBMIT DETAILS ____________________ ☐ ☐

PART C

1. Are you or your spouse or any dependent to be insured currently disabled or unable to perform their normal activities? ☐ ☐
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? ☐ ☐
3. Are you or any dependents to be insured currently pregnant, or an expectant parent? ☐ ☐
4. Are you or any dependents currently taking any medication? If yes, please specify medication and condition for which it is used: ____________________ ☐ ☐
5. Do you or any dependents have any conditions or symptoms for which a physician or other medical care provider has not been consulted? ☐ ☐
6. Have you or any dependent had medical expenses in excess of $5,000 in the last 12 months? ☐ ☐

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**)
   - A. Chest pain, heart attack, heart murmur, heart trouble, rapid, slow or irregular heart beat, other diseases of the heart, circulatory system or blood vessels, varicose veins, phlebitis, anemia or other disorder of the blood? ☐ ☐
   - B. Cancer, tumor or lymph node enlargement? (Indicate type of cancer and location ____________) ☐ ☐
   - C. Sexually transmitted disease? ☐ ☐
   - D. Mental, emotional, nervous disorder, depression, anxiety, psychotherapy or counseling of any kind? ☐ ☐
   - E. Brain disorder, neurologic problems, seizure disorder, any disorder of the central nervous system, stroke or paralysis? ☐ ☐
   - F. Alcohol or drug use, abuse and/or dependency? ☐ ☐
   - G. Medical diagnosis of AIDS (Acquired Immuno Deficiency Syndrome) or ARC (AIDS Related Complex)? ☐ ☐
   - H. Any disorder of the male/female reproductive organs including infertility and complications of pregnancy? ☐ ☐
   - I. Back, neck, bone, joint problems, Lupus, arthritis or autoimmune disorder? ☐ ☐
   - J. Diabetes? If so, specify date of diagnosis, type of treatment, amount of medications (if any): ☐ ☐
     ____
   - K. Any disorder of the stomach, intestines, gallbladder or esophagus? ☐ ☐
   - L. Any disorder of the lungs or respiratory system or Tuberculosis? ☐ ☐
   - M. Any disorder of the kidneys, bladder or urinary tract? ☐ ☐
   - N. Any disorder of the liver or pancreas? ☐ ☐
   - O. Any disorder of the endocrine system or glands? ☐ ☐

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:

	YES	NO		YES	NO		YES	NO
a. Asthma	☐	☐	d. Ear problems	☐	☐	g. Lyme Disease	☐	☐
b. Bronchitis	☐	☐	e. Eye problems	☐	☐	h. Nose/Throat/Sinus problems	☐	☐
c. Chiropractic Care	☐	☐	f. Headaches/Migraines	☐	☐	i. Skin problems/Allergies	☐	☐

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 fully 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 omissions, misrepresentations or misstatements 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.)