



I N D I V I D U A L

Your Application Kit is enclosed

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

- Print clearly and complete the application in ink.
- You may request an effective date of the 1st or 15th of the month, unless you are requesting continuous coverage. Continuous coverage is defined as no lapse between the cancellation date of your current coverage and the effective date of the Anthem coverage for which you are applying. Your application must be received by Anthem by the requested effective date in order to secure that date.
- The primary applicant and spouse, if applicable, must sign and date the application.
- 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 that can qualify you for pre-existing credit. Creditable Coverage is defined as prior coverage from a group plan, Medicare, Medicaid, health plan for active military personnel, including CHAMPUS, Indian Health Service, state risk pool, Federal Employees Health Benefits Program, public health plan, individual insurance policy or Peace Corps service.
- Select the deductible amount requested.
- Answer all health history questions in Section H. 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 5.
- For Automatic Bank Draft, complete the Authorization located in Section E 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 not required with the application. However, if you wish to submit the initial premium 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 need assistance filling out the application, please contact your agent.

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Indiana Individual Enrollment Application



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

Section A - Coverage Type										
Application Type (select one):										
<input type="checkbox"/> New Coverage <input type="checkbox"/> Change current coverage <input type="checkbox"/> Add dependent(s) to current coverage										
Effective date requested (complete one):										
<input type="checkbox"/> 1 st or <input type="checkbox"/> 15 th Month _____ For continuous coverage Date: ____/____/____										
Section B - Applicant Information (all fields required unless noted otherwise)										
Last Name			First Name			MI	Marital Status			
Home Address (street and P.O. Box if applicable)										
City					State		Zip		County	
Daytime Phone Number () ()			Evening Phone Number () ()			Email (optional)		Occupation (optional)		
Section C - Medical Coverage (select the medical coverage and deductible amount requested)										
<input type="checkbox"/> Blue Access Value (30% coinsurance) Select one:										
<input type="checkbox"/> \$2,000 deductible <input type="checkbox"/> \$3,000 deductible <input type="checkbox"/> \$5,000 deductible <input type="checkbox"/> \$10,000 deductible										
<input type="checkbox"/> Blue Access Economy (30% coinsurance) Select one:										
<input type="checkbox"/> \$500 deductible <input type="checkbox"/> \$1,000 deductible <input type="checkbox"/> \$1,500 deductible <input type="checkbox"/> \$2,500 deductible										
<input type="checkbox"/> Blue Access Saver for (HSA) Select one:										
Plan 1 (20% coinsurance)			Plan 4 (0% coinsurance)			Plan 5 (20% coinsurance)				
<input type="checkbox"/> \$2,400 single/\$4,800 family*			<input type="checkbox"/> \$1,200 single/\$2,400 family*			<input type="checkbox"/> \$2,700 single/\$5,350 family*				
Plan 2 (30% coinsurance)			<input type="checkbox"/> \$2,400 single/\$4,800 family*			Plan 6 (0% coinsurance)				
<input type="checkbox"/> \$2,400 single/\$4,800 family*			<input type="checkbox"/> \$2,500 single/\$5,000 family*			<input type="checkbox"/> \$2,700 single/\$5,350 family*				
Plan 3 (20% coinsurance)			<input type="checkbox"/> \$4,000 single/\$8,000 family*							
<input type="checkbox"/> \$1,200 single/\$2,400 family*			<input type="checkbox"/> \$5,000 single/\$10,000 family*							
<input type="checkbox"/> \$2,500 single/\$5,000 family*										
*The Blue Access Saver family deductible must be satisfied by either one member or all members collectively before any covered services will be paid by the plan.										
<input type="checkbox"/> Blue AccessSM or <input type="checkbox"/> Blue Traditional[®] Select one:										
Plan 1 (20% coinsurance)		<input type="checkbox"/> \$500		<input type="checkbox"/> \$1,000		<input type="checkbox"/> \$2,500		<input type="checkbox"/> \$5,000		
Plan 2 (20% coinsurance)		<input type="checkbox"/> \$250		<input type="checkbox"/> \$500		<input type="checkbox"/> \$1,000		<input type="checkbox"/> \$2,500		
Plan 3 (0% coinsurance)		<input type="checkbox"/> \$2,500		<input type="checkbox"/> \$5,000		<input type="checkbox"/> \$10,000				
Optional Rider: <input type="checkbox"/> Maternity (available with Plan 2 only)										
Section D - Covered Individuals Information (attach a separate sheet if necessary)										
Applicant information must be completed for all dependents (if any) that coverage is being requested for. An eligible dependent may be your spouse, your unmarried children, or your spouse's unmarried children (to the end of the calendar month in which they turn 19 or to the end of the calendar month in which they turn 25 if they qualify as full-time students or qualify as federal tax exemptions).										
Risk Tier	First, MI (last name if different)	Relationship to Applicant	Social Security or ID No.	Sex	Age	Date of Birth mm/dd/yyyy	Height Ft. / In.	Weight Lbs.	FT student or Tax Exempt	
		Self		M F			/			
		Spouse		M F			/			
		Child		M F			/		Y N	
		Child		M F			/		Y N	
		Child		M F			/		Y N	
		Child		M F			/		Y N	
Tobacco Use (required): Have you and/or your spouse used Tobacco in the last 12 months?										
				Applicant <input type="checkbox"/> Yes <input type="checkbox"/> No		If cigarettes, # per day _____				
				Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No		If cigarettes, # per day _____				
Risk Tier Key:										
Preferred (P1), (P2), (P3)			Standard (S1), (S2), (S3)			Modified (M1), (M2)				

Section E - Billing Options

Frequency (select one)

Monthly Quarterly Semi-annually Annually

Initial Premium (optional)

Premium check enclosed

Total premium amount enclosed \$ _____

If paying by check, make the check payable to **Anthem Blue Cross and Blue Shield.**

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
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AUTOMATIC BANK DRAFT (automatic premium withdrawals) - your premium will be deducted on the same day of the month as your assigned effective date. (You **MUST** attach a **blank** voided check)

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)

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

X

NEW LIST BILL - Billing through employer (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

**For Automatic Bank Draft,
attach a blank (voided) check.**

Section F - Other Health Coverage

Did you or your eligible dependents have creditable coverage within the past 63 days? YES NO (you may be eligible for pre-existing 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 everyone listed, indicate all.	Identification Number(s)
---	--------------------------

Name and phone number of prior carrier(s)	Reason for cancellation
---	-------------------------

Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Effective Date of Coverage	Cancellation Date of Coverage
--	----------------------------	-------------------------------

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

Are you or anyone applying for coverage currently covered by Medicare? Yes No If yes, whom? _____

Complete this section if more than one carrier in the last 18 months (Attach a separate sheet if necessary).

Name(s) of covered persons. If everyone listed, indicate all.	Identification Number(s)
---	--------------------------

Name and phone number of prior carrier(s)	Reason for cancellation
---	-------------------------

Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Effective Date of Coverage	Cancellation Date of Coverage
--	----------------------------	-------------------------------

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

Are you or anyone applying for coverage currently covered by Medicare? Yes No If yes, whom? _____

Section G - Healthy Lifestyle (optional)

You and your spouse 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	
1. Have you been a non-tobacco user for three years or longer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you exercise regularly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you in excellent health with no on-going medical conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Section H - Health History (IMPORTANT: This section has two steps)

Step 1: All applicants must answer all questions.

Questions 1-19: Within the past 5 years, has any person to be covered been treated for, diagnosed by or consulted a physician, psychotherapist, counselor, or any other provider, for any of the following illnesses, injuries, or conditions?

	YES	NO		YES	NO
1. Alcoholism/Drug Dependency-Habit	<input type="checkbox"/>	<input type="checkbox"/>	13. Kidney disease or disorders, including kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
2. Disease or disorders of the blood or circulatory system including anemia	<input type="checkbox"/>	<input type="checkbox"/>	14. Liver disorders or disease (including Cirrhosis)	<input type="checkbox"/>	<input type="checkbox"/>
3. Cancer (skin and internal)	<input type="checkbox"/>	<input type="checkbox"/>	15. Lung disorders or lung disease, including Emphysema, Tuberculosis, or Chronic Obstructive Pulmonary disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>
4. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	16. Multiple Sclerosis, Amyotrophic Lateral Sclerosis (Lou Gehrig's) or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
5. Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	17. Muscular Dystrophy, Parkinson's Disease Myotonia, or Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>
6. Diabetes or hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	18. Disease or disorders of the Pancreas	<input type="checkbox"/>	<input type="checkbox"/>
7. Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	19. Disease or disorders of the Spine or disc(s)	<input type="checkbox"/>	<input type="checkbox"/>
8. Epilepsy or seizure <input type="checkbox"/> Grand Mal <input type="checkbox"/> Petit Mal <input type="checkbox"/> Other Date of last seizure (mm/yyyy) _____	<input type="checkbox"/>	<input type="checkbox"/>			
9. Heart disease, disorder or heart surgery	<input type="checkbox"/>	<input type="checkbox"/>			
10. Heart attack, Angina, Aneurysm, Stroke or Transient Ischemic Attack (TIA)	<input type="checkbox"/>	<input type="checkbox"/>			
11. Irregular heart beat, Mitral Valve Prolapse (MVP) or heart murmur	<input type="checkbox"/>	<input type="checkbox"/>			
12. Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Chronic <input type="checkbox"/> Alcoholic <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>			

Questions 20-45: Within the past 5 years, has any person to be covered been treated for, diagnosed by or consulted a physician, psychotherapist, counselor, or any other provider, for any of the following illnesses, injuries, or conditions?

	YES	NO		YES	NO
20. Arthritis, Lupus or Gout	<input type="checkbox"/>	<input type="checkbox"/>	35. Migraines, chronic pain, fatigue, fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
21. Asthma or Allergies	<input type="checkbox"/>	<input type="checkbox"/>	36. Other nervous or mental conditions, including depression, bipolar disorder, obsessive-compulsive disorder, schizophrenia, mental retardation, or Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>
22. Attention Deficit Disorder (ADD)	<input type="checkbox"/>	<input type="checkbox"/>	37. Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>
23. Autism	<input type="checkbox"/>	<input type="checkbox"/>	38. Disease or disorder of the prostate	<input type="checkbox"/>	<input type="checkbox"/>
24. Anxiety, stress	<input type="checkbox"/>	<input type="checkbox"/>	39. Disease or disorder of the male or female reproductive system	<input type="checkbox"/>	<input type="checkbox"/>
25. Disease or disorders of the Bladder or Urinary Tract System	<input type="checkbox"/>	<input type="checkbox"/>	40. Neck Pain, back pain or other back disorders	<input type="checkbox"/>	<input type="checkbox"/>
26. Bone, muscle or nerve diseases or disorders	<input type="checkbox"/>	<input type="checkbox"/>	41. Genital Warts, Herpes Simplex II, or other sexually transmitted disease(s)	<input type="checkbox"/>	<input type="checkbox"/>
27. High cholesterol/triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	42. Any disease or disorder of skin (acne, psoriasis) or nail fungus	<input type="checkbox"/>	<input type="checkbox"/>
28. Cyst, tumor growth, lymph node or gland disorder	<input type="checkbox"/>	<input type="checkbox"/>	43. Disease or disorders of the stomach or intestines (including ulcers, colitis or gastroesophageal reflux disease (GERD), and Irritable Bowel Syndrome)	<input type="checkbox"/>	<input type="checkbox"/>
29. Disease or disorders of the eyes, ears, nose, or throat, including sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	44. Surgery for obesity or any eating disorders	<input type="checkbox"/>	<input type="checkbox"/>
30. Disease or disorders of the gallbladder, including gallstones	<input type="checkbox"/>	<input type="checkbox"/>	45. Hyperthyroidism, hypothyroidism, goiter or other thyroid disease or disorders	<input type="checkbox"/>	<input type="checkbox"/>
31. Hernia <input type="checkbox"/> Hiatal <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>			
32. Hypertension or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			
33. Implant(s), prosthetic device(s), internal fixation device(s), retained hardware (i.e. pins, wires, screws, shunts, stents, pacemaker or valve replacements)	<input type="checkbox"/>	<input type="checkbox"/>			
34. Disease or disorders of the joints (hip, knees, shoulders, etc.)	<input type="checkbox"/>	<input type="checkbox"/>			

Section H - Health History Continued

YES NO

- 46. **Within the past 5 years**, has any person to be covered had any of the following symptoms: unexplained weight loss, night sweats, persistent fever or cough, malaise, prolonged fatigue, chronic/recurrent skin rashes or lesions, recurrent episodes of diarrhea, lymph node enlargement, or unexplained recurrent headaches?
- 47. **Within the past 5 years**, has any person to be covered been treated for, diagnosed by or consulted a physician, psychotherapist, counselor, or any other provider, for any illness, injury or medical abnormality not stated in questions 1-46?
- 48. **Within the past 5 years**, has any person to be covered had abnormal results in any of the following tests: blood work, laboratory results, X-Ray, EKG, blood flow studies, MRI scan, or CAT scan, for conditions you have not already described in this application?
- 49. **Within the past 5 years**, has any person to be covered had surgery, been confined in a hospital, or been treated in an emergency room for conditions you have not already described in this application?
- 50. **Within the past 5 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?
- 51. Is any person to be covered currently taking medication or been prescribed medication by a physician?
- 52. Currently are you, your spouse, or any dependent child(ren), even if not named in this application, an expectant parent?

Name/Relationship _____ Due Date: _____

- 53. Has any person applying for coverage applied for disability or have a condition that is currently covered by Worker's Compensation?
- 54. Have you or any dependent listed ever been rated up or refused health coverage by an insurer?
If yes, explain reason for rate up/denial and date.

_____ Date: _____

55. Name, address and phone number of personal physician.

_____ Phone No. _____

56. Date last seen by physician: _____ Reason: _____

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 #27	Mary	Dr. John Doe 555-555-1000	Tonsillitis	Amoxicillin 250 mg. 4x day		8/2002	9/2002	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy 09/2002	Good
				8/2002	9/2002						
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		

Section I - Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application. If the applicant, or any person for whom coverage is sought incurs an illness or a change in medical condition during the period of time between the application date and the date underwriting approves the application, notification to Anthem (in writing) of such illness or change is mandatory, and a condition precedent to coverage.

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 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.
4. 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.
5. **I understand that pre-existing conditions are limited to 12 months after enrollment for conditions in existence within 12 months immediately prior to my enrollment for which medical advice, diagnosis, care or treatment was recommended or received. 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 payment 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. 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 D is answered "NO", I understand that the signature(s) below will attest to non-tobacco usage for the past 12 months.

All persons applying for coverage are legal residents of the United States.

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.

Signature of Applicant X	Date
Signature of Spouse (if to be covered) X	Date

Section J - Miscellaneous Information (optional)

How did you hear about Anthem?

<input type="checkbox"/> Insurance Agent	<input type="checkbox"/> Mail
<input type="checkbox"/> Website/Search Engine	<input type="checkbox"/> Friend/Family Member
<input type="checkbox"/> Television	<input type="checkbox"/> Phone book
<input type="checkbox"/> Radio	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Print Advertisement (Newspaper, Magazine, etc.)	Key Code (if available): _____

Section K - Agent Certification

Agent Name (please print)		Agent Tax ID	
Agent No.	Agent Phone Number	Agent Fax Number	
Agent Email Address		<i>Thank you for choosing Anthem Blue Cross and Blue Shield</i>	