Information for Applications Requesting a Special Enrollment Period

Anthem BlueCross BlueShield

To enroll for coverage during a Special Enrollment Period, you are required to submit supporting documentation of the qualifying event, and failure to submit this documentation may affect your enrollment.

Please review the list below which outlines supporting documentation requirements and send in a **copy** of the documentation for your specific qualifying event when you submit your completed application or upload a copy of the documentation when submitting your online application.

For paper applications, you should submit legible copies and keep all original documents for your personal records, as no original documentation will be returned to you. Please write your name on the top of each page of your supporting documentation.

Please note, loss of coverage due to fraud, intentional misrepresentation of a material fact or failure to pay premium does not constitute a qualifying event.

In all instances we reserve the right to request additional documentation to confirm eligibility. Please note that you must meet all eligibility requirements in order to be enrolled for coverage.

If you have further questions about qualifying events or the supporting documentation that is required, please call your agent or the number at the top of the page.

Qualifying Event	Description of Required Supporting Documentation
Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium	**Due to:** **Employment status change:** Letter from employer on business letterhead confirming loss of coverage (date and individuals) and reason for loss of MINIMUM ESSENTIAL COVERAGE (i.e. reduction in employment hours, etc.). **Loss of dependent eligibility status due to death:** Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage if available) confirming loss of coverage (date and individuals), and copy of death certificate or obituary. **Medicare eligibility:** Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage if available) confirming loss of coverage (date and individuals), and copy of Medicare card or approval letter from Social Security. **Over-age dependent status change:** Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage if available) confirming loss of coverage (date and individuals). **Legal separation, divorce, dissolution of domestic partnership (or civil union — Colorado only):** Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage if available) confirming loss of coverage (date and individuals), and Divorce Decree, legal separation agreement, or notarized/legal termination of domestic partnership or civil union (in Colorado only). **Change in service area:** Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage if available) confirming loss of coverage (date and individuals), and one of the following documents must include the name of the enrollee and the residential address declared on the application: • Current utility bill • Signed residential lease, rental agreement/contract, mortgage • Property deed **Exhaustion of COBRA or state continuation benefits:** Continuation termination letter OR Continuation offer letter and letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage if available) confirming loss of coverage (date and individuals).

Qualifying Event	Description of Required Supporting Documentation
Birth or Adoption/ Placement for Adoption	**Birth:** Birth certificate or medical records from hospital or pediatrician which indicate name and date of birth. **Adoption/placement for adoption:** Adoption certificate, placement agreement or other legal evidence of the enrollee's right to control the health care of the child.
Legal guardianship or qualified medical child support order	Legal documentation/court order which indicates that the dependent is mandated to be covered. For Kentucky only: Must show application filed with the court for guardianship.
Marriage or Domestic Partnership **Civil Union (Colorado only)**	For domestic partnership: In states where no formal registration/certificate is issued, we will not require additional proof beyond the signed/dated application. Certificate of marriage, domestic partnership or civil union in Colorado.
Move/permanent change in service area with access to new qualified health plans	Documentation of old address and new address each validated by one of the following: • Current utility bill • Signed residential lease • Signed rental agreement/contract/mortgage • Property deed Documentation must include both the name of the enrollee and the residential address declared on the application (for new address), and documentation for the previous address must include the name of the enrollee and the residential address before the move occurred. For **child only applications**, the name of the parent/guardian in the signature section of the application must match the name on the supporting documentation.
Release from incarceration (for all states except New York)	Papers from the State Department of Justice showing the date of legal discharge.
Pregnancy (New York only)	Certification from medical provider.
Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events	An official form such as a letter or other supporting documentation from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected. We reserve the right to request additional documentation to confirm eligibility.

Nevada
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 and 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) 330-1217.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage ☐ Change policy coverage Policy No._____ ☐ Add dependent(s) to current coverage 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 January. 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 apply for a health plan if he/she experiences 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 or renewal of non-calendar year health plan coverage, an application may be submitted up to 60 days in advance of the qualifying event date.

Outside the Open Enrollment period and without a qualifying event, the applicant can enroll, but may be subject to a waiting period where permitted by law. Dependents cannot be added to or change between plans outside the Open Enrollment period or without a qualifying event.

No qualifying event is required to apply for new dental coverage.

For existing dental plan members, dental coverage changes and/or addition of dependents may only occur during the Open Enrollment period or if you experience a qualifying event. Following a qualifying event, an applicant has 60 days to submit an application.

Please indicate the reason you are submitting this application:

☐ Open Enrollment Period

☐ Special Enrollment Period

If Special Enrollment Period, please provide the qualifying event date, qualifying event and, if applicable, the coverage effective date:

1. **Date of the qualifying event** (which includes the date of Loss of Minimum Essential Coverage):

   _____

2. **Qualifying Event:**

☐ 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;

☐ Birth or adoption or placement for adoption or appointment of guardianship;

☐ Moved to a new exchange service area or immigration status changed to lawfully present;

☐ Released from incarceration;

☐ Death of a family member enrolled under your current coverage;

☐ Renewal of non-calendar year health plan coverage;

☐ Court ordered coverage including child support order;

☐ 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);

☐ No qualifying event - when choosing this option your effective date will be the 1st of the month following a 90 day waiting period.

3. Coverage Effective Date:

If you are applying due to a qualifying event and your application is processed, your coverage effective date will be based on when the application is received. If 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. If 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. **However the following qualifying events allow for different effective dates:**

- In the case of marriage, domestic partnership, or Loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application.

For the following qualifying events, select one of the effective date options as described in the chart below.

- In the case of birth, or adoption, or placement for adoption, or appointment of guardianship; ☐ A ☐ B ☐C ☐D
- In the case of court ordered coverage including child support order; ☐ A ☐C
- In the case of death of a family member enrolled under your current coverage; ☐ B ☐C

Effective date options

A	Coverage is effective on the date of birth, or adoption, or placement for adoption, or appointment of guardianship, or date of court order.
B	First day of the month following receipt of your application.
C	Based on when the application is received. If 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. If 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.
D	First day of the month following the date of the qualifying event.

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 ☐ Single ☐ Married	Sex ☐ M ☐ 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 ☐ Spouse ☐ Domestic Partner

Social Security Number* (required)	Sex ☐ M ☐ F	Date of Birth

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 your Domestic Partner's children (to the end of the calendar month in which they turn age 26. (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 ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____

Last Name	First Name	MI	Sex	Date of Birth mm/dd/yyyy	Social Security Number* (required)	Relationship to Applicant
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ 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 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

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

If **YES**, who? _____

Preferred written language? (Optional) ☐ English (ENG) ☐ Spanish (SPN)

Preferred spoken language? (Optional) ☐ English (ENG) ☐ Spanish (SPN)

☐ Applicant **DOES** speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a "Statement of Accountability".

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 Bronze Pathway HMO

☐ $4,950/50% - (1X90) ☐ $5,000/40% - (1G40)
☐ $5,950/35% - (1X8X) ☐ $6,150/20% - (1G48)

Anthem Bronze Pathway PPO

☐ $4,500/20% - (1G4B) ☐ $5,200/20% - (1ZZA)
☐ $6,200/30% - (1G49)

Anthem Silver Pathway HMO

☐ $1,750/20% - (1G52) ☐ $2,250/20% - (1G4U)
☐ $2,000/40% - (1X9H) ☐ $2,250/30% - (1G4K)
☐ $2,350/15% - (1G2K) ☐ $2,500/40% - (1X9P)

Anthem Silver Pathway PPO

☐ $2,250/20% - (1G4X) ☐ $2,500/15% - (1ZZK)
☐ $2,750/10% - (1ZZJ) ☐ $3,500/0% - (1G50)
☐ $4,000/15% - (1ZZG)

Anthem Gold Pathway HMO

☐ $1,000/20% - (1X99) ☐ $1,100/10% - (1G2Q)
☐ $1,450/25% - (1X93) ☐ $1,800/50% - (1X9C)
☐ $1,800/50% - (1X96)

Anthem Gold Pathway PPO

☐ $0/25% - (1ZZD) ☐ $750/15% - (1ZZH)
☐ $1,000/15% - (1ZZL) ☐ $1,250/10% - (1ZZC)
☐ $1,500/10% - (1ZZM)

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

☐ $6,850/0% - (1G2W)

Anthem Catastrophic Pathway PPO (only available for Applicants under age 30 or otherwise qualified)

☐ $6,850/0% - (1ZZB)

HSA Plans

☐ **Anthem Bronze Pathway HMO 0% for HSA** - (1G44)

☐ **Anthem Bronze Pathway PPO 20% for HSA** - (1G4A)

☐ **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.

If you select an HMO plan, 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 (855) 330-1217. 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			☐ Yes ☐ No	
Spouse/ Domestic Partner			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ 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 and Vision Coverage

Dental

☐ **Yes, I wish to purchase additional dental coverage to supplement the pediatric Essential Health Benefits available to enrollees to the end of the month they turn age 19 which are included in the medical plans above.**

Select ONE Plan:

☐ **Anthem Dental Family** - (1FU5)
☐ **Anthem Dental Family Enhanced** - (1FU6)
☐ **Dental Prime Plan A*** - (1RCC)
☐ **Dental Prime Plan B*** - (1RCD)
☐ **Dental Prime Plan C*** - (1RCE)

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

*These plans do not include pediatric dental Essential Health Benefits that are required by the Affordable Care Act.

Vision

Supplemental vision coverage is also available. In order to enroll in this coverage, you must enroll in at least one of the medical or dental coverage options in this application. If you have enrolled in one of the medical or dental plans and would like to add vision coverage, please select your plan option below.

☐ **Blue View Vision Individual*** - (1RY8)

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

*These plans do not include pediatric vision Essential Health Benefits that are required by the Affordable Care Act.

Section G – Other Health and Dental Coverage

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

   If **YES**, who? _____

2) 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: ____/____/_____

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

If **YES**, please provide the following for health 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)		
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	
Will you be terminating this health coverage if approved for Anthem coverage? ☐ Yes ☐ No		If **YES**, what is the termination date?

4) Do you or anyone applying for coverage, currently have dental coverage? ☐ Yes ☐ No

If **YES**, please provide the following for dental 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)		
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	
Will you be terminating this dental coverage if approved for Anthem Dental coverage? ☐ Yes ☐ No		If **YES**, what is the termination date?

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

Please read this section carefully before signing the application.

I, the undersigned, understand that under the Anthem plan for which I am applying, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use an in-network hospital or physician.

- 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 and/or dental/vision 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: we have chosen to share one another's lives in an intimate and committed relationship of mutual caring; we desired by our own free will to enter into a domestic partnership; the NV Secretary of State has issued a Certificate of Registered Domestic Partnership to us; we share a common residence on at least a part time basis; 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.
- ☐ 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).
- I certify each Social Security Number listed on this application is correct.

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 cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

Rescission of Membership

I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered in this application, Anthem may revoke my coverage. This means Anthem may cancel membership as if it never existed. Also, after approval for membership, if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered by Anthem that was not provided to Anthem prior to the effective date of the policy, the plan may revoke coverage.

I understand that if my coverage is revoked, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for enrollment. I also understand that I may be required to pay for any claims that were paid while a member and that Anthem will refund all amounts paid by me except amounts owed to Anthem.

I have personally read and completed this application. If I am accepted, this application will become part of the contract between Anthem and me. I agree to abide by the terms of that contract.

REQUIREMENT FOR BINDING ARBITRATION:

I UNDERSTAND AND AGREE THAT ANY AND ALL DISPUTES BETWEEN ANTHEM AND ME MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE AFFORDABLE CARE ACT. ANTHEM AND I AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN OUR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT ANTHEM AND I ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS

ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

BEFORE COMMENCING ARBITRATION IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, THE PARTY SEEKING ARBITRATION MUST HAVE EXHAUSTED ALL LEVELS OF APPEAL AND REVIEW SET FORTH IN THE CERTIFICATE. ANY SUCH ARBITRATION WILL BE GOVERNED BY THE PROCEDURES AND RULES ESTABLISHED BY THE AMERICAN ARBITRATION ASSOCIATION. THE LAW OF THE STATE IN WHICH THE POLICY WAS ISSUED AND DELIVERED TO THE POLICYHOLDER SHALL GOVERN THE DISPUTE. THE DECISION IN ARBITRATION IS BINDING UPON BOTH ANTHEM AND ME. THE AWARD GIVEN IN ARBITRATION MAY BE ENFORCED OR REVIEWED IN ANY COURT THAT HAS PROPER JURISDICTION. IN THE EVENT ANY PERSON SUBJECT TO THIS ARBITRATION CLAUSE INITIATES LEGAL ACTION OF ANY KIND, THE OTHER PARTY MAY APPLY FOR A COURT OF COMPETENT JURISDICTION TO ENJOIN, STAY OR DISMISS ANY SUCH ACTION AND DIRECT THE PARTIES TO ARBITRATE IN ACCORDANCE WITH THIS PROVISION. THE QUESTION OF WHAT DISPUTES ARE SUBJECT TO THIS ARBITRATION CLAUSE SHALL BE DETERMINED BY THE ARBITRATOR.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE VOLUNTARILY AGREEING TO HAVE ANY DISPUTE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

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 218882	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)

Section J – Statement of Accountability

To be completed when the applicant cannot complete application.

NOTE: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I, _____ , personally read and completed this Individual Application for the applicant named below because:

☐ Agent assisted application ☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain):_____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

☐ Applicant Or by:_____

I also translated and fully explained the "Significant Terms, Conditions, and Authorizations (TERMS)" and "Payment Method".

Translator Signature ***(Required)***	Date ***(Required)***
X	

I confirm that the application was interpreted on my behalf.

Applicant Signature ***(Required)***	Date ***(Required)***
X	

Language interpreted (e.g. Spanish): _____

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

Payment Methods for Individual Applications – Nevada

Anthem BlueCross BlueShield

Applicant / Member Name:	Primary Applicant's SSN:

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.

☐ **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.

☐ Monthly Automatic Premium Payment (complete Section A)

☐ **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.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

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.

Provide your Routing and Account Numbers here:

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)	Account Holder Name (Please PRINT)	Date
X		

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
			$

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)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* 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.