Health Insurance Consulting

Contact Us: 760-576-6411

David C White
2330 Hosp Way #303
Carlsbad, CA 92008

Thank you for choosing Health Insurance Consulting. If you need any help in completing this application feel free to call us at (760) 576-6411. We are always here to help.

Send the completed application to:

David C White
Health Insurance Consulting
2330 Hosp Way # 303
Carlsbad, Ca 92008

For faster service, feel free to fax the completed application:
Fax **(760) 729-2832**

Our email address is: dcwhite4hins@gmail.com

Here at Health Insurance Consulting the customer is King. We will make every effort to see that your application is processed in a timely manner. We will provide prompt and courteous service. Over time, as your needs change and as the array of available health plans changes we will keep you abreast of current options to make sure that you always get the best value. If the occasion arises where you need help in dealing with claims, billing or any of the other myriad of matters that can crop up, we will intercede on your behalf.

We work for you, not for the Insurance Company.

CA Insurance License #0F60827

Anthem Blue Cross

Individual Application

Thank you for choosing Anthem Blue Cross for your health care coverage needs. Please use the following instructions to guide you in completing the application or go online now to complete this application with our assisted application wizard.

www.Anthem.com

General Guidelines:

Please follow these general guidelines to make sure your application is completed correctly. If complete information is not provided, the application may be returned to you, or we may try to call you to obtain the necessary information.

- Print clearly and complete the application in blue or black ink.
- If you make any changes while completing this form, be sure to initial and date those changes.
- The primary applicant, spouse/domestic partner, and any applicant 18 years or older if applicable, must sign and date the application. Signatures are required in both Section 7 and on the Authorization for Use of Protected Health Information Form in Section 8.
- For applicants applying for HMO coverage only, you will only receive benefits for services by or authorized by the physician selected on this application.
- If you have recently had health coverage, you may have the opportunity to decrease or waive your pre-existing condition exclusion period. Please make sure you fill out Section 5, Prior Insurance History, to apply for pre-existing credit. Prior coverage does not count as creditable coverage if there was a break of more than 63 days prior to applying for this coverage.
- If you choose to enroll in either monthly checking account deduction or monthly credit/debit card deduction, you will not be required to submit payment with your application. If you do not choose monthly deduction, please submit one month's premium with your application.

Checklist:

Please review the checklist before submitting your application.

- ☐ Is the requested date of coverage listed at the top of page 1? You may request an effective date of any day of the month after the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.
- ☐ Is the height and weight listed for each applicant in Section 4?
- ☐ Is the date of birth listed for each applicant in Section 4?
- ☐ Are the Medical, Dental and Life options desired selected in Section 2 and Section 3?
- ☐ Have all health history questions in Section 6 been answered? Failure to do so will delay the processing of your application.
- ☐ For all "YES" or "NOT SURE" answers to the medical questions, are all details provided in Section 6C?
- ☐ Have you signed the application in Section 7? Spouse/domestic partner and dependents 18 years old or over must also sign if included for coverage.
- ☐ Have you signed the Authorization for Use of Protected Health Information in Section 8? Spouses/domestic partners and dependents 18 years old or over must also sign if included for coverage.
- ☐ If you selected an HMO plan, did you choose a primary care physician and list the provider number in Section 4A? The provider number can be found at www.bluecrossca.com.

Individual Application

Anthem® Blue Cross

Reason for Application ***(Check one)***

☐ New plan/policy ☐ Change your current plan/policy ☐ Add dependent(s) to existing plan/policy

Indicate subscriber's ID Number for existing Anthem Blue Cross plan and/or Anthem Blue Cross Life and Health Insurance Company policy: _____

NOTE: If you are adding a dependent or changing benefit options the effective date will always be the first of the month following approval.

Effective date requested: If your application is approved your coverage can start on any day of the month after the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.

Please choose the date you would like your coverage to start: _____/_____/_____ MM/DD/YYYY

IMPORTANT: PREMIUM PAYMENT IS REQUIRED TO BE SUBMITTED WITH YOUR APPLICATION.

Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. Applications received with no premium payment will be returned which may impact your eligibility for coverage. If you have any questions, please call 1-800-333-0912.

1. Primary Applicant Information *(Please print)*

Last Name	First Name	M.I.	Social Security or ID No.

Home Address (Must be complete)	City	State	ZIP Code
Mailing Address (If different than above) or P.O. Box Private Mail Box (PMB) No.	**City**	**State**	**ZIP Code**

Daytime Phone Number	Evening Phone Number	Fax Number	E-mail Address

Marital Status ☐ Single ☐ Married ☐ Domestic Partnership

Language Choice (Optional) ☐ English (ENG) ☐ Spanish (SPA) ☐ Korean (KOR) ☐ Chinese (ZHO) (C/M) ☐ Vietnamese (VIE) ☐ Tagalog (TGL) ☐ Other (W09) _____

☐ Applicant **DOES** speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a Statement of Accountability (Section 9).

Please provide your communication method of choice for all underwriting correspondence during the review of your application: ☐ Email ☐ Fax ☐ Mail

2. Choice of Anthem Blue Cross Plan and/or Anthem Blue Cross Life and Health Insurance Company Policy

You can select a different medical plan/policy for each family member by using the FamilyElect℠ option. To do so, refer to the 4-digit codes in parentheses below and indicate your medical benefit options in Section 3B for each family member.

If you want one medical plan/policy for all family members, please select a box below. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will enroll all eligible family members unless otherwise instructed.

☐ I, the Applicant, request that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company not enroll any eligible applicants unless ALL family members qualify.

If you are choosing **Dental** coverage or **Term Life Insurance,** please complete the appropriate sections that follow.

Medical Benefit Options

Tonik	☐ 1500 (DN13)	☐ 3000 (DN14)	☐ 5000 (DN15)
Basic PPO	☐ 1000 (7900)	☐ 1000 without Life (PE25)	☐ 2500 (R418)
	☐ 2500 w Life (R419)		
ClearProtection	☐ 1000 (00RN)	☐ 3300 (00RP)	☐ 5000 (00RR)
PPO Saver	☐ Saver w Life (NM31)	☐ Saver without Life (PE27)	
PPO CORE	☐ CORE 5000 (DL96)		
CoreGuard	☐ 750 w Facility Copay (01C9)	☐ 1500 w Facility Copay (01CA)	☐ 2500 w Facility Copay (01CB)
	☐ 3500 (01CC)	☐ 5000 (01CD)	☐ 7500 (01CE)
	☐ 10000 (01CF)		

Agent Name/TIN David C White MFKHHJRTZ

2. Choice of Anthem Blue Cross Plan and/or Anthem Blue Cross Life and Health Insurance Company Policy – continued

Medical Benefit Options

PPO Share	☐ 3500 (00Y3)*	☐ 5000 (H062)	☐ 7500 (00Y4)*
3500 Deductible Non-HSA	☐ 3500 (R420)*		
SmartSense	☐ 500 Standard Rx (Z153)	☐ 500 w Rx Upgrade (Z161)	☐ 1500 w Standard Rx (Z155)
	☐ 1500 w Rx Upgrade (Z163)	☐ 2500 Standard Rx (Z157)	☐ 2500 w Rx Upgrade (Z165)
	☐ 5000 Standard Rx (Z159)	☐ 5000 w Rx Upgrade (Z167)	
RightPlan PPO 40	☐ Generic Rx (PE48)	☐ Rx Upgrade (PE49)	☐ No Rx (P958)
Premier	☐ 1000 (01KU)	☐ 1500 (01KV)	☐ 2500 (01KW)
	☐ 3500 (01L0)	☐ 5000 (01L1)	☐ 6000 (01L2)

HSA Compatible Plans

PPO 3500	☐ 3500 HSA Compatible (T160)		
Lumenos HSA (no Maternity)	☐ 1500 (Z126)	☐ 3000 (Z132)	☐ 5000 (Z129)
Lumenos HSA (with Maternity)	☐ 5000 (DX44)		

If you have chosen a Health Savings Account (HSA) product, choose the following:

☐ **Yes**, I would like to establish an HSA. Please forward my information to Anthem Blue Cross' banking partner.

☐ **No, I DO NOT** want to establish an HSA. Please **DO NOT** forward my information to Anthem Blue Cross' banking partner.

HMO Plans

HMO	☐ Select HMO (PE43)*	☐ HMO Saver (7896)*	☐ Individual HMO (7898)*

Other To apply for a plan/policy not listed, write in the name here:

☐ _____

* These products are administered by Anthem Blue Cross and are regulated by the California Department of Managed Health Care. All other products are administered by Anthem Blue Cross Life and Health and are regulated by the California Department of Insurance. Products are administered by Anthem Blue Cross Life and Health and are regulated by the California Department of Insurance.

Dental Benefit Options

PPO Plans	☐ Dental Blue Basic (01PU)	☐ Dental Blue Enhanced (01PW)
	☐ Other _____	
Enhanced Dental	☐ PPO Dental (DR53)	
DHMO Plan	☐ Dental SelectHMO (ZE7N)†	**Dental HMO Office Number** _____

Dental Select HMO plans are offered by Anthem Blue Cross. Dental Blue plans are offered by Anthem Blue Cross Life and Health Insurance Company.

† If you are enrolling in any of the Anthem Blue Cross Dental SelectHMO plans, please enter the number of the Dental Office you have chosen in the space above. If I purchase optional dental benefits, I understand that I may have a waiting period for the coverage.

3. List ALL Applicants for Medical/Dental Benefit Options

Primary Applicant's Name_____

For RightPlan PPO 40, each member will be enrolled on his/her own policy.
All approved applicants will be assigned the same effective date of coverage.

Sex	Last Name First M.I.	Social Security or ID No.*	Age	Birthdate mm/dd/yy	Height ft. in.	Weight lbs.	Select Coverage	PMG/ IPA*	Primary Care Physician (PCP)	Current Patient	3B. Indicate Medical or Dental Benefit Option Code from Section 2 for each family member *(if different)*
	3A. For HMO Use Only Choose a physician for each family member by calling 1-866-297-7647 or from the Provider Directory, which can be found at www.anthem.com/ca										
☐ M ☐ F	Primary Applicant			/ /	|		☐ Medical ☐ Dental			☐ Yes ☐ No	
☐ M ☐ F	Spouse/Domestic Partner			/ /	|		☐ Medical ☐ Dental			☐ Yes ☐ No	
☐ M ☐ F	Dependent			/ /	|		☐ Medical ☐ Dental			☐ Yes ☐ No	
☐ M ☐ F	Dependent			/ /	|		☐ Medical ☐ Dental			☐ Yes ☐ No	
☐ M ☐ F	Dependent			/ /	|		☐ Medical ☐ Dental			☐ Yes ☐ No	
☐ M ☐ F	Dependent			/ /	|		☐ Medical ☐ Dental			☐ Yes ☐ No	

☐ Please check box if any additional sheets of paper have been completed for this section.

My domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.

If a family member's last name is different from the primary applicant's last name, please explain: _____

All children listed above who are between the ages of 19 through 22 must be eligible dependents for Federal Income Tax purposes. Any ineligible dependents may complete a separate application for their own individual coverage.

Has any person listed on this application lived (not traveled) outside the U.S. for the past three (3) consecutive months? ☐ Yes ☐ No, if Yes, who?_____

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? ☐ Yes ☐ No, If No, who?

Are all applicants listed on this application United States citizens? ☐ Yes ☐ No If No, who _____ and how many months/years have they resided in the United States? _____ years and _____ months

4. Anthem Blue Cross Life and Health Term Life Insurance **(Products regulated by the California Department of Insurance)**

TERM LIFE BENEFIT OPTIONS

Applicants and/or any dependents who are approved for medical coverage will also qualify for an Anthem Blue Cross Life and Health Insurance Term Policy at an **additional charge**.

Applicants or dependents under the age of one year are not eligible for term life insurance.

If the applicant has existing life coverage or annuity, does the applicant intend to replace existing life insurance or an existing annuity with the Life policy applied for here? ☐ Yes ☐ No
If you answered 'Yes' to the question just above, please do not discontinue, change, or borrow against any existing life insurance or annuity contracts. Such actions are regarded as 'replacement,' and our policy is not designed or intended to replace existing coverage. Furthermore, if you replace existing coverage and we decline your application for life insurance, you may be left with diminished or no coverage. If you have questions about replacement, ask your agent.

DO NOT SUBMIT PREMIUM FOR LIFE INSURANCE.

Family Member Name	Birthdate mm/dd/yy	Amount of Benefit	Beneficiary Name	Relationship	Allocation	% Allocation
	/ /	☐ $15,000 ☐ $30,000 ☐ $50,000 ☐ $75,000 ☐ $100,000			☐ Primary ☐ Secondary	% %
	/ /	☐ $15,000 ☐ $30,000 ☐ $50,000 ☐ $75,000 ☐ $100,000			☐ Primary ☐ Secondary	% %
	/ /	☐ $15,000 ☐ $30,000 ☐ $50,000 ☐ $75,000 ☐ $100,000			☐ Primary ☐ Secondary	% %

NOTE: Amounts greater than or equal to $50,000 are not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to $30,000. If beneficiary is not listed and policy is issued, death benefits will be paid in accordance with the Beneficiary Provision in the Policy.

See Section 7 (Application Understandings, Conditions and Agreements) for additional terms.

* The social security number provided is for internal use only.
PMG = Participating Medical Group, IPA = Independent Practice Association

5. Prior Insurance History

Primary Applicant's Name_____

Please answer ALL of the following questions.

Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company credits prior coverage toward the preexisting period for those applicants who apply for coverage within 63 days after termination of qualifying prior coverage. To obtain credit toward the preexisting waiting period, please complete the following questions. Attach a separate sheet if necessary.

Pre-existing Conditions: No payment will be made for services or supplies for the treatment of a Preexisting Condition during a period of six (6) months following your Effective Date. However, we may apply Creditable Coverage to satisfy or partially satisfy the six (6) month period if you become eligible for coverage within 62 days of termination of your qualifying prior coverage (exclusive of any waiting or affiliation period), and you apply with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company no longer than 63 days after termination of your qualifying prior coverage. HMO medical plans do not have a preexisting waiting period.

1. Are any applicants eligible for Medicaid or Medicare? ☐ Yes ☐ No
   If yes, who? _____
   Please provide your Medicare or Medicaid Number _____
2. Has any applicant been previously insured by a Anthem Blue Cross plan or Anthem Blue Cross Life and Health Insurance policy? ☐ Yes ☐ No
   If yes, indicate Certificate No. _____
3. Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits or unable to work due to disability or receiving Workers' Compensation? ☐ Yes ☐ No
4. Do you currently have coverage? ☐ Yes ☐ No
   If yes, please provide the following information for each applicant below.
   If no, has any applicant had coverage in the last 63 days? ☐ Yes ☐ No
   If you answered "Yes", please provide the following information for each applicant:

Applicant Name(s) OR ☐ All applicants	Insurer Name and Phone Number			Policyholder ID Number
Plan/Policy Name	State	Effective date of Coverage / /	Coverage End Date / /	Type of Coverage ☐ Group ☐ Individual ☐ Other
Reason for Cancellation		Will you cancel this coverage if approved by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company ☐ Yes ☐ No		

Applicant Name(s) OR ☐ All applicants	Insurer Name and Phone Number			Policyholder ID Number
Plan/Policy Name	State	Effective date of Coverage / /	Coverage End Date / /	Type of Coverage ☐ Group ☐ Individual ☐ Other
Reason for Cancellation		Will you cancel this coverage if approved by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company ☐ Yes ☐ No		

The Health Insurance Portability and Accountability Act (HIPAA)

HIPAA Coverage

While I understand that I am applying for an Individual plan/policy, if I do not qualify, I would like to be considered for benefits under HIPAA. ☐ Yes* ☐ No

*For HIPAA, I understand that no underwriting is required and rates may be higher than for the Individual Plans/Policies. If I qualify, please offer the HIPAA coverage and have complete details sent to me regarding my options and rates for HIPAA. If you have any questions regarding the HIPAA application process, please contact Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company customer service at 1-800-333-0912. **If yes,** please provide the following information:

Name of Applicant(s) requesting HIPAA

1. Are you currently covered by or eligible for Medicaid, Medicare, or any other employer-sponsored health insurance benefits, or do you have other health insurance benefits? ☐ Yes ☐ No
   If yes, you are not eligible for HIPAA.
2. Have you had a minimum of 18 months of continuous health coverage most recently under an employer-sponsored group health plan, ("employer" includes a governmental entity or church), that ended within the last 63 days for a reason other than fraud or non-payment of premium? ☐ Yes ☐ No
   If yes, you will be asked to provide documentation of such coverage, preferably the Certificate of Coverage from your former employer or carrier OR a letter from the employer giving us the following:

Name of Applicant	Effective Date *(Mo/Day/Yr)* / /	End Date *(Mo/Day/Yr)* / /
Name of insurance carrier(s):	Phone No.	

If no, you are not eligible for HIPAA.

3. Were you eligible for continuing coverage under COBRA or Cal-COBRA? ☐ Yes ☐ No **If yes,** please provide the following:

	Effective Date *(Mo/Day/Yr)* / /	End Date *(Mo/Day/Yr)* / /

If no, please explain:

If COBRA or Cal-COBRA is not exhausted, you are not eligible for HIPAA.

6. Health History

Primary Applicant's Name_____

Each applicant must complete a separate Health History Questionnaire. Applicants for HIPAA only do not need to complete Section 6. HIPAA law guarantees coverage.

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

NOTICE: Underwriting is the process whereby Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company determines if you are eligible for coverage. As part of this process, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company relies on the information you provide in this application to determine whether you are eligible for coverage. You must provide truthful and complete answers to the following questions to the best of your ability. Even if you have health coverage or had prior coverage with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, you must fully answer all health history questions. In addition to the information you provide in this application, we have the right to obtain and review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, you should not assume or take for granted that we will obtain and review all of your medical records before approving your application. Consistent with California law, if Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company issues coverage to you and later discovers that you intentionally misstated or omitted material information in response to a question, we may rescind your coverage even after the contract has been issued. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may revoke your coverage. (See Rescission of Membership in Section 7).

All questions must be answered or the application will be returned. If you can not answer either "Yes" or "No" for a specific question, check the "Not Sure" box. For example, you can check the "Not Sure" box if you do not understand a medical term being used, are not sure whether you have or had a the listed medical condition, cannot remember the exact timeframe when you had a medical condition, when you consulted with a physician, or do not recall or remember the information requested. For any question where you answer either "Yes" or "Not Sure" please provide the information requested in Question 6C. Anthem Blue Cross Life and Health/Anthem Blue Cross may need to contact you and ask further questions regarding your "Yes" or "Not Sure" responses in order to process your application.

6A. Health History Questionnaire

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test, see Section 7 for HIV testing disclosure) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	☐	☐	☐
2. Within the last 5 years have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	☐	☐	☐
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Section 6D)	☐	☐	☐
4a. (This question applies to all females age 13 years and older) Has it been more than 40 days since your last menstrual period?	☐	☐	☐
4b. If you answered yes to 4a, check any reasons that apply			
A. Pregnant	☐	☐	☐
B. Due to birth control method	☐	☐	☐
C. Due to breast feeding	☐	☐	☐
D. Hysterectomy or menopause	☐	☐	☐
5. Are you pregnant or an expectant father, have you entered into a surrogate pregnancy agreement, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	☐	☐	☐
6. Do you have implants, prosthesis or retained hardware?			
A. Breast implants	☐	☐	☐
B. Eye/limb prosthesis	☐	☐	☐
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	☐	☐	☐
D. Joint replacement/internal or external fixations devices (pins, rods, screws, plates) neurostimulators	☐	☐	☐
E. Any other prosthesis or implant (other than dental)	☐	☐	☐

	YES	NO	NOT SURE
7. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Headaches requiring prescription medication	☐	☐	☐
B. Loss of consciousness	☐	☐	☐
C. Sleep apnea/breathing difficulties while sleeping	☐	☐	☐
D. Recurrent fainting, weakness or dizziness	☐	☐	☐
E. Paralysis or chronic limb weakness or numbness/tingling in limbs	☐	☐	☐
F. Chest pain	☐	☐	☐
G. Increased/irregular heart beat	☐	☐	☐
H. Low or high blood pressure	☐	☐	☐
I. High cholesterol	☐	☐	☐
J. Shortness of breath	☐	☐	☐
K. Heartburn (recurrent)	☐	☐	☐
L. Abnormal and/or recurrent bleeding (unrelated to menstruation)	☐	☐	☐
M. Recurrent diarrhea and/or recurrent vomiting	☐	☐	☐
N. Unexplained weight loss	☐	☐	☐
O. Blood, sugar, and/or protein in urine	☐	☐	☐
P. Recurrent pain (including back pain)	☐	☐	☐
Q. Jaundice	☐	☐	☐
R. Mass, cyst(s), or lump(s) in any body part including breast	☐	☐	☐

6A. Health History Questionnaire – continued

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
8. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Abnormal Pap smear	☐	☐	☐
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	☐	☐	☐
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)	☐	☐	☐
D. Male infertility	☐	☐	☐
E. Female fertility/infertility	☐	☐	☐
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart valve, circulatory or blood disorder(s)	☐	☐	☐
G. Kidney, bladder or prostate disorder(s)	☐	☐	☐
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	☐	☐	☐
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	☐	☐	☐
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	☐	☐	☐
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	☐	☐	☐
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	☐	☐	☐
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	☐	☐	☐
N. Psoriasis, rosacea, acne or skin disorder(s)	☐	☐	☐
O. Cataract, glaucoma, eye or ear disorder(s)	☐	☐	☐
P. Diabetes, thyroid or endocrine (glandular) disorder(s)	☐	☐	☐
9. Within the last 5 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	☐	☐	☐
10. Within the last 5 years, have you been advised by a health care provider to reduce alcohol intake?	☐	☐	☐
11. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	☐	☐	☐
12. Within the last 5 years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in section 6C.)	☐	☐	☐
A. Obsessive Compulsive Disorder	☐	☐	☐
B. Minor depression	☐	☐	☐
C. Anxiety/panic disorder	☐	☐	☐
D. Attention Deficit Disorder (ADD/ADHD)	☐	☐	☐

	YES	NO	NOT SURE
13. In the last 10 years, have you been diagnosed with, had treatment or treatment recommended for any of the following?			
A. Schizophrenia, Major Depression/BiPolar Disorder	☐	☐	☐
B. Eating disorder	☐	☐	☐
C. Down's Syndrome	☐	☐	☐
D. Autism	☐	☐	☐
E. Cerebral Palsy	☐	☐	☐
14. Within the last 10 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to drug abuse?	☐	☐	☐
15. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	☐	☐	☐
16. Have you ever been diagnosed with hepatitis? (check all types that apply)			
A. Hepatitis A	☐	☐	☐
B. Hepatitis B	☐	☐	☐
C. Hepatitis C, D, E	☐	☐	☐
D. Hepatitis non A - E	☐	☐	☐
17. Have you ever been diagnosed with, or treated for any of the following?			
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment (except HIV treatment)	☐	☐	☐
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma	☐	☐	☐
18. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	☐	☐	☐
19a. Within the last 2 years, have you had any serious illness or serious physical injury not mentioned elsewhere on this application that has not been evaluated by a licensed health practitioner?	☐	☐	☐
19b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	☐	☐	☐
20. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	☐	☐	☐

6B. Other Health Questions

	YES	NO	NOT SURE
21. During the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco?	☐	☐	☐
22. Have you used marijuana within the last 2 years? (if yes, check appropriate box)	☐	☐	☐

☐ less than 4 times per month

☐ 5-7 times per month

☐ 8 or more times per month

	YES	NO	NOT SURE
23. Within the last 10 years, has any applicant used or is now using barbiturates, amphetamines, cocaine, heroin, or other narcotics, except as prescribed by a physician?	☐	☐	☐
24. Have you ever used illegal intravenous (IV) drugs?	☐	☐	☐

25. Please check the appropriate box below based on your average weekly consumption of alcoholic beverages over the past year. (One beverage equals 12 oz beer, 4 oz wine or 1 oz liquor.)

☐ 0-14 per week ☐ 15-26 per week ☐ 27 or more per week

6C. Medical Details

Primary Applicant's Name______________________________

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 6A and 6B.

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: ____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other ______ ☐ Internal Medicine ☐ Cardiac ______
Name of Condition/Illness			Address / Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City / State / ZIP Code
			Phone Number / FAX Number *(Optional)*

If you answered "Not Sure" please check the box(es) that apply.

- ☐ Do not understand the medical term(s) used in the question
- ☐ Do not know if you have the listed condition or symptom
- ☐ Do not recall exact time when you consulted a health care provider or were hospitalized
- ☐ Do not understand the question
- ☐ Had the listed condition or symptom but cannot remember when
- ☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care
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Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

6C. Medical Details – continued

Primary Applicant's Name_____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other _____ ☐ Internal Medicine ☐ Cardiac _____	
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_____

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To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant.

No. of sheets attached ☐

6D. Prescription Medications

List all medications taken within the last 12 months by any family member listed on this application.

Family Member	**Medication/Dosage/Frequency** (i.e., Lopressor/100mg/daily)	**Illness for which Medication is Prescribed**	**Date Prescribed** (Mo/Day/Yr)	**Date Discontinued** (Mo/Day/Yr)	**Physician or Hospital**
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone

6A. Health History Questionnaire

Primary Applicant's Name_____

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

NOTICE: Underwriting is the process whereby Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company determines if you are eligible for coverage. As part of this process, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company relies on the information you provide in this application to determine whether you are eligible for coverage. You must provide truthful and complete answers to the following questions to the best of your ability. Even if you have health coverage or had prior coverage with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, you must fully answer all health history questions. In addition to the information you provide in this application, we have the right to obtain and review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, you should not assume or take for granted that we will obtain and review all of your medical records before approving your application. Consistent with California law, if Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company issues coverage to you and later discovers that you intentionally misstated or omitted material information in response to a question, we may rescind your coverage even after the contract has been issued. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may revoke your coverage. (See Rescission of Membership in Section 7).

All questions must be answered or the application will be returned. If you can not answer either "Yes" or "No" for a specific question, check the "Not Sure" box. For example, you can check the "Not Sure" box if you do not understand a medical term being used, are not sure whether you have or had a the listed medical condition, cannot remember the exact timeframe when you had a medical condition, when you consulted with a physician, or do not recall or remember the information requested. For any question where you answer either "Yes" or "Not Sure" please provide the information requested in Question 6C. Anthem Blue Cross Life and Health/Anthem Blue Cross may need to contact you and ask further questions regarding your "Yes" or "Not Sure" responses in order to process your application.

6A. Health History Questionnaire

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test, see Section 7 for HIV testing disclosure) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	☐	☐	☐
2. Within the last 5 years have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	☐	☐	☐
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Section 6D)	☐	☐	☐
4a. (This question applies to all females age 13 years and older) Has it been more than 40 days since your last menstrual period?	☐	☐	☐
4b. If you answered yes to 4a, check any reasons that apply			
A. Pregnant	☐	☐	☐
B. Due to birth control method	☐	☐	☐
C. Due to breast feeding	☐	☐	☐
D. Hysterectomy or menopause	☐	☐	☐
5. Are you pregnant or an expectant father, have you entered into a surrogate pregnancy agreement, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	☐	☐	☐
6. Do you have implants, prosthesis or retained hardware?			
A. Breast implants	☐	☐	☐
B. Eye/limb prosthesis	☐	☐	☐
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	☐	☐	☐
D. Joint replacement/internal or external fixations devices (pins, rods, screws, plates) neurostimulators	☐	☐	☐
E. Any other prosthesis or implant (other than dental)	☐	☐	☐

	YES	NO	NOT SURE
7. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Headaches requiring prescription medication	☐	☐	☐
B. Loss of consciousness	☐	☐	☐
C. Sleep apnea/breathing difficulties while sleeping	☐	☐	☐
D. Recurrent fainting, weakness or dizziness	☐	☐	☐
E. Paralysis or chronic limb weakness or numbness/tingling in limbs	☐	☐	☐
F. Chest pain	☐	☐	☐
G. Increased/irregular heart beat	☐	☐	☐
H. Low or high blood pressure	☐	☐	☐
I. High cholesterol	☐	☐	☐
J. Shortness of breath	☐	☐	☐
K. Heartburn (recurrent)	☐	☐	☐
L. Abnormal and/or recurrent bleeding (unrelated to menstruation)	☐	☐	☐
M. Recurrent diarrhea and/or recurrent vomiting	☐	☐	☐
N. Unexplained weight loss	☐	☐	☐
O. Blood, sugar, and/or protein in urine	☐	☐	☐
P. Recurrent pain (including back pain)	☐	☐	☐
Q. Jaundice	☐	☐	☐
R. Mass, cyst(s), or lump(s) in any body part including breast	☐	☐	☐

6A. Health History Questionnaire – continued

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
8. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Abnormal Pap smear	☐	☐	☐
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	☐	☐	☐
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)	☐	☐	☐
D. Male infertility	☐	☐	☐
E. Female fertility/infertility	☐	☐	☐
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart valve, circulatory or blood disorder(s)	☐	☐	☐
G. Kidney, bladder or prostate disorder(s)	☐	☐	☐
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	☐	☐	☐
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	☐	☐	☐
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	☐	☐	☐
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	☐	☐	☐
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	☐	☐	☐
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	☐	☐	☐
N. Psoriasis, rosacea, acne or skin disorder(s)	☐	☐	☐
O. Cataract, glaucoma, eye or ear disorder(s)	☐	☐	☐
P. Diabetes, thyroid or endocrine (glandular) disorder(s)	☐	☐	☐
9. Within the last 5 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	☐	☐	☐
10. Within the last 5 years, have you been advised by a health care provider to reduce alcohol intake?	☐	☐	☐
11. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	☐	☐	☐
12. Within the last 5 years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in section 6C.)	☐	☐	☐
A. Obsessive Compulsive Disorder	☐	☐	☐
B. Minor depression	☐	☐	☐
C. Anxiety/panic disorder	☐	☐	☐
D. Attention Deficit Disorder (ADD/ADHD)	☐	☐	☐

	YES	NO	NOT SURE
13. In the last 10 years, have you been diagnosed with, had treatment or treatment recommended for any of the following?			
A. Schizophrenia, Major Depression/BiPolar Disorder	☐	☐	☐
B. Eating disorder	☐	☐	☐
C. Down's Syndrome	☐	☐	☐
D. Autism	☐	☐	☐
E. Cerebral Palsy	☐	☐	☐
14. Within the last 10 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to drug abuse?	☐	☐	☐
15. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	☐	☐	☐
16. Have you ever been diagnosed with hepatitis? (check all types that apply)			
A. Hepatitis A	☐	☐	☐
B. Hepatitis B	☐	☐	☐
C. Hepatitis C, D, E	☐	☐	☐
D. Hepatitis non A - E	☐	☐	☐
17. Have you ever been diagnosed with, or treated for any of the following?			
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment (except HIV treatment)	☐	☐	☐
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma	☐	☐	☐
18. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	☐	☐	☐
19a. Within the last 2 years, have you had any serious illness or serious physical injury not mentioned elsewhere on this application that has not been evaluated by a licensed health practitioner?	☐	☐	☐
19b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	☐	☐	☐
20. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	☐	☐	☐

6B. Other Health Questions

	YES	NO	NOT SURE
21. During the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco?	☐	☐	☐
22. Have you used marijuana within the last 2 years? (if yes, check appropriate box)	☐	☐	☐

☐ less than 4 times per month

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23. Within the last 10 years, has any applicant used or is now using barbiturates, amphetamines, cocaine, heroin, or other narcotics, except as prescribed by a physician?	☐	☐	☐
24. Have you ever used illegal intravenous (IV) drugs?	☐	☐	☐

25. Please check the appropriate box below based on your average weekly consumption of alcoholic beverages over the past year. (One beverage equals 12 oz beer, 4 oz wine or 1 oz liquor.)

☐ 0-14 per week ☐ 15-26 per week ☐ 27 or more per week

6C. Medical Details

Primary Applicant's Name____________________________

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 6A and 6B.

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: ____________________________________

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care
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If you answered "Not Sure" please check the box(es) that apply.

- ☐ Do not understand the medical term(s) used in the question
- ☐ Do not know if you have the listed condition or symptom
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- ☐ Do not understand the question
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Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

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____

____

IU2138 7/10-OL

6C. Medical Details – continued

Primary Applicant's Name_____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
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No. of sheets attached

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6A. Health History Questionnaire

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6A. Health History Questionnaire

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ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test, see Section 7 for HIV testing disclosure) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	☐	☐	☐
2. Within the last 5 years have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	☐	☐	☐
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Section 6D)	☐	☐	☐
4a. (This question applies to all females age 13 years and older) Has it been more than 40 days since your last menstrual period?	☐	☐	☐
4b. If you answered yes to 4a, check any reasons that apply			
A. Pregnant	☐	☐	☐
B. Due to birth control method	☐	☐	☐
C. Due to breast feeding	☐	☐	☐
D. Hysterectomy or menopause	☐	☐	☐
5. Are you pregnant or an expectant father, have you entered into a surrogate pregnancy agreement, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	☐	☐	☐
6. Do you have implants, prosthesis or retained hardware?			
A. Breast implants	☐	☐	☐
B. Eye/limb prosthesis	☐	☐	☐
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	☐	☐	☐
D. Joint replacement/internal or external fixations devices (pins, rods, screws, plates) neurostimulators	☐	☐	☐
E. Any other prosthesis or implant (other than dental)	☐	☐	☐

	YES	NO	NOT SURE
7. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Headaches requiring prescription medication	☐	☐	☐
B. Loss of consciousness	☐	☐	☐
C. Sleep apnea/breathing difficulties while sleeping	☐	☐	☐
D. Recurrent fainting, weakness or dizziness	☐	☐	☐
E. Paralysis or chronic limb weakness or numbness/tingling in limbs	☐	☐	☐
F. Chest pain	☐	☐	☐
G. Increased/irregular heart beat	☐	☐	☐
H. Low or high blood pressure	☐	☐	☐
I. High cholesterol	☐	☐	☐
J. Shortness of breath	☐	☐	☐
K. Heartburn (recurrent)	☐	☐	☐
L. Abnormal and/or recurrent bleeding (unrelated to menstruation)	☐	☐	☐
M. Recurrent diarrhea and/or recurrent vomiting	☐	☐	☐
N. Unexplained weight loss	☐	☐	☐
O. Blood, sugar, and/or protein in urine	☐	☐	☐
P. Recurrent pain (including back pain)	☐	☐	☐
Q. Jaundice	☐	☐	☐
R. Mass, cyst(s), or lump(s) in any body part including breast	☐	☐	☐

6A. Health History Questionnaire – continued

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
8. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Abnormal Pap smear	☐	☐	☐
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	☐	☐	☐
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)	☐	☐	☐
D. Male infertility	☐	☐	☐
E. Female fertility/infertility	☐	☐	☐
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart valve, circulatory or blood disorder(s)	☐	☐	☐
G. Kidney, bladder or prostate disorder(s)	☐	☐	☐
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	☐	☐	☐
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	☐	☐	☐
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	☐	☐	☐
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	☐	☐	☐
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	☐	☐	☐
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	☐	☐	☐
N. Psoriasis, rosacea, acne or skin disorder(s)	☐	☐	☐
O. Cataract, glaucoma, eye or ear disorder(s)	☐	☐	☐
P. Diabetes, thyroid or endocrine (glandular) disorder(s)	☐	☐	☐
9. Within the last 5 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	☐	☐	☐
10. Within the last 5 years, have you been advised by a health care provider to reduce alcohol intake?	☐	☐	☐
11. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	☐	☐	☐
12. Within the last 5 years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in section 6C.)	☐	☐	☐
A. Obsessive Compulsive Disorder	☐	☐	☐
B. Minor depression	☐	☐	☐
C. Anxiety/panic disorder	☐	☐	☐
D. Attention Deficit Disorder (ADD/ADHD)	☐	☐	☐

	YES	NO	NOT SURE
13. In the last 10 years, have you been diagnosed with, had treatment or treatment recommended for any of the following?			
A. Schizophrenia, Major Depression/BiPolar Disorder	☐	☐	☐
B. Eating disorder	☐	☐	☐
C. Down's Syndrome	☐	☐	☐
D. Autism	☐	☐	☐
E. Cerebral Palsy	☐	☐	☐
14. Within the last 10 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to drug abuse?	☐	☐	☐
15. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	☐	☐	☐
16. Have you ever been diagnosed with hepatitis? (check all types that apply)			
A. Hepatitis A	☐	☐	☐
B. Hepatitis B	☐	☐	☐
C. Hepatitis C, D, E	☐	☐	☐
D. Hepatitis non A - E	☐	☐	☐
17. Have you ever been diagnosed with, or treated for any of the following?			
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment (except HIV treatment)	☐	☐	☐
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma	☐	☐	☐
18. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	☐	☐	☐
19a. Within the last 2 years, have you had any serious illness or serious physical injury not mentioned elsewhere on this application that has not been evaluated by a licensed health practitioner?	☐	☐	☐
19b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	☐	☐	☐
20. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	☐	☐	☐

6B. Other Health Questions

	YES	NO	NOT SURE
21. During the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco?	☐	☐	☐
22. Have you used marijuana within the last 2 years? (if yes, check appropriate box)	☐	☐	☐

☐ less than 4 times per month

☐ 5-7 times per month

☐ 8 or more times per month

	YES	NO	NOT SURE
23. Within the last 10 years, has any applicant used or is now using barbiturates, amphetamines, cocaine, heroin, or other narcotics, except as prescribed by a physician?	☐	☐	☐
24. Have you ever used illegal intravenous (IV) drugs?	☐	☐	☐

25. Please check the appropriate box below based on your average weekly consumption of alcoholic beverages over the past year. (One beverage equals 12 oz beer, 4 oz wine or 1 oz liquor.)

☐ 0-14 per week ☐ 15-26 per week ☐ 27 or more per week

6C. Medical Details

Primary Applicant's Name ______________________

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 6A and 6B.

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: ______________________

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Internal Medicine ☐ Family ☐ Cardiac ☐ Other ______		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State	ZIP Code
			Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

- ☐ Do not understand the medical term(s) used in the question
- ☐ Do not know if you have the listed condition or symptom
- ☐ Do not recall exact time when you consulted a health care provider or were hospitalized
- ☐ Do not understand the question
- ☐ Had the listed condition or symptom but cannot remember when
- ☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Internal Medicine ☐ Family ☐ Cardiac ☐ Other ______		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State	ZIP Code
			Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

- ☐ Do not understand the medical term(s) used in the question
- ☐ Do not know if you have the listed condition or symptom
- ☐ Do not recall exact time when you consulted a health care provider or were hospitalized
- ☐ Do not understand the question
- ☐ Had the listed condition or symptom but cannot remember when
- ☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Internal Medicine ☐ Family ☐ Cardiac ☐ Other ______		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State	ZIP Code
			Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

- ☐ Do not understand the medical term(s) used in the question
- ☐ Do not know if you have the listed condition or symptom
- ☐ Do not recall exact time when you consulted a health care provider or were hospitalized
- ☐ Do not understand the question
- ☐ Had the listed condition or symptom but cannot remember when
- ☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

6C. Medical Details – continued

Primary Applicant's Name_____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other _____ ☐ Internal Medicine ☐ Cardiac _____	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State / ZIP Code
			Phone Number	FAX Number *(Optional)*

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not understand the question
☐ Do not know if you have the listed condition or symptom
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

_____

_____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other _____ ☐ Internal Medicine ☐ Cardiac _____	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State / ZIP Code
			Phone Number	FAX Number *(Optional)*

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not understand the question
☐ Do not know if you have the listed condition or symptom
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

_____

_____

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant.

☐ **No. of sheets attached**

6D. Prescription Medications

List all medications taken within the last 12 months by any family member listed on this application.

Family Member	**Medication/Dosage/Frequency** (i.e., Lopressor/100mg/daily)	**Illness for which Medication is Prescribed**	**Date Prescribed** (Mo/Day/Yr)	**Date Discontinued** (Mo/Day/Yr)	**Physician or Hospital**
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone

6A. Health History Questionnaire

Primary Applicant's Name_____

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

NOTICE: Underwriting is the process whereby Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company determines if you are eligible for coverage. As part of this process, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company relies on the information you provide in this application to determine whether you are eligible for coverage. You must provide truthful and complete answers to the following questions to the best of your ability. Even if you have health coverage or had prior coverage with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, you must fully answer all health history questions. In addition to the information you provide in this application, we have the right to obtain and review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, you should not assume or take for granted that we will obtain and review all of your medical records before approving your application. Consistent with California law, if Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company issues coverage to you and later discovers that you intentionally misstated or omitted material information in response to a question, we may rescind your coverage even after the contract has been issued. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may revoke your coverage. (See Rescission of Membership in Section 7).

All questions must be answered or the application will be returned. If you can not answer either "Yes" or "No" for a specific question, check the "Not Sure" box. For example, you can check the "Not Sure" box if you do not understand a medical term being used, are not sure whether you have or had a the listed medical condition, cannot remember the exact timeframe when you had a medical condition, when you consulted with a physician, or do not recall or remember the information requested. For any question where you answer either "Yes" or "Not Sure" please provide the information requested in Question 6C. Anthem Blue Cross Life and Health/Anthem Blue Cross may need to contact you and ask further questions regarding your "Yes" or "Not Sure" responses in order to process your application.

6A. Health History Questionnaire

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test, see Section 7 for HIV testing disclosure) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	☐	☐	☐
2. Within the last 5 years have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	☐	☐	☐
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Section 6D)	☐	☐	☐
4a. (This question applies to all females age 13 years and older) Has it been more than 40 days since your last menstrual period?	☐	☐	☐
4b. If you answered yes to 4a, check any reasons that apply			
A. Pregnant	☐	☐	☐
B. Due to birth control method	☐	☐	☐
C. Due to breast feeding	☐	☐	☐
D. Hysterectomy or menopause	☐	☐	☐
5. Are you pregnant or an expectant father, have you entered into a surrogate pregnancy agreement, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	☐	☐	☐
6. Do you have implants, prosthesis or retained hardware?			
A. Breast implants	☐	☐	☐
B. Eye/limb prosthesis	☐	☐	☐
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	☐	☐	☐
D. Joint replacement/internal or external fixations devices (pins, rods, screws, plates) neurostimulators	☐	☐	☐
E. Any other prosthesis or implant (other than dental)	☐	☐	☐

	YES	NO	NOT SURE
7. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Headaches requiring prescription medication	☐	☐	☐
B. Loss of consciousness	☐	☐	☐
C. Sleep apnea/breathing difficulties while sleeping	☐	☐	☐
D. Recurrent fainting, weakness or dizziness	☐	☐	☐
E. Paralysis or chronic limb weakness or numbness/tingling in limbs	☐	☐	☐
F. Chest pain	☐	☐	☐
G. Increased/irregular heart beat	☐	☐	☐
H. Low or high blood pressure	☐	☐	☐
I. High cholesterol	☐	☐	☐
J. Shortness of breath	☐	☐	☐
K. Heartburn (recurrent)	☐	☐	☐
L. Abnormal and/or recurrent bleeding (unrelated to menstruation)	☐	☐	☐
M. Recurrent diarrhea and/or recurrent vomiting	☐	☐	☐
N. Unexplained weight loss	☐	☐	☐
O. Blood, sugar, and/or protein in urine	☐	☐	☐
P. Recurrent pain (including back pain)	☐	☐	☐
Q. Jaundice	☐	☐	☐
R. Mass, cyst(s), or lump(s) in any body part including breast	☐	☐	☐

6A. Health History Questionnaire – continued

Primary Applicant's Name _____

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 6C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
8. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Abnormal Pap smear	☐	☐	☐
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	☐	☐	☐
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)	☐	☐	☐
D. Male infertility	☐	☐	☐
E. Female fertility/infertility	☐	☐	☐
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart valve, circulatory or blood disorder(s)	☐	☐	☐
G. Kidney, bladder or prostate disorder(s)	☐	☐	☐
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	☐	☐	☐
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	☐	☐	☐
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	☐	☐	☐
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	☐	☐	☐
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	☐	☐	☐
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	☐	☐	☐
N. Psoriasis, rosacea, acne or skin disorder(s)	☐	☐	☐
O. Cataract, glaucoma, eye or ear disorder(s)	☐	☐	☐
P. Diabetes, thyroid or endocrine (glandular) disorder(s)	☐	☐	☐
9. Within the last 5 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	☐	☐	☐
10. Within the last 5 years, have you been advised by a health care provider to reduce alcohol intake?	☐	☐	☐
11. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	☐	☐	☐
12. Within the last 5 years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in section 6C.)	☐	☐	☐
A. Obsessive Compulsive Disorder	☐	☐	☐
B. Minor depression	☐	☐	☐
C. Anxiety/panic disorder	☐	☐	☐
D. Attention Deficit Disorder (ADD/ADHD)	☐	☐	☐

	YES	NO	NOT SURE
13. In the last 10 years, have you been diagnosed with, had treatment or treatment recommended for any of the following?			
A. Schizophrenia, Major Depression/BiPolar Disorder	☐	☐	☐
B. Eating disorder	☐	☐	☐
C. Down's Syndrome	☐	☐	☐
D. Autism	☐	☐	☐
E. Cerebral Palsy	☐	☐	☐
14. Within the last 10 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to drug abuse?	☐	☐	☐
15. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	☐	☐	☐
16. Have you ever been diagnosed with hepatitis? (check all types that apply)			
A. Hepatitis A	☐	☐	☐
B. Hepatitis B	☐	☐	☐
C. Hepatitis C, D, E	☐	☐	☐
D. Hepatitis non A - E	☐	☐	☐
17. Have you ever been diagnosed with, or treated for any of the following?			
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment (except HIV treatment)	☐	☐	☐
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma	☐	☐	☐
18. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	☐	☐	☐
19a. Within the last 2 years, have you had any serious illness or serious physical injury not mentioned elsewhere on this application that has not been evaluated by a licensed health practitioner?	☐	☐	☐
19b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	☐	☐	☐
20. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	☐	☐	☐

6B. Other Health Questions

	YES	NO	NOT SURE
21. During the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco?	☐	☐	☐
22. Have you used marijuana within the last 2 years?	☐	☐	☐

(if yes, check appropriate box)

☐ less than 4 times per month

☐ 5-7 times per month

☐ 8 or more times per month

	YES	NO	NOT SURE
23. Within the last 10 years, has any applicant used or is now using barbiturates, amphetamines, cocaine, heroin, or other narcotics, except as prescribed by a physician?	☐	☐	☐
24. Have you ever used illegal intravenous (IV) drugs?	☐	☐	☐

25. Please check the appropriate box below based on your average weekly consumption of alcoholic beverages over the past year. (One beverage equals 12 oz beer, 4 oz wine or 1 oz liquor.)

☐ 0-14 per week ☐ 15-26 per week ☐ 27 or more per week

6C. Medical Details

Primary Applicant's Name________________________________

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 6A and 6B.

Responses in sections 6A, 6B, 6C and 6D pertain to the following applicant: ____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*			Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*		Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other ______ ☐ Internal Medicine ☐ Cardiac ______		
Name of Condition/Illness				Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*				City	State	ZIP Code
				Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not know if you have the listed condition or symptom
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not understand the question
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*			Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*		Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other ______ ☐ Internal Medicine ☐ Cardiac ______		
Name of Condition/Illness				Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*				City	State	ZIP Code
				Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not know if you have the listed condition or symptom
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not understand the question
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*			Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*		Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other ______ ☐ Internal Medicine ☐ Cardiac ______		
Name of Condition/Illness				Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*				City	State	ZIP Code
				Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not know if you have the listed condition or symptom
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not understand the question
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

6C. Medical Details – continued

Primary Applicant's Name_____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other _____ ☐ Internal Medicine ☐ Cardiac _____	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State / ZIP Code
			Phone Number	FAX Number *(Optional)*

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not understand the question
☐ Do not know if you have the listed condition or symptom
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

_____

_____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other _____ ☐ Internal Medicine ☐ Cardiac _____	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State / ZIP Code
			Phone Number	FAX Number *(Optional)*

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not understand the question
☐ Do not know if you have the listed condition or symptom
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

_____

_____

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant.

No. of sheets attached

6D. Prescription Medications

List all medications taken within the last 12 months by any family member listed on this application.

Family Member	**Medication/Dosage/Frequency** (i.e., Lopressor/100mg/daily)	**Illness for which Medication is Prescribed**	**Date Prescribed** (Mo/Day/Yr)	**Date Discontinued** (Mo/Day/Yr)	**Physician or Hospital**
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone

7. Application Understandings, Conditions and Agreement

You, the applicant, are solely responsible to review and attest to the completeness and validity of information provided on this application. It is important that you carefully read and fully understand the following:

All Applicants

I, the undersigned, understand that under the Anthem Blue Cross plan and/or Anthem Blue Cross Life and Health Insurance Company policy in which I am enrolling, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician. Contact customer service at 1-866-297-7647 with any questions about the use of network providers and the financial impact of using out-of-network providers.

HIV Testing PROHIBITED:

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

CURRENT HEALTH COVERAGE:

If you currently have health coverage, we strongly recommend that you maintain your current coverage and request an effective date of 60 to 75 days from the date of application. This will help ensure that your application is processed before you surrender your present insurance.

Agreement *(all applicants)*

By applying for coverage, I, the undersigned, agree to the following:

1. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may decline my application. No coverage comes into effect until Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company at its discretion.
2. Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company nor any affiliated company shall have any liability to me or anyone else listed on it. If this application is not accepted, neither I nor anyone listed on it will be entitled to benefits or coverage from Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
3. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company underwriting policy or the terms of any Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company coverage.
4. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
5. In no event shall Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company or any affiliated company have any liability to the applicant if the application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by the Medical Underwriting Department of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
6. I understand Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.
7. If I purchase optional dental coverage, I understand that I may have a waiting period for the coverage of major services.
8. I understand that it is mandatory that I notify Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, in writing, immediately if I (the applicant) or any other person for whom coverage is sought received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date. I understand that in this situation, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be denied, rescinded, or delayed, or reformed or benefits denied due to the illness, injury or condition being treated as a preexisting condition.
9. I understand and agree that I am applying for an individual health coverage policy which is not part of any employer-sponsored plan and the policy, if issued, shall not be used as an employer-sponsored health benefit plan. If the policy is issued, I understand and agree that I am responsible for 100% of the premium and I must ensure that premiums are paid timely. I certify that no employer of any person covered under this policy will pay any premium for this health coverage policy, directly or indirectly, through wage adjustments or otherwise. If my employer has agreed to remit my premium payment to Anthem Blue Cross/Anthem Blue Cross Life and Health on my behalf, my employer will not directly or indirectly contribute to that payment and will only forward to Anthem Blue Cross/Anthem Blue Cross Life and Health my premium payment that is directly funded by the regular wages paid to me by my employer.

7. Application Understandings, Conditions and Agreement – continued

10. ☐ By checking this box, I expressly consent to receive calls made by or on behalf of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliated companies, contractors, and vendors that use an automated dialing system or deliver prerecorded messages, including telemarketing sales calls that encourage the purchase of goods or services, to any of the telephone numbers I have provided in this Application. All calls made pursuant to this provision shall be limited to information regarding benefits, services or discounts available under health benefit plans offered or administered by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and its affiliated companies. I also understand that my consent to receive such calls is voluntary and may be discontinued by calling Anthem. The benefits available under health benefit plans offered or administered by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates will not be altered in any way if I do not consent to calls made under this provision.
11. I understand that my domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.
12. When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will be considered and applied only to the individual in question.

Term Life Insurance Coverage:

I am applying for the benefits provided by the policy indicated in Section 4. I understand that receipt of money with this application does not create coverage. Coverage will come into effect only on approval by Anthem Blue Cross Life and Health Insurance Company.

Initials

I understand that if Anthem Blue Cross Life and Health Insurance Company denies my application for term life coverage, I will be notified in writing and no benefit will be payable. I understand that (1) I alone am responsible for accurately completing this application and that (2) if I, or any person for whom life coverage is sought, incurs an illness or a change in medical health status during the period of time between the application signature date and the approved effective date of life coverage that is not disclosed in Section 6 of this application, notification to Anthem Blue Cross (our agent) of such illness or change in health status is mandatory.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes a claim containing false, incomplete or misleading information to obtain the proceeds of an insurance policy is guilty of a felony.

NOTE: Life insurance is to be underwritten by Anthem Blue Cross Life and Health Insurance Company.

Life Replacement Warning:

I understand that buying this life policy (if applicable) in order to discontinue or change an existing life policy is a mistake. Furthermore, I understand that my life insurance replacement requires a careful comparison of my existing policy and the replacing policy, my understanding of the facts, and my asking the company or agent that sold me my existing policy to give me information about it. In this way I would be sure I was making a decision that is in my best interest.

Rescission of Membership

Every applicant age 18 or older acknowledges the following: I have provided true and complete answers to all questions in the application to the best of my knowledge and understand that all answers are important and will be considered in the acceptance or denial of this application. I understand that all information I know, that is responsive to a question on this application, must be provided in my answers consistent with California law. If Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company discovers that I intentionally misstated or omitted any such material information, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may rescind my plan/policy within the first 24 months from my effective date. I understand this means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will revoke my plan/policy as if it never existed back to the original Effective Date. Rescission may occur even if we review your medical records or seek medical confirmation of your health information as part of our processing of your application.

The primary applicant additionally acknowledges the following: All of my dependents listed on this application who are 18 years of age or older have read this application and have provided complete and accurate information for this application to the best of my knowledge and have signed the application below. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about all applicants, including my children under the age of 18, listed on this application is true and complete. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may deny or rescind the entire plan/policy if it discovers that in applying for coverage I intentionally misstated or omitted any material information I know that is responsive to any question in this application. Enrollees/insureds other than the individual(s) whose information led to the rescission on such plans/policies may be able to obtain coverage as set forth in the section **Eligibility following Rescission**.

I understand that if my plan/policy is rescinded, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for benefits. I also understand that, consistent with California law, I will be required to pay for any services Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company paid on my behalf and that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will refund any premium paid by me, less my medical expenses that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company paid.

7. Application Understandings, Conditions and Agreement – continued

Eligibility following Rescission

For individual plans/policies that have been rescinded, eligible enrollees/insureds other than the individuals whose information led to the rescission on such plans/policies may continue coverage, without medical underwriting, in one of the following ways:

- enroll in a new individual plan/policy that provides equal benefits, or
- remain covered under the individual plan/policy that was rescinded.

In either instance, premium rates may be revised to reflect the number of persons on the plan/policy.

Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will notify in writing all enrollees/insureds of the right to coverage under an individual plan/policy, at a minimum, when it rescinds the individual plan/policy.

Eligible enrollees/insureds who continue coverage as a result of a rescinded plan/policy may be subject to completing the pre-existing condition exclusion period that was not fulfilled on the rescinded plan/policy. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will credit any time that the eligible Insured was covered under the rescinded plan/policy. The time period in the new plan/policy for the pre-existing condition exclusion period will not be longer than the one in the plan/policy that was rescinded.

Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will provide 60 days for enrollees to accept the offered new individual plan/policy and this contract shall be effective as of the effective date of the original plan/policy and there shall be no lapse in coverage.

I have personally read and attest to the completeness and validity of the information provided on this application. If I am accepted, this application will become part of the plan contract/policy between Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and me. I, and any enrolled family members, agree to abide by the terms of that plan contract/policy. With the exception of minors and persons for whom this application has been interpreted (a signed Statement of Accountability must be attached, see Section 9) all persons applying for coverage agree that they have personally answered all health history questions directed to them. If an Applicant does not read English, the interpreter must sign and submit a Statement of Accountability for interpreting this entire application (see Section 9).

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN /POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. ***It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*** **THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.**

Applicant/Parent or Legal Guardian	Today's Date	Applicant's Spouse/Domestic Partner	Today's Date
✗		✗	
Applicant's Dependent age 18 or over	Today's Date	Applicant's Dependent age 18 or over	Today's Date
✗		✗	

IMPORTANT: ALL APPLICANTS AGE 18 AND OVER MUST PERSONALLY READ, AGREE TO, SIGN AND DATE THIS APPLICATION.

8. Authorization for Use of Protected Health Information

NOTE: This form is not required if you are ONLY applying for HIPAA coverage.

By signing below:

I authorize Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations. I further authorize Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company to disclose protected health information it may collect about me to MIB, Inc., which may re-disclose such information to other insurance companies pursuant to the MIB's information exchange.

I also authorize any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans, medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations to furnish any medical records or health history information concerning me and any family member listed on my Application to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company. This information is needed to determine eligibility for coverage and Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company's acceptance of coverage requested for myself and/or any family members listed on my Application or so that a determination of coverage regarding a claim for specified benefits can be made.

I understand that my application will not be considered if this form is not signed and returned with my completed Application if I am initially applying for acceptance in a medically underwritten health plan/policy offered by Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or signed and returned with my completed Change of Coverage Form if I wish to add a family member or upgrade my coverage in the future. This Authorization will expire 24 months following Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company's acceptance of coverage, if not previously revoked.

I understand that I may revoke this Authorization at any time while Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company is determining eligibility for the coverage requested. To do so, I must submit a completed Authorization Revocation Form to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company. An Authorization Revocation Form is available by calling 1-866-297-7647, going to our website, www.anthem.com/ca, or writing to: Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9041, Oxnard, CA 93031. If I revoke this Authorization after I initially apply for coverage, I understand that I/we will not be considered by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company for acceptance in one of its medically underwritten health plans/policies. If I revoke this Authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by recipient and, in some circumstances, may no longer be protected by federal regulations governing the privacy of health information.

Printed name of Applicant/Member	Signature of Applicant/Member or his/her Legal Representative	Date
	✗	

Printed name of Spouse/Domestic Partner or Dependent Child age 18 or over listed on Application	Signature of Spouse/Domestic Partner or Dependent Child* or his/her Legal Representative	Date
	✗	

Printed name of Spouse/Domestic Partner or Dependent Child age 18 or over listed on Application	Signature of Spouse/Domestic Partner or Dependent Child* or his/her Legal Representative	Date
	✗	

**If listed on your Application or Change Form, your spouse/domestic partner and each dependent child age 18 or over must sign above.*

If a legal representative signs on behalf of the applicant or spouse or domestic partner, a copy of the legal representative's authority must be attached to the application.

A photocopy of this form will be as valid as the original.
You or an authorized representative have the right to receive a copy of this Authorization upon request.

9. Statement of Accountability

Primary Applicant's Name_____

To be completed when the applicant cannot complete the application.

NOTE: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I, _____ , personally read and completed this Individual Application for the applicant named below because:

☐ Agent assisted application ☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English
☐ Applicant is Limited English Proficient ☐ Other (explain): _____

I interpreted the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the: ☐ Applicant
Or by:_____

I also interpreted and fully explained the 'Application Understandings, Conditions and Agreement,' the 'Authorization for Use of Protected Health Information' and the 'Payment Method'

_____ _____
Signature of Interpreter *(Required)* Today's Date *(Required)*

I confirm that the application was interpreted on my behalf.

_____ _____
Signature of Applicant *(Required)* Today's Date *(Required)*

Language interpreted (e.g. Spanish): _____

TO BE COMPLETED BY ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY-APPOINTED AGENT

1. Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting? ☐ Yes ☐ No
   If yes, please attach explanation.
2. Did you see the proposed subscriber (and spouse/domestic partner, if applying) at the time this application was executed? ☐ Yes ☐ No
   If no, please explain: _____
3. I certify that, to the best of my knowledge and belief, the responses herein are accurate.
4. Please check one of the following and complete the information below:

☐ I have not had any interactions whatsoever with this applicant either by phone, email or in person and did not provide any information, advise or assist the applicant in any manner in providing answers or responses to any questions in the application.

☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code Section 1389.8(c)/Insurance Code Section 10119.3.

Signature of Agent *(Required)*	Date *(Required)*
✗	

4. **Breakdown of funds collected:** Total Medical funds $ _____
   Total Dental funds $ _____
   Total funds collected $ _____

Name of Agent (Print Name)		Agent Street Address / Suite No./Personal Mail Box (PMB) No.	
David C White		**2330 Hosp Way**	**Suite 303**
Agent ID Number **MFKHHJRTZ** –	Sub-Agent ID Number –	City/State/ZIP Code **Carlsbad, CA 92008**	Location No.
Phone Number **(760) 576-6411**	FAX Number **(760) 729-2832**	E-mail Address **dcwhite4hins@gmail.com**	

Mail ID Cards to: ☐ Agent ☐ Primary Applicant **PLEASE NOTE:** If neither box is checked, the Service Agreement will be mailed directly to the primary applicant.

Agent: Please mail this application to the following address:

Anthem Blue Cross
P.O. Box 9041
Oxnard, CA 93031-9041

OR **Fax to: (800) 327-9255**

Anthem Blue Cross

CAINDAPP 2/10

IU2138 7/10-OL

Payment Methods for Individual Applications – California

Premium payment is required. Initial payment will be credited to approved applicants only.

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.

A. Monthly Checking Account Automatic Premium Payment

☐ **Monthly Checking Account Automatic Premium Payment**

Name of Bank or Financial Institution: _____

Account No.: I___i___i___i___i___i___i___i___i___i___I Bank Routing No.: I___I___I___I___I___I___I___I___I___I

If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account on the first of the month ONLY. Premiums may be prorated in order to adjust the initial paid to date, as a result of change(s) during the underwriting process or in the event of membership changes.

Monthly Checking Account Automatic Premium Payment Authorization – As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during underwriting, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and will be billed monthly. **You will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Date
X	

B. Credit / Debit Card

☐ **Initial Premium** ☐ **Monthly Premiums**

Monthly Credit Card Authorization – As a convenience to me, I request and authorize Anthem Blue Cross to charge my card for a one time initial debit upon approval or for recurring premiums on each due date. I understand that if this option is selected: 1) For initial premium only, my account will be debited one month of premium after approval; or 2) For recurring debits, I will be required to pay premium on a monthly basis and my account will be debited or charged on each due date. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **We accept Visa, MasterCard, Discover and Star*.** For Star, we accept 16 digit card numbers only.

Credit Card: ☐ Visa ☐ MasterCard ☐ Discover

Card No.:I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I__I Exp.: _____ Cardholder's Zip Code: I__I__I__I__I__I – I__I__I__I__I

Cardholder's Name (as it appears on the credit card) PRINT	Authorized Signature (As it appears on the credit card)	Date
X	**X**	

C. Billing (To be used if an automatic payment option is NOT selected from A or B above.)

☐ **Bi-monthly (Submit 2 months premium)** ☐ **Quarterly (Submit 3 months premium)**

Anthem Blue Cross

Language Assistance Services

English

Can you read the attached document? If not, we can have somebody help you read it. You may also be able to get this written in your language. For free help, please contact your agent.

Spanish

Puede usted leer este documento anexo? Si no, podemos asignarle alguien que le ayude. También puede recibir esto escrito en su idioma. Para asistencia gratuita, por favor contacte a su agente.

Chinese (Traditional)

您能讀懂所附文件嗎？如果不懂，我們可以請人幫您。也許您還可以收到中文版本。請聯絡您的代理人要求免費的協助。

Korean

첨부 서류를 읽으실 수 있습니까? 읽지 못하신다면 읽어드릴 사람을 구해드릴 수 있습니다. 한국어 번역본도 받으실 수 있습니다. 도움은 무료이며 담당 에이전트에게 연락하십시오.

Vietnamese

Quý vị đọc được tài liệu đính kèm không? Nếu không, chúng tôi sẽ cho người đọc giúp quý vị. Ngoài ra, quý vị cũng có thể được cấp tài liệu này bằng ngôn ngữ của quý vị. Vui lòng liên lạc với nhân viên đại diện của quý vị để được giúp đỡ miễn phí.

Tagalog

Kaya mo bang basahin ang nakakabit na dokumento? Kung hindi naman, maaaring patulungan ka namin sa ibang tao sa pagbasa nito. Maaari mo ring makuha ito na nasusulat sa iyong lengguwahe. Para sa libreng pagtulong, paki-kontakin ang iyong ahente.

MCASH6334CML 01/09

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-249-4844. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-249-4844. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打1-866-249-4844 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-249-4844 .Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin. Maaari mong ipabasa sa iyo ang mga dokumento at maaari mong hingin na ipadala ang ilang mga dokumento sa iyo sa Tagalog. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-249-4844. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

무료 통역 서비스. 귀하는 통역 서비스를 받으실 수 있습니다. 한국어로 서류를 낭독해주는 서비스 받으실 수 있으며 한국어로 번역된 서류를 받아보실 수도 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-249-4844번으로 문의해 주십시오. 보다 자세한 문의 사항은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-249-4844 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-249-4844. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-249-4844までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-249-4844 تماس بگیرید. برای دریافت کمک بیشتر، به (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357تلفن کنید. Persian CA Dept. of Insurance

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-249-4844 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នក ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទ មកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-249-4844 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-866-249-4844. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357.Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-249-4844. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357. Hmong