Insurance ISMA Agency

322 Canal Walk • Indianapolis, IN 46202-3268

(317) 261-2060 • Toll free: (800) 257-4762 • www.ismanet.org

The ISMA Insurance Agency is pleased to provide this packet of information on the Indiana State Medical Association sponsored Anthem Medicare Supplement plan for ISMA members and their spouses with Medicare as their primary carrier.

This packet includes:

- Medicare Supplement Brochure
- ISMA Insurance Agency Privacy Notice
- Anthem Enrollment Application
- Acknowledgment of Receipt of Privacy Notice

To apply for a Medicare Supplement policy, please complete the Anthem Enrollment Application and Acknowledgment of Receipt of Privacy Notice, then scan and email them to ismaia@ismanet.org, or fax them to our private fax line, (317) 261-2238.

Upon receipt, we will forward the application to Anthem Underwriting for review. We will then email you to inform you whether Anthem approved the application.

If you have any questions, please email the ISMA Insurance Team at ismaia@ismanet.org or call (317) 261-2060 and say you're calling with questions about the ISMA-sponsored Anthem Medicare Supplement.

Insurance ISMA Agency

ISMA-SPONSORED

ANTHEM MEDICARE SUPPLEMENT

SilverSneakers®

NOW INCLUDES SILVERSNEAKERS!

ISMA-SPONSORED ANTHEM MEDICARE SUPPLEMENT

The ISMA and Anthem are excited to bring you a high-quality, affordable health plan designed just for ISMA members to help you stay healthy and active. The ISMA Medicare Supplement pays health care costs not covered by Original Medicare such as deductibles, co-payments, coinsurance and health care when traveling outside the U.S.

The ISMA Medicare Supplement is available to all ISMA members and spouses who are eligible for Medicare as their primary carrier. If you already have ISMA-sponsored individual Anthem health insurance, you will automatically be enrolled in the ISMA Medicare Supplement when you become eligible for Medicare due to attaining age 65. If not, you will need to submit an enrollment application and be approved by underwriting. A physician age 65 or older who purchases the ISMA Medicare Supplement can insure their spouse who is under age 65 and eligible children under an ISMA-sponsored individual Anthem policy, which offers a much broader provider network than a Marketplace plan.

QUALITY COVERAGE AT A COMPETITIVE PRICE

The ISMA Medicare Supplement will provide you with the quality coverage you need at a competitive price. It features both Basic benefits and Major Medical benefits that pay some of the costs not covered by Medicare at all, such as medical services outside the U.S.

With this plan, you have a low deductible (the amount you pay before your insurance starts to pay) that is equal to the Medicare Part B deductible. Thereafter, the plan pays 100% of the costs allowed under this plan for most covered care.

FREEDOM TO CHOOSE

No referrals, and you can go to any provider or facility that accepts Medicare patients.

SILVERSNEAKERS INCLUDED!

SilverSneakers is a fitness benefit, designed to improve your health and help you stay independent. Once you enroll in SilverSneakers – at no cost to you – you'll have access to a free membership at any of the 15,000+ participating gym locations, with support from trained instructors. Whether you play tennis, swim laps or lift weights, SilverSneakers has you covered. For more information, go to **www.SilverSneakers.com/Learn** or call **(888) 423-4632**.

ABOUT PRESCRIPTION DRUGS

This plan does not cover prescription drugs. For information on a Medicare Part D Prescription Drug Plan, go to www.medicare.gov.

Anthem Blue Cross Blue Shield provides the medical and dental insurance plans for members of the Indiana State Medical Association and their spouses. Anthem Blue Cross Blue Shield is a member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

For information on a new or existing policy, go to **www.ismaia.com** or call: **(317) 261-2060**

This brochure is not a contract and it is not a complete description of the benefits, exclusions and limitations of any plan.

Effective January 1, 2020 - December 31, 2020.

BASIC BENEFITS

When Medicare pays a portion of the cost of a medical service, Anthem coordinates with Medicare so that Basic Benefits pay all or most of what Medicare does not pay, up to the Medicare-approved amount. Providers who participate with Medicare accept assignment, meaning they agree to accept the Medicare-approved amount as full payment for Medicare-covered services. When other providers are used, the Medicare recipient may have additional costs.

COVERED SERVICES	MEDICARE PAYS	ISMA MEDICARE SUPPLEMENT PAYS	YOU PAY
MEDICARE PART A			
Inpatient Hospital Care			
First 60 days	All but Part A deductible	Part A deductible	$0
Days 61 - 90	All but Part A daily coinsurance	Part A daily coinsurance	$0
60 day lifetime reserve days	All but Part A daily coinsurance	Part A daily coinsurance	$0
Continuous inpatient care after Medicare lifetime reserve is exhausted up to additional 365 days	Nothing	100% of all eligible expenses	$0
Skilled Nursing Facility (starting within 30 days after at least 3 consecutive days in the hospital)			
First 20 days of skilled care	100% of approved amount	$0	$0
Days 21 - 100 of continued skilled care	All but daily coinsurance	SNF daily coinsurance	$0
After 100 days	$0	$0	All costs
Home Health			
Non-custodial medical and nursing care	100% of approved amount	$0	$0
Hospice care *(room and board is not covered)*	100% of approved amount	$0	$0
MEDICARE PART B			
Annual deductible	Plan pays after the deductible	$0	Amount of Part B deductible
Doctors' care including inpatient and outpatient visits	80%	20%	$0
Outpatient services (includes surgeries, diagnostic services, physical therapy, x-rays)	80%	20%	$0
Clinical laboratory services	100%	$0	$0
Durable medical equipment such as wheelchairs, walkers and hospital beds	80%	20%	$0
Mental health counseling	80%	20%	$0
Ambulance	80%	20%	$0
Medicare designated preventive services[2] received from providers who accept Medicare assignment	100%	$0	$0

[1] This chart is a summary of benefits only. Please refer to the Certificate for details about benefits, maximums, limits and exclusions. [2] Medicare-covered preventive services are based on your age, gender, and risk factors. See **Medicare.gov** booklet, *Your Guide to Medicare's Preventive Services*.
[3] Providers who participate with Medicare accept assignment, meaning they agree to accept the Medicare-approved amount as full payment for Medicare-covered services. When other providers are used, the Medicare recipient may have additional costs. Providers who are not contracted with Anthem can balance bill for any difference between billed amounts and Anthem's allowable amounts. All charges may be reviewed by Medicare and Anthem to determine if they're medically necessary.

MAJOR MEDICAL BENEFITS

Medicare does not cover some medical services. Major Medical Benefits pay some of the costs not covered by Medicare.

Major medical benefits are subject to an annual deductible equal to the Medicare Part B deductible. Because these are not Medicare benefits, Anthem will use its own standards for determining medical necessity and allowed amounts, not Medicare's.

COVERED SERVICES	MEDICARE PAYS	ISMA MEDICARE SUPPLEMENT PAYS	YOU PAY
Continuous inpatient days beyond an additional 365	$0	100% after deductible	$0
Medical services outside the U.S.	$0	100% after deductible	$0
Excess charges for providers that don't accept Medicare assignment[2]	$0	100% after deductible	$0
Out-of-hospital skilled private duty nursing, and visiting nurse's association	$0	100% after deductible	$0
Accidental dental	$0	100% after deductible	$0
Morbid obesity	$0[3]	100% of charges not covered by Medicare; after deductible	$0
Routine/preventative physical exams not covered by Medicare	$0	100% after deductible, up to $150 annual max.	Amounts above $150
Hearing exam	$0	$50	Amounts above $50

[1] You must pay one annual Major Medical deductible. Providers who are not contracted with Anthem can balance bill for any difference between billed amounts and Anthem's allowable amounts. [2] Providers who haven't signed a contract with Medicare to accept assignment can charge you for amounts in excess of Medicare's Allowed Amount. Most doctors, providers and suppliers accept assignment, but you should always check to make sure.
[3] Medicare covers some bariatric surgical procedures, like gastric bypass surgery and lap banding surgery, when you meet certain conditions related to morbid obesity.

MONTHLY RATES
JANUARY - DECEMBER, 2020

Monthly rates for the Medicare Supplement start at $130 per month for subscribers age 65. The monthly rate for the optional Dental plan is $40.00 per person.

ENROLLMENT DISCOUNT

Applicants who are approved for coverage are eligible for a $10 per month discount during the first 12 months of coverage, if 1) they start a policy when newly eligible for Medicare at age 65; or 2) they are older and start a policy on the same date that they start Medicare Part B, if they delayed starting Medicare Part B because they had employer-provided health insurance and then lost that coverage.

OPTIONAL ISMA-SPONSORED ANTHEM DENTAL PLAN

You may include Anthem Dental Plan coverage for the additional monthly rate shown in the rate chart. The Anthem Dental Plan is available only in addition to medical coverage.

DEDUCTIBLE

- $50 per person per calendar year.
- Applies to all benefits except diagnostic, preventive, and orthodontia.

DIAGNOSTIC AND PREVENTIVE

- No deductible; covered in full if service provided by Anthem Dental PPO provider, otherwise 80% benefit.
- Covered services include Oral evaluations, X-rays, cleanings, space maintainers and other selected diagnostic and preventive services.

GENERAL (ADJUNCTIVE), RESTORATIVE, ENDODONTIC, ORAL SURGERY, PERIODONTAL

- Subject to annual $50 deductible; 80% benefit.
- Covered services include Emergency palliative treatment, consultations, general anesthesia and I.V. sedation for surgical procedures, office visits for observation, and other selected general services. Amalgam and composite restorations and pin retention procedures. Root canal therapy, apexification, therapeutic pulpotomy and other selected endodontic services. Simple and surgical tooth extractions and other selected oral surgery services. Gingivectomy, crown lengthening, osseous surgery, soft tissue grafts and other selected periodontal services.

PROSTHODONTIC

- Covered after 12-month waiting period. Subject to annual $50 deductible; 50% benefit
- Covered services include crowns/onlays, partial and full dentures and other selected prosthodontic services

ANNUAL MAXIMUM BENEFIT

- There is a maximum dental benefit of $1,500 per person per calendar year.

INDIANA ANTHEM DENTAL NETWORK

- If you purchase the Anthem Dental Plan and your dentist is in the Indiana Anthem Dental network, you will not be responsible for amounts billed over the Usual and Customary Allowance. And your preventive and diagnostic services will not be subject to the deductible. To determine whether your dentist is in the Indiana Anthem Dental network, visit anthem.com and search for Indiana Anthem Dental network providers.

EXCLUSIONS FOR THE ANTHEM DENTAL PLAN

- Charges which the insured is not legally obligated to pay, such as services from a dental or medical department maintained by an employer, charges for U.S. Government Hospital confinement and services, and charges payable as Worker's Compensation claims.
- Charges for any portion of a dental procedure performed before the effective date or after the termination of the individual's insurance
- Charges for facings on crowns, or pontics, posterior to the second bicuspid
- Charges for replacement of lost or stolen appliances, dentures, or bridgework Implants
- Be sure to check your dental plan booklet for a complete list of dental charges not covered

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ISMA Insurance Agency is a wholly-owned subsidiary of

ISMA
INDIANA
STATE
MEDICAL
ASSOCIATION

Insurance ISMA Agency

PRIVACY NOTICE

WHY?	Federal and state law require us to tell you how we collect, share, and protect your personal information. Please read this notice carefully. If you have a policy covered by the HIPAA regulations, you received a privacy notice that relates to the privacy of your medical information.	
WHAT?	In order to provide services to you, we collect from you certain types of personal information, including: ▪ Name ▪ Social Security number ▪ Date of birth ▪ Gender ▪ Height/Weight ▪ Address ▪ Phone number	▪ Fax number ▪ Email address ▪ Insurance policy information, including policy numbers, effective dates, and coverage types ▪ Bank account information ▪ Tax ID information ▪ Income
HOW?	Companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons the ISMAIA can share your personal information and with whom we share your personal information.	

Reasons we can share your personal information	**Does ISMAIA share?**	**With whom do we share?**
For our everyday business purposes – such as to process plan applications or to assist you with your policies	Yes – potentially all Personal Information we collect from you	Our Affiliate and Nonaffiliate service providers, including consultants that advise us in our business
For our marketing purposes – to offer products and services to you	Yes – limited Personal Information, such as name and address	Our Affiliate and Nonaffiliate service providers that perform some marketing services on our behalf
For our affiliates' everyday business purposes	No	N/A
For our affiliates/nonaffiliates to market to you	No	N/A
Questions?	Call the ISMAIA team at 1-800-257-4762	

WHAT WE DO	
How does ISMAIA protect my personal information?	To protect your personal information from unauthorized access and use, we restrict access to those employees who need to know your personal information to provide services to you and run our business. We also use security measures that comply with federal law, including computer safeguards, secured files, and a secured office environment.
How does ISMAIA collect my personal information?	We collect your personal information, for example, when you: ▪ Submit an application for health insurance coverage ▪ Submit an authorization for direct payment via an automated clearinghouse ▪ Communicate with us regarding your personal information so that we may provide services to you
Why can't I limit all sharing?	The law gives you the right to limit only certain types of disclosures of your Personal Information and we do not make those types of disclosures.
DEFINITIONS	
Affiliates	Companies related by common ownership or control. They can be financial or nonfinancial companies.
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies.

Enrollment Application

Individual

Anthem

Indiana State Medical Association

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 Blue Access℠ PPO Providers, visit www.anthem.com

1. Billing Address					
Group #		**Request. Effective Date**			**Applicant # / Dept. name**
		/ /			
Anthem use: Plan	**Health Effective Date**		**Dental Effective Date**	**COB**	**Pre-ex (date)**
	/ /		/ /	☐ Yes ☐ No	/ /
ISMA use: Agent	**Risk Class**	**Bill Cycle**		**Record #**	
ISMAIA	N/A	M Q S Y		**ME #**	

2. Reason for Application

☒ New enrollment ☐ New hire
☐ Waiver ☐ Rehire (date) ___/___/___
☐ Annual open enrollment ☐ Add dependent (see section 3)

Qualifying event _____ Event date ___/___/___

3. Status Change/Event

Event date ___/___/___ ☐ Adoption* ☐ Legal Guardianship*
☐ Marriage ☐ Other _____
☐ Birth
**Include legal documentation.*

4. Type of Coverage/Plan

Health Coverage		***Dental Coverage***
☐ Physician ☐ Physician's Spouse	Medical Plan Name Medicare Supplement	☐ Yes ☐ No

5. Physician Information

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

Home address	City	State	ZIP code	County (KY residents include Municipality)

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

Are you: Retired? ☐ Yes ☐ No	Disabled? ☐ Yes ☐ No	Hospitalized? ☐ Yes ☐ No	Occupation	Full-time hire date (if working) / /	Hours working per week	Income reported by: ☐ 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 ☐ M ☐ F	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)

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 ☐ M ☐ F	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)

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 ☐ M ☐ F	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)

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 ☐ M ☐ F	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)

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 ☐ M ☐ F	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)

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7. 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(s)	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)

8. 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
☐ Employee ☐ Employee / Spouse ☐ Employee / Child(ren) ☐ Employee / Spouse / Child(ren)

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

9. Medical Information

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, circle condition)

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, circle condition)

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. 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. #	Name of individual	Diagnosis	Treatment	Medication	Date(s) of treatment	Hospitalized? (Y/N)	Surgery? (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

10. 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 / /

11. 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	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 / /

Acknowledgement of Receipt of
ISMA Insurance Agency
Privacy Notice

I acknowledge that I received a copy of the ISMA Insurance Agency Privacy Notice as part of the packet of information to obtain a quote for ISMA-sponsored Anthem health insurance for:

Physician Name

Signature of Authorized Signer

Date

Name of Authorized Signer