

Connecticut Individual Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Anthem Blue Cross Blue Shield (Anthem), premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 212-1793. If you have questions about a previously submitted application, please call 1 (855) 837-8537.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

- New Coverage Change policy coverage Add dependent(s) to current coverage
- Policy No. _____ Policy No. _____

Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. The earliest Effective Date for the annual Open Enrollment period is the first day of the following Calendar Year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable premium payment.

Applications can be received during the Open Enrollment period. Outside the Open Enrollment period referenced above, the applicant may still enroll if he/she has a qualifying event as defined below. Following a qualifying event, an applicant has 60 days to submit an application. In the case of a future Loss of Minimum Essential Coverage, applications may be submitted up to 30 days in advance of the qualifying event date.

Qualifying Events

Please check the qualifying event:

- Open Enrollment;
- Involuntary Loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;
- Loss of Minimum Essential Coverage due to dissolution of marriage/domestic partnership;
- Marriage/Domestic Partnership;
- Adoption or placement for adoption or appointment of guardianship (Notification of a newly adopted child may be up to 61 days after the date of adoption);
- Birth (Notification of birth of newly born child may be up to 61 days after the date of birth);
- Moved to a new exchange service area or immigration status changed to lawfully present;
- Other Qualifying Event: _____ (Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events).

Please provide the date of the qualifying event (which includes the date of Loss of Minimum Essential Coverage): _____

If you are applying due to a qualifying event and your application is approved, your effective date is as follows:

- In the case of birth, adoption or placement for adoption or appointment of guardianship, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship; or
- In the case of marriage, or Loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application; or.
- In the case of all other qualifying events, when the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. When the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month.

Section B – Applicant Information

Last Name		First Name		MI	Social Security Number* (required)
Home Address					
City			State	ZIP	County
Billing Address (street and P.O. Box if applicable)					
City			State	ZIP	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	
Primary Phone Number ()	Secondary Phone Number ()		E-mail		

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name		First Name		MI	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner
Social Security Number* (required)		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth / /	

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

NOTE: IF ELECTING DEPENDENT COVERAGE, PLEASE LIST ALL ELIGIBLE CHILDREN UP TO AGE 26. An eligible child dependent may be your children or your spouse’s or your Domestic Partner’s children (to the end of the calendar month in which they turn age 26). You must complete a Certification form for a Mentally or Physically Incapacitated Dependent Child if your child is disabled, incapable of self-support, and age 26 or over. The form must also be completed by your physician. (List all dependents beginning with the eldest).

Last Name	First Name	MI	Sex	Date of Birth mm/dd/yyyy	Social Security Number* (required)	Relationship to Applicant
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____
			M F <input type="checkbox"/> <input type="checkbox"/>	/ /		<input type="checkbox"/> Child <input type="checkbox"/> Other: _____

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Are all applicants listed on this application legal residents of the United States and residents of the state in which you are applying for coverage? Yes No

If NO, who? _____

Are all applicants listed on this application United States citizens, nationals or lawfully present non-citizens? Yes No

If NO, who? _____

Are any of the applicants listed on the application currently incarcerated (except pending disposition of charges)? Yes No

If YES, who? _____

Has any applicant used tobacco products 4 or more times per week, on average, excluding religious or ceremonial usage in the last 6 months? Yes No

If YES, who? _____

Preferred written language? (Optional)

English (ENG)

Spanish (SPN)

Preferred spoken language? (Optional)

English (ENG)

Spanish (SPN)

Section E – Medical Coverage

Plan Name and Deductible/Coinsurance Options

Select ONE Plan...then select ONE Individual Deductible/Coinsurance option.

Total Family Deductible is two (2) times the amount shown.

Anthem HMO BlueCare

\$1,500/0% - (1GVJ)

\$3,000/0% - (1GVF)

\$3,500/0% - (1GVG)

\$5,500/0% - (1GVB)

\$6,000/0% - (1GVC)

Anthem PPO Century Preferred

\$2,500/20% - (1GW1)

\$2,750/20% - (1GVH)

Anthem HMO Catastrophic BlueCare (only available for Applicants under age 30 or otherwise qualified)

\$6,600/0% - (1GV8)

HSA Plans – (HSA Plans are only permitted to be sold in conjunction with a health savings account.)

Anthem HMO BlueCare 3000/6000/0% for HSA - (1GVE)

Anthem HMO BlueCare 5500/11000/0% for HSA - (1GV9)

Anthem HMO BlueCare 6000/12000/0% for HSA - (1GVA)

Anthem PPO Century Preferred 5700/11400/20% for HSA - (1GVD)

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. I already have an account established with a banking partner. Please **DO NOT** forward my information to Anthem's banking partner.

Please choose a Primary Care Physician for each family member from the Provider Directory, which can be found at www.anthem.com, or by calling 1 (800) 922-3242. If you do not choose a PCP, then one will be selected for you.

Applicant	Primary Care Physician (PCP)	PCP ID	Current Patient	PMG/IPA ID*
Primary Applicant			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse/ Domestic Partner			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent Name:			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent Name:			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent Name:			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent Name:			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent Name:			<input type="checkbox"/> Yes <input type="checkbox"/> No	

*PMG = Participating Medical Group, IPA = Independent Practice Association

Please check box if any additional sheets of paper have been completed for this section. If so, please attach and return the additional sheets with this application.

Section F – Dental Coverage

Yes, I wish to purchase additional dental coverage to supplement the pediatric Essential Health Benefits to age 19 which are included in the medical plans above.

Select All that Apply:

Anthem Blue Cross Dental Family - (1FRP)

Anthem Blue Cross Dental Family Enhanced - (1FRQ)

Select who you are enrolling (applies to individuals listed on this application only):

Applicant only

Applicant & all dependent children listed

Applicant & Spouse or Domestic Partner only

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

Section G – Other Health Coverage

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

If **YES**, who? _____

Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits? Yes No

If **YES**, who and reason:

Start date of benefits/coverage: ____/____/____ End date of benefits/coverage: ____/____/____

Do you, or anyone applying for coverage, currently have health care coverage? Yes No

If YES, please provide the following:

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)	
Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Effective Date of Coverage

Will you be cancelling this coverage if approved for Anthem coverage? Yes No

If **YES**, what is the cancellation date? _____

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- I understand that although Anthem requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Anthem, does not mean that coverage has been approved. I may not assign any payment under my Anthem program. I am applying for the coverage selected on this application. 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. I understand that if my application is denied, my bank account or credit card will not be charged.
- I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
- 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.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
- I understand 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.
- 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 at least 18 years old; 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.
- By checking this box, I authorize and expressly consent that Anthem and its affiliated companies may send and deliver to me any communication that is not required to be provided to me by United States mail, including but not limited to legally required Plan Notices, policies, agreements, evidence of coverage booklets and underwriting, enrollment and billing and explanation of benefits statements, electronically, either by e-mail or via the Internet. Examples of documents that will not be sent by electronic means and will continue to be sent by U.S. Mail include notices of cancellation, notices of grace period, notices that will terminate your coverage, and notices regarding a denial of coverage. I understand that I can revoke this authorization or request paper copies at any time by contacting Anthem customer service or online at www.anthem.com.
- 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).
- As part of the W-9 Certification required by the Internal Revenue Service, I certify that the SSN number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

ANTHEM INDIVIDUAL PRODUCTS ARE ISSUED ON AN INDIVIDUAL BASIS AND ARE REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN.

I acknowledge receipt of an outline of coverage provided by the policy checked above. I certify that neither I nor any family member listed is eligible for Medicare. I understand that all coverage and services are subject to the Exclusions, Limitations and Conditions of the Subscriber Agreement.

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.

This application shall be altered solely by the applicant or with his or her written consent.

**SIGN
HERE**

Signature of Applicant* or Legal Representative X	Date
Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

* (or Custodial Parent's or Guardian's signature if applicant is under age 18)

Section I – Agent/Broker Certification

To be completed by your Anthem-appointed agent/broker:

Did you see the proposed subscriber and spouse/domestic partner, if applying at the time this application was executed? Yes No

If **NO**, please explain: _____

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

Agent/Broker Signature X		Date		
Agent/Broker Name (please print) Trevor Croley /ENROLLMENT		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No. PO BOX A		
Agent/Broker ID/TIN 491869663	Agency ID/Parent TIN	City Springfield	State MO	ZIP 65808
Agent/Broker Phone No. (417) 881-3520	Agent/Broker Fax No. (417) 881-4556	Agent/Broker E-mail tcroley@croleyinsurance.com		
GA (if applicable)		GA code (if applicable)		



Please mail this application to the following address:

Anthem Blue Cross and Blue Shield
P.O. Box 9041
Oxnard, CA 93031-9041

Or

Fax to: 1 (800) 327-9255

Anthem Blue Cross and Blue Shield is the trade name for Anthem Health Plans, Inc. Independent licensee of the Blue Cross and Blue Shield Association. @ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Applicant / Member Name:	Primary Applicant's SSN:
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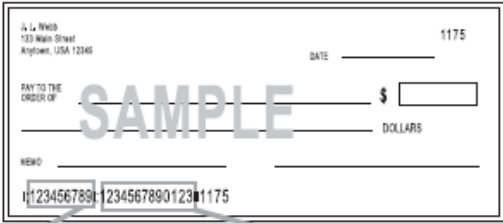
Premium Payment is required. Please choose from Option 1 or 2
Please Note: All Payments will be debited as soon as the date of enrollment.

<input type="checkbox"/> OPTION 1 – If you choose the following option for INITIAL and FUTURE MONTHLY payments, you are NOT required to make a selection from Option 2 for your initial payment. <input type="checkbox"/> Monthly Automatic Premium Payment (complete Section A)	<input type="checkbox"/> OPTION 2 – If you did not select OPTION 1 , please choose from the options below for your INITIAL premium payment. If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment. <input type="checkbox"/> Paper Check* <input type="checkbox"/> Electronic Check (complete Section B) <input type="checkbox"/> Credit / Debit Card (complete Section C)
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A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

Checking Account
 Savings Account
 (You may need to contact your financial institution for routing and account number information.)

Requested Debit Day: ____ (1st to 6th of each month).
 If no date is requested, your premiums will be debited on the first of each month.



9-Digit Bank Routing Number

Bank Account Number

As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield (“Anthem”) to pay and charge to my account checks drawn on that account by and made payable to the order of Anthem Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem’s rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing Anthem a 30-day written notice. I agree that Anthem shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Anthem’s withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution’s records) X	Account Holder Name (Please PRINT)	Date
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B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount \$
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C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield (“Anthem”) to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **Anthem accepts Visa and MasterCard.**

Card Number: Expiration Date:

Billing address for this Credit / Debit Card: City: Zip Code:

Authorized Signature (as it appears on the credit card) X	Cardholder Name (as it appears on the credit card – Please Print)	Date
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* When you provide a check as payment, you authorize Anthem either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Anthem uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.