

Ohio Blue AccessSM Saver Application

Lead Source



Please complete application in blue or black ink. Do not write in shaded areas; these are for internal use only.

Check one. (subject to underwriting approval)

- I am applying for NEW coverage
 I am applying to upgrade/downgrade coverage
 I am applying to add dependent(s) to my current coverage
- List Bill
 List Bill Reclass
 (If you have selected List Bill, please complete List Bill forms)
- Requested effective date, month _____ 1st 15th
 For continuous coverage effective date _____

Section A Applicant Information

Risk Tier	Last name of applicant	First name	MI	Social Security number		
Home address: Street and P.O. box if applicable				City, State, ZIP code		
County	Height	Weight	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of birth	
Billing address information (<input type="checkbox"/> For premium notices <input type="checkbox"/> If mailing address different than above)				City, State, ZIP code		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Home phone (include area code)	Business phone (include area code)		Occupation		
Select type of health coverage: <input type="checkbox"/> Single <input type="checkbox"/> Parent/Child(ren) <input type="checkbox"/> Child(ren) <input type="checkbox"/> Couple <input type="checkbox"/> Family			Are all persons applying for coverage legal residents of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Section B Select Coverage Desired

Select deductible (Deductibles shown below are in Network):

Plan 1 (20% coinsurance)	Plan 2 (30% coinsurance)	Plan 3 (20% coinsurance)	Plan 4 (0% coinsurance)
<input type="checkbox"/> \$2,400 single	<input type="checkbox"/> \$2,400 single	<input type="checkbox"/> \$1,200 single	<input type="checkbox"/> \$2,500 single
<input type="checkbox"/> \$4,800 family*	<input type="checkbox"/> \$4,800 family*	<input type="checkbox"/> \$2,400 family*	<input type="checkbox"/> \$5,000 family*
		<input type="checkbox"/> \$4,000 single	<input type="checkbox"/> \$5,000 single
		<input type="checkbox"/> \$8,000 family*	<input type="checkbox"/> \$10,000 family*

*The family deductible must be satisfied by either one member or all members collectively before any covered services will be paid by the plan.

Section C Billing Information

Select premium frequency: <input type="checkbox"/> monthly <input type="checkbox"/> quarterly <input type="checkbox"/> semi-annually <input type="checkbox"/> annually	Select billing method: <input type="checkbox"/> bill direct <input type="checkbox"/> automatic bank draft (You must complete Section H, premium will be deducted on same day of the month as your assigned effective date.)	Total Premium Payment Amount enclosed \$ _____ Make your check for the first premium period payable to "Anthem Blue Cross and Blue Shield."
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Section D Dependent Information (Attach a separate sheet if necessary.)

Dependent information must be completed for all dependents (if any) to be covered under this coverage. Eligible dependents may be your spouse, your unmarried dependents, your spouse's unmarried dependents (to the end of the calendar month in which they turn 19, or to age 25 if the child qualifies as a full time student or qualifies for federal income tax exemption.)

Risk Tier	First, MI (Last name if different from applicant)	Social Security number	Sex	Age	Date of birth	Relationship to Applicant	Height	Weight	Federal Tax Exemption?

Does any dependent listed above, who is over age 19, currently qualify for federal income tax exemption or as a full time student?
 Yes No

If yes, provide dependent's name and address, if different than the applicant's address. (Documentation of qualification for federal income tax exemption or as a full time student may be required.)

Do not write in shaded area

Assigned Effective date	Decision date	Pre-existing Provision	UW initials	Risk Code
Risk Tier Key: (P) Preferred (S1) Standard 1 (S2) Standard 2 (M1) Modified 1 (M2) Modified 2				

Section E Complete the following medical questions for all persons to be covered

1. Has any person applying for coverage **ever** had any diagnosis, consultation, treatment, testing or taken any medication or received follow up care or examinations for:
 - a. High blood pressure, high cholesterol and/or triglycerides, irregular heart beat, mitral valve prolapse, heart murmur, coronary artery disease, arteriosclerosis, aneurysm, stroke, peripheral vascular disease, chest pain, heart disease or any condition related to the heart or circulatory system? Yes No
 - b. Any cancer, tumor, cyst, polyp or growth of any kind, leukemia, Hodgkin's disease, malignant melanoma, or multiple myeloma? Yes No
 - c. Abuse or dependency of alcohol, drugs, narcotic or controlled substances, been advised to seek treatment or convicted of 2 or more DUI's? Yes No
If yes, Drivers License No. _____
 - d. Jaundice, cirrhosis, hepatitis, ulcer, hernia, gastritis, intestinal disorders, gastroesophageal reflux disorder (GERD), colitis, gallstones, diverticulitis, hemorrhoids or other disorders of the stomach or digestive system, intestines, liver, pancreas, gallbladder, spleen or surgery for obesity? Yes No
 - e. Arthritis, gout, rheumatism, connective tissue disorder, systemic lupus erythematosus, sclerodema, herniated disc, back pain or disorder of the muscles or bones including jaw, knee, back, spine or joints, or any amputation due to disease? Yes No
2. Has any person applying for coverage ever had any diagnosis, consultation, treatment, taken any medication or received follow-up care for Acquired Immune Deficiency syndrome (AIDS), AIDS Related Complex (ARC) or other immune deficiency disease or abnormality of the immune system, or tested positive for HIV or HTLV? Yes No
3. Has any person applying for coverage in the past 5 years had any diagnosis, consultation, treatment, testing or taken any medication or received follow up treatment or examination for:
 - a. Allergies, asthma, emphysema, bronchitis, chronic obstructive pulmonary disease, sleep apnea or other disease or disorder of the lungs or respiratory system? Yes No
 - b. Parkinson's disease, multiple sclerosis, myasthenia gravis, cerebral palsy, seizures, muscular dystrophy or any other muscle disorder, paralysis, epilepsy or other convulsive disorder, or any other disease or disorder of the brain or nervous system? Yes No
 - c. Anemia, or other disease or disorder of the blood? Yes No
 - d. High or low blood sugar, diabetes, Cushing's syndrome, Addison's disease, thyroid or other endocrine, lymph node, gland diseases or disorders? Yes No
 - e. Sugar or albumin in the urine, stones or other disorders of the kidney, bladder or prostate, any disorder of the genital or urinary system, cystitis, prostatitis, bladder infection? Yes No
 - f. Alzheimer's disease, autism, mental retardation, any mental, emotional or nervous condition or disorder, eating disorder, or had any psychiatric counseling or care from any medical practitioner or social practitioner? Yes No
 - g. Any disease or disorder of the male or female reproductive organs, irregular menstruation, endometriosis, abnormal pap smear, pregnancy complications, breast disease or disorder, infertility, testicular or prostate disorder? Yes No
 - h. Any disease or disorder of the eyes, ears, nose, throat, sinuses, skin disorders, including acne, psoriasis, cataracts, glaucoma, ear infections, tonsillitis, nail fungus or Meniere's disease? Yes No
 - i. Chronic pain, chronic fatigue syndrome, fibromyalgia, chronic headaches or migraines? Yes No
4. Has any person applying for coverage been hospitalized, had surgery, or advised that hospitalization or surgery may be required in the future for any reason, including inpatient and/or outpatient surgery? Yes No
5. Has any person applying for coverage sought advice or medical treatment, or been advised by a medical or social practitioner to seek advice or treatment for any condition or symptoms not indicated by your answers to any of the preceding questions? Yes No
6. Is any person taking medication? (List reason and medication below). Yes No
7. Has any person applying for coverage applied for disability or have a condition that is currently covered by Worker's Compensation? Yes No
8. Have you or any dependent been seen by any physician in the past 6 months? Yes No
(If yes, list name(s), dates, reason for visit and name, address and phone no. of treating physician below)
9. Have you or any dependent smoked or used tobacco products in the past 12 months? Yes No
If yes, who? _____
10. Have you or any dependent listed ever been rated up or refused health coverage by an insurer? Yes No
If yes, explain reason for rate up/denial and date _____
11. Are you, your spouse or any of your dependents whether they are to be covered or not by this certificate, currently pregnant or an expectant parent? Yes No
If yes, due date _____
12. Name and address of personal physician.

Phone No. _____ Date last seen _____

Reason _____

Section F Medical Details (If you answered "Yes" to any of the Medical Questions 1 through 11 provide details below.)

Question number	Name of individual	Name of condition, illness or injury	Dates of treatment	Name of medication and dosage (milligrams, pills per day, etc.)	Name and address of practitioner or hospital facility	Current status

Section G Other Health Coverage

Did you or your eligible dependents have creditable coverage within the past 63 days? Yes No You may be eligible for pre-existing credit. **The following information must be completed in order for credit to be given.** Please provide the previous 18 months of coverage.

1. Name and telephone number of prior carrier

If Anthem Blue Cross and Blue Shield was this: Group coverage
 Individual coverage

Identification number	Name(s) of covered person(s)
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Effective date	Cancellation date
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Reason for cancellation

2. Are you replacing this coverage with Anthem Blue Cross and Blue Shield? Yes No

3. Are you or anyone applying for coverage currently covered by Medicare? Yes No
If yes, whom? _____

Complete this section if more than one carrier (Attach a separate sheet if necessary.)

1. Name and telephone number of prior carrier

If Anthem Blue Cross and Blue Shield was this: Group coverage
 Individual coverage

Identification number	Name(s) of covered person(s)
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Effective date	Cancellation date
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Reason for cancellation

Section H Automatic Bank Draft authorization

If you completed Section C 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	Account holder's signature (if other than the applicant)
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**Attach
a blank (voided) check
here.**

Section I 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.
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 that pre-existing conditions are limited to 12 months after enrollment for conditions in existence within 6 months immediately prior to my enrollment for which medical advice, diagnosis, care or treatment was recommended or received.**
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.

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).

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 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 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.

If question #9 in Section E is answered "NO," your signature(s) below will attest to non-tobacco usage for the past 12 months.

I understand I am applying for individual health coverage (under Anthem's Group Trust) which is not part of any employer-sponsored plan. I certify that neither I nor any dependent are receiving any form of reimbursement 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.

Signature of Applicant	Date
Signature of spouse (if to be covered)	Date

Section J Agent Certification

Agent Name (please print)	Agent Tax ID 31-1302066
Agent No.	
GA	GA code

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

Thank you for choosing Anthem Blue Cross and Blue Shield.