Blue Short Term℠ Individual Enrollment Application

Do not write in shaded area.

Effective date

Section A Please print clearly in ink, or type.

Last name of applicant			**First name**		**Middle initial**
Home address: Street			**City**	**State**	**ZIP code**
County	**Home phone** *(include area code)*			**Social Security no.**	
Date of birth	**Age**	**Sex** ☐ Male ☐ Female	**Height**	**Weight**	**Marital status** ☐ Single ☐ Married
Are all persons applying for coverage legal U.S. residents? ☐ Yes ☐ No *(If no, attach a copy of your green card or visa.)*			**Current occupation (if unemployed, previous occupation)**		
Name of employer				**Work phone** *(include area code)*	

Section B Coverage desired

Deductible level desired: ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500

Type of coverage desired ☐ Single ☐ Children ☐ Parent/Children ☐ Couple ☐ Family

Term desired (months) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

Check one: Coverage paid in full options:
☐ Premium Check Enclosed ☐ VISA
☐ MasterCard

Credit Card no. ______________________

Expiration date:

Monthly payment options: ($10 monthly fee)
☐ Automatic Bank Draft (Complete section F. Premium will be deducted on the same day of the month as your assigned effective date.)
☐ Bill me monthly (One month's premium must accompany this application.)

Total premium due: (Make check payable to **Anthem Blue Cross and Blue Shield.)**

$ ______________________

Requested future effective date:

Section C Dependent information

Applicant information must be completed for all dependents (if any) that coverage is being requested for. An eligible dependent may be your spouse, your unmarried children, or your spouse's unmarried children **(to the end of the calendar month in which they turn 19 or to the end of the calendar month in which they turn 25 if they qualify as full-time students or qualify as federal tax exemptions)**.

First name	Middle initial	Last name (if different from applicant)	Social Security no.	Height	Weight	Birthdate Mo.	Day	Year	Sex (M or F)	Relationship to applicant

If there are additional dependents, please attach a separate page with all requested information.

Section D Other coverage information

Will this coverage replace a previous short-term or temporary plan?	☐ Yes ☐ No	If Yes, previous identification number	Expiration date
Do you or any person to be covered now have health coverage in force?	☐ Yes ☐ No	If Yes, expiration date (This coverage cannot be issued while any other coverage is in force.)	

Have you or any other person to be covered ever been denied health coverage for health reasons? ☐ Yes ☐ No

Section E Other information

Question	Answer
Are you, your spouse or any of your eligible dependents (whether or not named on this application) currently pregnant or an expectant parent (including adoptions)? **If Yes, who?**	☐ Yes ☐ No
Are you, your spouse or any of your eligible dependents an insulin dependent diabetic?	☐ Yes ☐ No
Is any person named on the application currently hospitalized or in a nursing home? **If Yes, provide the name of each person.**	☐ Yes ☐ No
Within the last five years, have you, your spouse or any dependent to be covered, received any medical or surgical consultation, advice, or treatment including medication for: heart or circulatory system disorder including heart attack or chest pain; stroke; diabetes; cancer or tumor; alcoholism or alcohol abuse; drug abuse or chemical dependency? **If Yes, who?** **Specify condition(s):**	☐ Yes ☐ No
Within the last five years, has any person to be covered ever tested positive for Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) or other immune system disorder? **If Yes, who?**	☐ Yes ☐ No
During the term of this plan, will you or any dependent turn age 65, or will any dependent turn age 19 or no longer be eligible for coverage? **If Yes, who?** *(Dependents are eligible to age 19 or to age 25 if they qualify as full-time students or qualify as federal tax exemptions. When no longer eligible, dependents may apply for their own temporary coverage.)*	☐ Yes ☐ No

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.
In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc. In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.
Independent licensees of the Blue Cross and Blue Shield Association. ® Registered marks Blue Cross and Blue Shield Association.

Section F Automatic Bank Draft Authorization

If you completed Section B and selected Automatic Bank Draft, please complete this section. You **MUST** attach a **blank** voided check for checking account deduction and premium will be deducted on the same day of the month as your assigned effective date. **I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the account indicated and the designated financial institution to debit the same account. I understand that this authorization is in effect until I notify Anthem in writing that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals if they wish to do so.**

Account holder's name	Applicant's Social Security no.
Account holder's signature (if other than the applicant)	
Deduct premium from: ☐ Checking account ☐ Savings account (Premium will be deducted on the same day of the month as your assigned effective date.)	

Section G Significant Terms, Conditions and Authorizations (TERMS)

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

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I am applying for the coverage selected on this application.
3. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application.
4. I understand that any premium quote provided is preliminary and review of my application by medical underwriting may change the premium or result in a denial of coverage.
5. **I understand the pre-existing conditions in existence within 24 months immediately prior to my enrollment, for which medical advice, diagnosis, care or treatment was recommended or received, are not covered. Pregnancy is considered a pre-existing condition.**
6. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
7. I understand Anthem may convert my payments by check to an electronic Automated Clearinghouse (ACH) debit transaction. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem automatic debit process and will only occur each time I send a check to Anthem. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
8. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
9. I understand I am applying for individual health coverage (in Ohio, under Anthem's Group Trust) which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
10. THIS PARAGRAPH APPLIES ONLY TO OHIO RESIDENTS, AND DOES NOT APPLY TO INDIANA OR KENTUCKY RESIDENTS: I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 C.F.R. Parts 160 and 164) and the Ohio Revised Code § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief and I understand they are being relied on by Anthem in accepting this application. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

In Kentucky: Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or other form of health care coverage containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

In Ohio: Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Your health coverage will be provided by one of the following companies based upon the state where you reside:

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.

In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.

In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Signature of applicant	**Date**
Signature of spouse *(if to be covered)*	**Date**

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

Section H Agent Certification

I hereby certify that I have asked the applicant all questions set forth above, and that I have accurately recorded the answers supplied by the applicant. Any reporting form that is required due to a positive response to this question has been completed and submitted with this application. I further certify that I have explained the exclusions and limitations of the policy.

Agent's name (please print) Ohio Health Benefits	**Agent's signature** (Kentucky Agents only)	
Agent no. G631	**Agent tax ID**	**Agent phone no.** 330-633-7713
Agent fax no.	**Agent e-mail address**	**Date**

IMPORTANT: No person, including an employee or agent of Anthem Blue Cross and Blue Shield, has the authority to change or omit any of the questions or statements on this application.