



**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.
- Select the deductible amount desired.
- Answer all medical questions. Failure to do so will delay the processing of your application.
- 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 Blue Access<sup>SM</sup> Economy Plan Application

Lead Source



Check here if this is a change or an addition to an existing policy or a submitted application. Policy # \_\_\_\_\_

Requested effective date  
Enter month \_\_\_\_\_  1<sup>st</sup>  15<sup>th</sup> For continuous coverage, effective date \_\_\_\_\_

**Section A Select Type of Coverage and Plan Deductible Desired**

Select one:  Single  Parent/Child(ren)  Family  Child(ren)  Couple

Select one:  \$500 deductible  \$1,000 deductible  \$1,500 deductible

**Section B Applicant Information**

Risk Tier	Last Name	First Name	M.I.	Social Security Number
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Home address (street and P.O. Box if applicable)	City, State, ZIP Code
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County	Height _____ft. _____in.	Weight _____lbs.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of birth
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Billing address (if different from above)	City, State, ZIP Code
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Used tobacco within the past 12 months?  Yes  No (If cigarettes, number per day \_\_\_\_\_)

Email address	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Occupation
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Telephone Number(s) (____) _____ (____) _____ (____) _____ Daytime Evening Fax
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Are all persons applying for coverage legal residents of the U.S.?  Yes  No

**Section C Dependent Information (attach a separate sheet if necessary)**

Dependent information must be completed for all dependents (if any) to be covered under this coverage. Eligible dependents may be your spouse, your unmarried dependents, your spouse's unmarried dependent's (to the end of the calendar month in which they turn 19, or to age 25 if they qualify as full-time students or qualify for federal income tax exemptions).

Risk Tier	First, MI (last name if different)	Social Security Number	Sex	Age	Date of Birth	Relationship to Applicant	Height Ft. / In.	Weight Lbs.	Tobacco Use?*	Occupation
						Spouse	/		Y N	

\*If cigarettes, number smoked per day \_\_\_\_\_

Risk Tier	First, MI (last name if different)	Social Security Number	Sex	Age	Date of Birth	Relationship to Applicant	Height Ft. / In.	Weight Lbs.	FT student or Tax Exemption?
						Child	/		
						Child	/		
						Child	/		
						Child	/		

Assigned Effective date	Decision date	Pre-existing Provision	UW initials	Risk Code
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**Risk Tier Key**  
(P) Preferred (S1) Standard 1 (S2) Standard 2 (M1) Modified 1 (M2) Modified 2

**Section D Billing Options (Select billing method)**

<b>BILL AT HOME</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually	<b>AUTOMATIC BANK DRAFT</b> <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually	<input type="checkbox"/> New List Bill <input type="checkbox"/> Change to existing List Bill (If you have selected List Bill, you must complete List Bill forms.)
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**Total premium amount enclosed \$** \_\_\_\_\_  
 If paying by check, make the check payable to **Anthem Blue Cross and Blue Shield.**

**Section E Automatic Bank Draft Authorization**

If you completed Section D and selected Automatic Bank Draft, please complete this section. 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 (Please print)	Account holder's signature (if other than the applicant)
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**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)
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Name and phone number of prior carrier(s)	Reason for cancellation
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Type of Coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Effective Date of Coverage	Cancellation Date of Coverage
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Are you replacing this coverage with Anthem Blue Cross and Blue Shield?  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 (Attach a separate sheet if necessary.)**

Name(s) of covered persons. If everyone listed, indicate all.	Identification Number(s)
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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
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Are you replacing this coverage with Anthem Blue Cross and Blue Shield?  Yes  No

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

**Section G Medical Information (IMPORTANT: This section has two steps.)**

**Step 1: All applicants must answer all questions.**

**Step 2: Where "yes" is answered, list complete details in the chart located on page 5.**

**Questions 1-18. 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 the following illnesses, injuries, or conditions?**

	Y	N		Y	N
1. Alcoholism/Drug Dependency-Habit	<input type="checkbox"/>	<input type="checkbox"/>	12. Kidney disease or disorders, including kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
2. Cancer, Kaposi's Sarcoma, Leukemia, or Hodgkin's Disease	<input type="checkbox"/>	<input type="checkbox"/>	13. Liver disorders or disease (including Cirrhosis), or disease or disorders of the pancreas	<input type="checkbox"/>	<input type="checkbox"/>
3. Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	14. Lung disorders or lung disease, including emphysema, tuberculosis, or chronic obstructive pulmonary disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>
4. Diabetes, high or low blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	15. Multiple Sclerosis or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
5. Disorders of the spine or disc(s)	<input type="checkbox"/>	<input type="checkbox"/>	16. Muscular Dystrophy, Parkinson's Disease, Cerebral Palsy, or Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>
6. Epilepsy or seizure	<input type="checkbox"/>	<input type="checkbox"/>	17. Disease or disorders of the blood or circulatory system	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Grand Mal <input type="checkbox"/> Petit Mal <input type="checkbox"/> Other			18. Acquired Immunodeficiency Syndrome or Human Immunodeficiency Virus (must have been diagnosed) (HIV) or other immune disorder	<input type="checkbox"/>	<input type="checkbox"/>
Date of last seizure (mm/yyyy) _____					
7. Heart disease, disorders or heart surgery	<input type="checkbox"/>	<input type="checkbox"/>			
8. Heart attack, angina, or chest pain	<input type="checkbox"/>	<input type="checkbox"/>			
9. Aneurysm or stroke	<input type="checkbox"/>	<input type="checkbox"/>			
10. Irregular heart beat, Mitral Valve Prolapse (MVP) or heart murmur	<input type="checkbox"/>	<input type="checkbox"/>			
11. Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Chronic <input type="checkbox"/> Alcoholic <input type="checkbox"/> Other					

**Questions 19-41. 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 the following illnesses, injuries, or conditions?**

	Y	N		Y	N
19. Anxiety, stress	<input type="checkbox"/>	<input type="checkbox"/>	34. Hernia	<input type="checkbox"/>	<input type="checkbox"/>
20. Attention Deficit Disorder or Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hiatal <input type="checkbox"/> Other		
21. Arthritis, Lupus or Gout	<input type="checkbox"/>	<input type="checkbox"/>	35. Hypertension or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
22. Cyst, tumor growth, lymph node or gland disorder	<input type="checkbox"/>	<input type="checkbox"/>	36. Hyperthyroidism, hypothyroidism, goiter or other thyroid disease or disorders	<input type="checkbox"/>	<input type="checkbox"/>
23. Asthma or Allergies	<input type="checkbox"/>	<input type="checkbox"/>	37. 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"/>
24. Neck Pain, back pain or other back disorders	<input type="checkbox"/>	<input type="checkbox"/>	38. Other nervous or mental conditions, including depression, bipolar disorder, obsessive-compulsive disorder, schizophrenia, mental retardation, or Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>
25. Bone diseases or disorders	<input type="checkbox"/>	<input type="checkbox"/>	39. 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	<input type="checkbox"/>	<input type="checkbox"/>
26. High cholesterol/triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	40. Surgery for obesity or any eating disorders	<input type="checkbox"/>	<input type="checkbox"/>
27. Disease or disorders of the eyes, ears, nose, or throat, including sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	41. Any disease or disorder of skin (acne, psoriasis) or nail fungus	<input type="checkbox"/>	<input type="checkbox"/>
28. Disease or disorders of the gallbladder, including gallstones	<input type="checkbox"/>	<input type="checkbox"/>			
29. Disease or disorders of the joints (knees, shoulders, etc.)	<input type="checkbox"/>	<input type="checkbox"/>			
30. Disease or disorder of bladder, urinary or prostate, male or female reproductive system	<input type="checkbox"/>	<input type="checkbox"/>			
31. Disease or disorders of the stomach or intestines (including ulcers, colitis or gastroesophageal reflux disease (GERD), Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>			
32. Genital Warts, Herpes Simplex II, or other sexually transmitted disease(s)	<input type="checkbox"/>	<input type="checkbox"/>			
33. Migraines, chronic pain, fatigue, Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>			

**Y N**

42. **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 1-41?
43. **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?
44. **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?
45. Is any person to be covered currently taking medication or been prescribed medication by a physician?
46. Currently, are you, your spouse, or any dependent child(ren), even if not named in this application, an expectant parent?
- Name/Relationship \_\_\_\_\_ Due Date: \_\_\_\_\_
47. Has any person applying for coverage applied for disability or have a condition that is currently covered by Worker's Compensation?
48. 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.

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

\_\_\_\_\_ Phone No. \_\_\_\_\_

50. Date last seen by physician: \_\_\_\_\_ Reason: \_\_\_\_\_

**NOTE: If you answered YES to any of the health questions, give complete details (see the example below.)**

Question Number	Patient First Name	Physician Name & Telephone No. (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
				mm/yy	mm/yy	mm/yy	mm/yy	YES	NO		
EXAMPLE #27	Mary	Dr. John Doe 555-555-1000	Tonsillitis	Amoxicillin 250 mg. 4x day 8/2002	9/2002	8/2002	9/2002	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy 09/2002	Good
								<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 H Significant Terms, Conditions and Authorizations (TERMS)**

**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.**

**Please read this section carefully before signing the application.**

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.
- 4. I understand that pre-existing conditions are limited to 12 months after enrollment for conditions in existence within 6 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.**
5. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
6. 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 statements 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.
7. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.

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).

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.

***If tobacco use question in Section B and/or C is answered "NO," your signature(s) below will attest to non-tobacco usage for the past 12 months.***

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 are 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.

***Thank you for choosing Anthem Blue Cross and Blue Shield.***

Signature of Applicant <b>X</b>	Date
Signature of Spouse (if to be covered) <b>X</b>	Date

**Section J Agent Certification**

Agent Name (please print) <b>Sharon Han</b>		Agent Tax ID
Agent No. <b>706025</b>	Agent Phone No. <b>866-398-0644</b>	Agent Fax No.
Agent Email Address		

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