Enrollment Application

Anthem Anthem Life Indiana State Medical Association

Individual

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. *All information given should apply to this employer.*
To search for *Blue Access℠ PPO Providers,* visit www.anthem.com

1. Billing Address

Request. Effective Date	**Anthem use:**	Sub-group # / Life Division #	Risk Class	Record #
/ /		0000 /		

Plan	**ISMA use:** Agent	Health Effective Date	Dental Effective Date	Waiting Period	COB	Pre-ex (date)
		/ /	/ /		☐ Yes ☐ No	/ /

Bill Cycle M ☐ Q ☐ S ☐ Y ☐

2. Reason for Application
- ☐ New enrollment
- ☐ Waiver
- ☐ Annual open enrollment (N/A to life)
- ☐ Loss of previous coverage (date) / /
- ☐ New hire
- ☐ Rehire (date) / /
- ☐ Add dependent (see section 3)

3. Status Change/Event

Event date / /
- ☐ Marriage
- ☐ Birth
- ☐ Adoption*
- ☐ Legal Guardianship*
- ☐ Other _____

**Include legal documentation.*

4. Type of Coverage/Plan

Health Coverage
- ☐ Applicant only
- ☐ Applicant + spouse
- ☐ Applicant + child(ren)
- ☐ Family coverage
- ☐ No coverage

Medical Plan Name _____

Dental Coverage
- ☐ Yes
- ☐ No

5. Applicant Information

Last name	First name, M.I.	Date of birth	Age	Sex	Social security #		Height	Weight
		/ /		☐ M ☐ F	– –	☐ Single ☐ Divorced ☐ Married		

Home address	APT #	City	State	ZIP code	County

Home telephone	Business telephone	eMail Address
( )– –	( ) –	

Are you:	Retired?	Disabled?	Hospitalized?	Occupation	Full time hire date	Hours working per week	Income reported by:
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		/ /		☐ W2 ☐ 1099 ☐ Other: _____

6. Family Information ***Spouse and dependents to be covered. (Attach a separate sheet if necessary.)***

1 Last name | First name, M.I. | Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____ | Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth	Sex	Social Security #	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)
/ /	☐ M ☐ F	– –			

2 Last name | First name, M.I. | Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____ | Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth	Sex	Social Security #	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)
/ /	☐ M ☐ F	– –			

3 Last name | First name, M.I. | Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____ | Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth	Sex	Social Security #	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)
/ /	☐ M ☐ F	– –			

4 Last name | First name, M.I. | Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____ | Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth	Sex	Social Security #	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)
/ /	☐ M ☐ F	– –			

5 Last name | First name, M.I. | Relationship to applicant ☐ Spouse ☐ Son ☐ Daughter ☐ Other _____ | Fulltime student? ☐ Yes ☐ No

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Date of birth	Sex	Social Security #	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)
/ /	☐ M ☐ F	– –			

8. Other Health Coverage ***Please check one:*** ☐ *YES (complete below.)* ☐ *NO*

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Provide name, phone number and address of the HMO or insurance company		Policy/certificate number	Effective date / /
Policy/certificate holder's name	Social Security number – –	Date of birth / /	Relationship to applicant

If you and/or your dependents are enrolled in Medicare Part A or Medicaid, complete the following.

Enrollee's name		Medicare/Medicaid ID #	
Medicare Part A effective date / /	Medicare Part B effective date / /	ESRD onset date / /	
Enrollee's name		Medicare/Medicaid ID #	
Medicare Part A effective date / /	Medicare Part B effective date / /	ESRD onset date / /	

Reason for Medicare enrollment: ☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

9. Prior Health Coverage ***Please check one:*** ☐ *YES (complete below.)* ☐ *NO*

Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No Policy/Certificate #:	Group name/ ID #	Dates policy in effect: / / — / /
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? ☐ Yes ☐ No	List prior carrier(s)	Dates policy in effect: / / — / /

Please check the type of prior coverage ☐ Applicant ☐ Applicant / Spouse ☐ Applicant / Child(ren) ☐ Applicant / Spouse / Child(ren)

Termination reason: ☐ Divorce/legal separation ☐ Death of spouse ☐ COBRA exhausted ☐ Employment terminated ☐ Group plan terminated ☐ Employer/group contribution ceased ☐ Other:

10. Medical Information, Applicants complete questions 1-10. Attach an extra sheet of paper if necessary.

Please note that no person will be denied health coverage on an individual basis due to the answers provided below, except for Medicare Carve-Out.

(If yes, please list the diagnosis below)

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? ☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No

   If yes, name _____ due date ___/___/___
4. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor; disorder of the blood or immune system; stroke, aneurysm, diabetes **(list age of onset below);** mental/nervous disorder, depression, alcohol or drug abuse/dependency; kidney, liver or pancreas disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; or muscular dystrophy? ☐ Yes ☐ No
5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ Yes ☐ No
6. Have you or any of your dependents visited the emergency room on 2 or more occurrences for the same condition in the last 12 months? ☐ Yes ☐ No
7. Have you or your dependents used tobacco products in the last 12 months? ☐ Yes ☐ No

(If yes, please list the diagnosis below)

8. To the best of your knowledge, have you or any of your dependents, within the last 5 years, had a diagnosis of or treatment for the following:
   a. Ulcer, hernia, diverticulitis, irritable bowel or other intestinal disorder? ☐ Yes ☐ No
   b. Thyroid, goiter or gallbladder disorder? ☐ Yes ☐ No
   c. High blood pressure, cholesterol or triglycerides? ☐ Yes ☐ No
   d. Anemia, chest pain, heart murmur or disorder of the veins/circulatory system? ☐ Yes ☐ No
   e. Rheumatic fever, carpal tunnel syndrome or disorder of the muscles or joints? ☐ Yes ☐ No
   f. Epilepsy, convulsions, paralysis or disorder of the brain or nervous system? ☐ Yes ☐ No
   g. Asthma, allergies, sinus, or disorder of the respiratory system? ☐ Yes ☐ No
   h. Any STD or disorder of the prostate, genital, reproductive or urinary system? ☐ Yes ☐ No
   i. Any disorder of the skin, ears, or eyes? ☐ Yes ☐ No
9. Have you or any of your dependents, within the last 2 years, engaged in skydiving, hang gliding, underwater diving, racing (any type), rodeo, mountaineering, professional sports, piloting a plane or are any such activities contemplated? ☐ Yes ☐ No
10. Are you or any of your dependents presently disabled or had a condition not identified above during the past 5 years? ☐ Yes ☐ No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest. #	Patient Name	Diagnosis	Treatment	Medication	Generic/ Brand (G/B)	Treatment Dates	Surgery? Hospitalized? (Y/N)	Recovered? (Y/N)		Physician's name
						/ /				
						/ /				
						/ /				
						/ /				
						/ /				
						/ /				

Please read the TERMS on the reverse side of this page. Your Signature is required on the reverse side of this to submit this application.

Significant terms, Conditions and Authorizations (TERMS)

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 authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
3. I am applying for the coverage selected on this application. If I select a coverage, or combination of coverages, not available to me and / or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions. (Ohio only - unless I applied for HMO/HIC coverage, in which case there is no such exclusion.)
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
6. By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or recission or cancellation of my coverage(s).

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

Your health coverage will be provided by

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

Thank you for choosing Anthem Blue Cross and Blue Shield

11. Read the TERMS section above carefully before signing. Please review your application for errors or omissions.
By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Applicant Signature	Date / /

12. PLEASE READ: If you are declining coverage for yourself, spouse, or dependents, you must complete and list all below, and sign and date application.

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #)	☐ Other carrier (give name, ID #)

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #)	☐ Other carrier (give name, ID #)

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #)	☐ Other carrier (give name, ID #)

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All

Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #)	☐ Other carrier (give name, ID #)

Check all that apply

☐ I certify that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures.
If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

☐ I certify that I have been given the opportunity to apply for the available group life benefits offered by my employer/group, the benefits have been explained to me, and I and / or my dependent(s) decline to participate. Neither my dependent(s) nor I were induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Applicant signature	Date / /

Only sign at bottom of section 12 if you are waiving coverage.