Anthem BlueCross BlueShield

Your Individual Application Kit is enclosed

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

- ☐ Print clearly and complete the application in blue or black ink.
- ☐ If you make any changes while completing this form (for example, if you cross out something you wrote), be sure to **initial and date** those changes.
- ☐ If any **corrections** are needed or if the form is incomplete, the application may have to be returned to you, or we may try to call you, to obtain the necessary information. In that case, we will record your information on a form that will be attached to your application.
- ☐ 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.
- ☐ **The primary applicant, spouse/domestic partner, if applicable, and any dependent children age 18 or over must sign and date the application in two places (in Section K).**
- ☐ List the height and weight for each applicant.
- ☐ List the date of birth for each applicant.
- ☐ For applicants age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, if you have had creditable health coverage in the past 63 days, please fill out Section H to apply for preexisting credit. Creditable Coverage is defined as prior coverage from a group plan, Medicare, Medicaid, health plan for active military personnel, including TRICARE, Indian Health Service, state risk pool, Federal Employees Health Benefits Program, state children's health insurance program, public health plan, U.S. Government plans, foreign health plans, individual insurance policy or Peace Corps service. Prior coverage does not count as Creditable Coverage if there was a break of 63 days or more prior to applying for this coverage.
- ☐ Select the plan, deductible amount, Rx option and any applicable riders requested.
- ☐ Answer all health history questions in Section J. Failure to do so will delay the processing of your application.
- ☐ If you answered "yes" to any of the health history questions, give complete details on page 10.
- ☐ If you are eligible for Medicare, you are not eligible to apply for our individual products.

If you need assistance filling out the application, please contact your agent.

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Missouri
Individual Enrollment Application

Anthem Life | Anthem BlueCross BlueShield

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one): ☐ New Coverage ☐ Change Anthem Individual policy coverage - Policy No. _____
☐ Add dependent(s) to current coverage - Policy No. _____

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

Section B – Applicant Information

Risk Tier	Last Name	First Name	MI	Social Security Number*

Home Address (street and P.O. Box if applicable)

City	State	ZIP	County

Marital Status ☐ Single ☐ Married	Height (Ft. / In.) /	Weight	Sex ☐ M ☐ F	Age	Date of Birth / /

Daytime Phone Number ( )	Evening Phone Number ( )	E-mail*

Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? . . . . . ☐ Yes ☐ No

Are all applicants listed on this application United States citizens? . . . . . ☐ Yes ☐ No

If NO, who? _____

and how many years/months have they resided in the United States? _____ years and _____ months

Tobacco Use: Have you used tobacco in the last 12 months? . . . . . ☐ Yes ☐ No

If cigarettes, how many do you smoke per day? _____

Autism Extended Coverage Option: If your application is accepted, benefits for the diagnosis and treatment of Autism will be enhanced in your health care coverage by checking the box below to purchase the additional coverage.

☐ I wish to purchase the Autism Extended Coverage. (Checking this option will affect your premium.)

Section C – Spouse or Domestic Partner Information

Risk Tier	Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner

Social Security Number*	Height (Ft. / In.) /	Weight	Sex ☐ M ☐ F	Age	Date of Birth / /

Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? . . . . . ☐ Yes ☐ No

Tobacco Use: Have you used tobacco in the last 12 months? . . . . . ☐ Yes ☐ No

If cigarettes, how many do you smoke per day? _____

**This information is used for internal purposes only and will not be disclosed.*

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary.)

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage.
An eligible dependent may be your children, or your spouse's or domestic partner's children (to the end of the calendar month in which they turn age 26). (List all dependents beginning with the eldest.)

Risk Tier	First, MI (last name if different)	Relationship to Applicant	Social Security Number*	Sex	Age	Date of Birth mm/dd/yyyy	Height Ft. / In.	Weight Lbs.
		Child		M ☐ F ☐			/	
		Child		M ☐ F ☐			/	
		Child		M ☐ F ☐			/	
		Child		M ☐ F ☐			/	
		Child		M ☐ F ☐			/	

**This information is used for internal purposes only and will not be disclosed.*

Section E – Medical Coverage

Plan Name, In Network Coinsurance, Deductible Options	Optional Benefits

Select ONE Plan…then select ONE Individual Deductible and any optional benefits.
Total Family Deductible is two (2) times the amount shown.

☐ **SmartSense® Plus**

(30% coinsurance) ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $3,500 ☐ $5,000 ☐ $10,000

☐ **Upgrade Drug Coverage**

☐ **Premier Plus**

(20% coinsurance) ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $1,500 - no office visit copay

(0% coinsurance) ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $3,500 ☐ $5,000 ☐ $10,000 ☐ $2,500 - no office visit copay

☐ **Upgrade Drug Coverage**

☐ **Add Maternity Coverage** (available on $2,500 or higher deductible options)

☐ **CoreShare**

(40% coinsurance) ☐ $750 ☐ $1,500 ☐ $2,500 ☐ $3,500 ☐ $5,000

(0% coinsurance) ☐ $7,500 ☐ $10,000 ☐ $15,000 ☐ $25,000

HSA Compatible Plans

Select ONE Plan…then select ONE Deductible (Individual/Family).

☐ **Lumenos® HSA Plus**

(40% coinsurance) ☐ $1,500/3,000

(20% coinsurance) ☐ $1,750/3,500

(0% coinsurance) ☐ $1,500/3,000 ☐ $2,500/5,000 ☐ $3,500/7,000 ☐ $5,500/11,000

☐ **YES**, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Anthem's banking partner. (Please fill in your social security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Anthem's banking partner.

Section F – Dental Coverage Selection

☐ **Dental Blue® Basic 100** ☐ **Dental Blue® Essential 100** ☐ **Dental Blue® Essential 200**

☐ Yes, I wish to add dental coverage (at an extra cost per individual)

If Yes, select ONE coverage type (applies to individuals listed on this application only):

☐ Applicant only ☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

☐ Applicant & Spouse or Domestic Partner only ☐ Applicant & all dependent children listed

☐ Yes, if myself or any listed family member are declined for medical coverage, still enroll **all members selected above, if eligible.**

Section G – Anthem Life Insurance Company's Term Life Insurance

Blue Preferred® Term Life

☐ Yes, in addition to my medical coverage, I wish to apply for Term Life Insurance (at an extra cost per individual).
Provide information below.

Applicants must meet Anthem Life's Underwriting Guidelines to qualify for Term Life Insurance Coverage. Applicants under the age of one year are not eligible for Life Insurance. All Term Life policies terminate at age 65.

Applicants	Coverage Amount (select one)	Beneficiary**	Relationship	Beneficiary Street Address City/State/ZIP
☐ Applicant	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		
☐ Spouse ☐ Domestic Partner	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		
☐ Child(ren)	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		

* The $50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to $25,000.

** **If a beneficiary is not listed** and a policy is issued, death benefits will be paid in accordance with the Beneficiary Provision of the Policy.

Section H – Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare? . . . . . ☐ Yes ☐ No

If yes, give name. _____

Did you or your eligible dependents have creditable coverage within the past 63 days, including any Anthem coverage? (You may be eligible for preexisting credit. Preexisting condition limitations do not apply to applicants under the age of nineteen (19), if applying for non-grandfathered coverage.) . . . . . ☐ Yes ☐ No

The following information must be completed in order for credit to be given.
Please provide the previous 18 months of coverage.

Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name and phone number of prior carrier(s)		Reason for cancellation
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	Cancellation Date of Coverage

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

Complete this section if you've had more than one carrier in the last 18 months (attach a separate sheet if necessary).

Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name and phone number of prior carrier(s)		Reason for cancellation
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	Cancellation Date of Coverage

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

Section I – Healthy Lifestyle (optional)

You and your spouse or domestic partner may qualify for a better rate based on your lifestyle. Complete the section below if you would like to be considered for this special rate.

	Applicant	**Spouse or Domestic Partner**
1. Have you been tobacco-free for the last 3 years?	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you exercise regularly?	☐ Yes ☐ No	☐ Yes ☐ No
3. Are you in excellent health with no ongoing medical conditions?	☐ Yes ☐ No	☐ Yes ☐ No
4. How many times a week do you exercise?	☐ 0-2 ☐ 3-4 ☐ 5-7	☐ 0-2 ☐ 3-4 ☐ 5-7

Section J – Health History (IMPORTANT: This section has two steps)

STEP 1: Health history questions must be answered by each/every person applying for coverage.

Health History Questionnaire — All Questions Must Be Answered Or The Application Will Be Returned.

GIVE COMPLETE DETAILS IN STEP 2 (page 10) FOR ALL QUESTIONS ANSWERED "YES".

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: You must provide truthful and complete answers to the following questions to the best of your ability. We are relying on the information you provide to determine whether you are eligible for coverage. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician(s) to clarify your specific condition. We have the right to review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, do not assume we will review all of your medical records before approving your application. If we issue coverage to you and then discover an act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact, we may rescind your coverage, even after it has been issued. This means that you may lose your health benefits including coverage for treatment already received. Rescission may occur even if we review your medical records or seek medical confirmation of your health information as part of processing your application. Even if you currently have health insurance coverage or had prior coverage with Anthem Blue Cross and Blue Shield, you must fully disclose and answer all health history questions.

	YES	NO
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) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	☐	☐
2. Within the last 12 months 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 prescription medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (This includes any prescription samples provided by your physician. If yes, explain in Step 2.)	☐	☐
4. Are you pregnant or an expectant father, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	☐	☐
5. 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 fixations (i.e. pins, plates, rods etc.), neurostimulators	☐	☐
E. Any other prosthesis or implant (other than dental)	☐	☐

	YES	NO
6. 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?		
(all answers must be checked yes or no)		
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 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	☐	☐

Section J – Health History (IMPORTANT: This section has two steps) *(continued)*

	YES	NO
7. 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, 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, endocrine glands	☐	☐
8. Within the last 5 years, have you experienced, suffered from, consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	☐	☐
9. Within the last 5 years, have you been advised by a health care professional to reduce alcohol intake?	☐	☐
10. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	☐	☐
11. Within the last five 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 Step 2.)	☐	☐
A. Obsessive Compulsive Disorder	☐	☐
B. Minor depression	☐	☐
C. Anxiety/panic attacks	☐	☐
D. Attention Deficit Disorder (ADD/ADHD)	☐	☐
12. In the last 10 years have you had consultation, experienced symptoms, been diagnosed, had treatment or treatment recommended for any of the following:		
A. Schizophrenia, Major Depression/ BiPolar Disorder	☐	☐
B. Eating disorder (i.e. anorexia/bulimia)	☐	☐
13. Within the last 10 years, have you experienced (suffered from) or consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to drug abuse?	☐	☐
14. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	☐	☐
15. Have you ever been diagnosed with hepatitis? (check all types that apply)	☐	☐
A. Hepatitis A	☐	☐
B. Hepatitis B	☐	☐
C. Hepatitis C, D, E	☐	☐

Section J – Health History (IMPORTANT: This section has two steps) *(continued)*

	YES	NO
16. Have you ever been positively diagnosed with, or treated for any of the following?		
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment for AIDS or ARC	☐	☐
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Diabetes, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma.	☐	☐
17. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	☐	☐
18a. Within the last five years, have you had any illness, physical injury, persisting or new physical symptoms and/or health problems not mentioned elsewhere on this application that have not been evaluated or that you plan to have evaluated by a licensed health practitioner?	☐	☐
18b. Within the last two 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?	☐	☐
19. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	☐	☐

Prescription Medications

List ***ALL*** prescription medications taken within the last 12 months by any family member listed on this application (if not indicated in Step 2.)

Family Member	**Medication/Dosage/Frequency** (i.e., Lopressor/100mg/daily)	**Illness for which Medication is Prescribed**	**Date Prescribed** (mm/dd/yyyy)	**Date Discontinued** (mm/dd/yyyy)	**Name, Phone No. of Physician or Hospital**
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____

☐ Please check box if an additional sheet(s) of paper has been completed for this section.

Section J – Health History (IMPORTANT: This section has two steps) *(continued)*

STEP 2: If you answered "YES" to any of the health history questions, give complete details (see the example below)

Question Number	Patient First Name	Physician Name & Telephone (with area code)	Specific Diagnosis & Treatment	Name & Dosage of Medication & Dates of Use		Duration of Condition		Was Surgery Performed?		Description of Surgery/ Procedures & Date(s) (mm/yyyy)	Current Status
				Begin (mm/yyyy)	End (mm/yyyy)	Begin (mm/yyyy)	End (mm/yyyy)	YES	NO		
#18b	Mary	Dr Joe Doe 555 555-1000	Tonsillitis	Amoxicillin 250 mg 4x day 08/2009	09/2009	08/2009	09/2009	☑	☐	Tonsillectomy 09/2009	Good
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		

☐ Please check box if an additional sheet(s) of paper has been completed for this section.

Section K – Significant Terms, Conditions and Authorizations (Please read carefully.)

Please read this section carefully before signing the application.

1. **I understand that it is mandatory that I notify Anthem, in writing, immediately if I (the applicant) or any other person for whom coverage is sought has a symptom of, has been advised of, or 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 has the right to underwrite my application again, using the new information and that, as a result, my coverage/ family members' coverage might be delayed or reformed or, for applicants age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, benefits denied due to the illness, injury or condition being treated as a preexisting condition.**
2. I understand that sending my initial premium with this application, and the receipt of my payment by Anthem, does not mean that coverage has been approved. I understand that if my application is denied, my bank account or credit card will not be charged.
3. If my request for coverage is being handled by a producer, I understand that the producer is not authorized to waive a complete answer to any question in the application, pass on insurability, make or alter any contract or waive any of Anthem's other rights or requirements.
4. I may not assign any payment under my Anthem program. I am applying for the coverage selected on this application. 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. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application, and that no right whatsoever is created by this application.
5. **For applicants age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, I understand that pre-existing conditions are not covered for 12 months after my enrollment. I also understand that a pre-existing condition is any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12 months immediately prior to my enrollment or that produced symptoms within 12 months immediately prior to my enrollment that would have caused an ordinarily prudent person to seek medical diagnosis or treatment. Pregnancy is considered a pre-existing condition.**
6. If the plan I purchase offers maternity coverage, and I purchase that coverage, I understand that 1) these benefits apply only to me or my covered spouse/domestic partner and not to any dependent child and 2) these benefits will not begin until after my membership has been in effect for 18 months.
7. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
8. I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is mentally competent; he or she is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
9. I understand Anthem may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. 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.
10. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
11. **I understand and agree I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.**
12. If I purchase optional dental coverage for the Dental Blue® Essential plan, I understand that I will have a twelve month waiting period for coverage of Major Restorative Services. *(For a description of Preventive, Diagnostic and Major Restorative services, please refer to your marketing materials.)*
13. By signing this application I represent that I understand that Anthem Life has the right to deny my application for Term Life Insurance Coverage, and if it does, I will be notified in writing. I understand that if Anthem Life declines this coverage, no benefits will be payable. I understand that I alone am responsible for reading and accurately completing this application, and I must communicate any changes to my status. I also understand that all other conditions of my medical application apply for the life application.

Section K – Significant Terms, Conditions and Authorizations (Please read carefully.) *(continued)*

14. Please check the box below, if appropriate:

☐ Instead of sending communications by mail, I authorize and expressly consent that Anthem and its affiliated companies may send e-mail communications, including but not limited to legally required Plan Notices and underwriting, enrollment and billing and explanation of benefits statements, to the e-mail address I have provided on this Application. I understand that I can revoke this authorization or request paper copies at any time free of charge by contacting Anthem customer service or online at Anthem.com.

15. 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 act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission, or cancellation of my coverage(s).

If tobacco use question in Section B or Section C is answered "NO", I understand that the signature(s) shown on the following page will attest to non-tobacco usage for the past 12 months.

Any person who, with 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.

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.

SIGN HERE

Signature of Applicant ***(or Custodial Parent's or Guardian's signature if applicant is under age 18)*** **X**	Date
Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) **X**	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) **X**	Date

Section L – Agent Certification

To be completed by your Anthem-appointed agent:

1. Does the applicant intend to replace, discontinue or change any existing life policy or annuity contract? . . . . . ☐ Yes ☐ No

2. 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

3. I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent Signature **X**			Date
Agent Name (please print)	Agent Street Address/Suite No./Personal Mail Box (PMB) No.		
Agent ID No.	City/State/ZIP	County Code	Area
Agent Phone No.	Agent Fax No.	Agent E-mail	

Authorization for Use of Protected Health Information

The following authorization must be signed by all of the following persons if they are applying for coverage or changing existing coverage:

- the applicant;
- the applicant's spouse or domestic partner; and
- any Dependent Child age 18 or over.

If the authorization is not signed by all of the persons listed above who are seeking coverage, the application may be returned to you as incomplete or acted upon without regard to any person whose required signature was not included. This Authorization will expire 24 months following Anthem Blue Cross and Blue Shield's or Anthem Life Insurance Company's acceptance of coverage, if not previously revoked.

By signing below:

I authorize Anthem Blue Cross and Blue Shield or Anthem Life Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield or Anthem Life 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, MIB, Inc., formerly Medical Information Bureau (MIB), and/or insurance support organizations. I further authorize Anthem Blue Cross and Blue Shield or Anthem Life Insurance Company to disclose protected health information it may collect about me to MIB, which may re-disclose such information to other insurance companies pursuant to the MIB 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 Blue Shield or Anthem Life Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield or Anthem Life Insurance Company. This information is needed to determine eligibility for coverage and Anthem Blue Cross and Blue Shield's or Anthem Life 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.

This authorization is subject to revocation at any time by written notice to Anthem except to the extent that Anthem has already taken action in reliance on this authorization. If I revoke this authorization after I initially apply for coverage, I understand that I/we will not be considered for coverage. 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 if my and/or my family's information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans governed by federal privacy regulations, my/our information might be re-disclosed by any of those recipients and will not be protected by federal privacy regulations. A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

SIGN HERE

X _____ Printed name of Applicant/Member	X _____ Signature of Applicant/Member or his/her Legal Representative	_____ Date
X _____ Printed name of Spouse or Domestic Partner or Dependent Child* age 18 or over listed on Application	X _____ Signature of Spouse or Domestic Partner or Dependent Child* or his/her Legal Representative	_____ Date
X _____ Printed name of Dependent Child* age 18 or over listed on Application	X _____ Signature of 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.

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If you have an Anthem agent, please mail directly to:
your Anthem agent.

If you do NOT have an Anthem agent, please mail to:

Anthem Blue Cross and Blue Shield
P.O. Box 659806
San Antonio, TX 78265-9106

Payment Methods for Individual Coverage
Missouri

Anthem

Anthem Life

Please complete in blue or black ink.

Applicant / Member Name (Please Print):	Primary Applicant's Social Security Number:

INITIAL PREMIUM PAYMENT IS REQUIRED WITH APPLICATION. PLEASE CHOOSE ONE:

- ☐ Automatic Bank Payment (complete Section A). **If you choose this option, you must also select the Automatic Bank Payment option for future premiums.**
- ☐ Credit/Debit Card (complete Section B)
- ☐ One-time Electronic Bank Payment (complete Section C)
- ☐ Check or Money Order attached (make payable to Anthem)*

*When you provide a check as payment, you authorize us to either use the 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 will be withdrawn from your account as soon as the day of approval, and you will not receive your check back from your financial institution.

FUTURE PREMIUM PAYMENTS (MAKE ONE SELECTION OUT OF EACH COLUMN):

Frequency (you must select one):

- ☐ Monthly
- ☐ Quarterly
- ☐ Semi-annually
- ☐ Annually

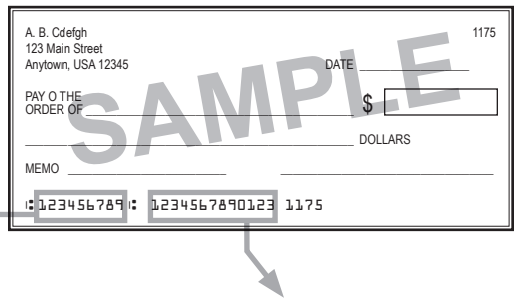
Method of payment (you must select one):

- ☐ Automatic Bank Payment (You must complete Section A)
- ☐ Bill me for future premiums. (Bills will be sent to address on application, unless a different address is listed below.)

Name _____ Address _____

City _____ State _____ ZIP _____

A. Automatic Bank Payment – If you select this option for your initial payment, <u>your bank account may be debited one month's premium as soon as the day of approval</u>. This will include all products selected, including dental and/or life. I hereby authorize Anthem to initiate a withdrawal on the same day of each month as my assigned effective date from the bank account named below.



- ☐ Checking Account
- ☐ Savings Account **(account number will be different than that of checking account)**. Check with your financial institution to be sure automatic recurring deductions are allowed against this account.

Provide your Bank Account Information here:

9-Digit Bank Routing Number	Bank Account Number
|___|___|___|___|___|___|___|___|___|	

I authorize Anthem to initiate premium deductions (and corrections to premium deductions) from the bank account indicated, and the designated financial institution to debit the same account. **I understand that the initial premium amount may vary as a result of change(s) during the underwriting process and that following premium amounts may vary as a result of change(s) I make once enrolled.** These may include, but are not limited to, adding and deleting dependents or moving my residence. I understand that Anthem's rights with each premium deduction are the same as if I submit a check signed by me. This authorization is in effect until I provide Anthem thirty (30) days written notice that I no longer desire this service, and Anthem and the designated financial institution have the right to discontinue the premium deductions if they wish to do so. **I also understand that a service charge may be incurred for any withdrawal not honored.**

Authorized Signature (as it appears on the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

B. Credit/Debit Card – As a convenience to me, I request and authorize Anthem to charge the credit/debit card indicated one time for the initial premium payment amount upon approval. I understand that if this option is selected, the credit/debit card indicated will be charged for the initial premium payment amount as early as the date of approval. **If the initial premium payment amount varies from the quote generated by the system or due to changes during the underwriting process, I also authorize Anthem to charge the credit/debit card indicated for the different amount.** I agree that Anthem is fully protected in honoring any credit/debit card payments. I further agree that if any credit/debit card payment is dishonored, with or without cause, intentionally or inadvertently, Anthem is under no liability whatsoever, including any fees imposed by credit/debit card company or my bank, if my credit/debit card is rejected even though such dishonor results in termination of coverage. **We accept Visa and MasterCard.**

Type Of Card: ☐ Visa ☐ MasterCard

Card Number: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Expiration Date: |___|___|/|___|___|

Authorized Signature (as it appears on the credit/debit card) **X**	Cardholder Name (as it appears on the credit/debit card – Please PRINT)		Date
Cardholder Billing Address	City	State	ZIP

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

C. One-time Electronic Bank Payment – Please complete the information below.

Account Holder Name (Please PRINT)	9-Digit Bank Routing Number |___|___|___|___|___|___|___|___|___|	Account Number
Authorized Signature (as it appears on the financial institution's records) **X**		Date

☐ Checking Account

☐ Savings Account **(account number will be different than that of checking account).** Check with your financial institution to be sure automatic deductions are allowed against this account.

I authorize Anthem to initiate a one-time deduction from the bank account indicated and the designated financial institution to debit the same account.

I understand that the initial premium amount may vary as a result of change(s) during the underwriting process, and I authorize Anthem to debit the bank account for the different amount. If this option is selected, I understand my account may be debited the initial premium payment amount as early as the date of approval.

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

☐ **NEW LIST BILL –** Billing through third-party ☐ **CHANGE TO EXISTING LIST BILL** **List Bill Arrangement Number:** _____

(This option must have prior approval and requires separate List Bill forms to be completed and submitted with the application.)