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.

Division of Insurance

COLORADO UNIFORM INDIVIDUALAPPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's initial application for coverage. Please contact your carrier with questions regarding this form

Federal financial assistance may be available for coverage purchased through Connect for Health Colorado. If purchasing coverage through Connect for Health Colorado, you will need to provide additional information for determination of eligibility for federal financial assistance. Further informationmay be found at www.connectforhealthco.com.

COVERAGE INFORMATION

Application Type:	☐New Coverage ☐Change/Modification to Existing Coverage ☐Open Enrollment ☐Special Enrollment*
Requested Effective Date:	_____/_____/_____(MM/DD/YYYY)

* Proof of eligibility for special enrollment will be required – information on eligibility for special enrollment periods is available at: www.dora.colorado.gov/DOI/HealthApp

PRIMARY APPLICANT/INSURED INFORMATION

Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.

First Name:		Middle Initial:		Last Name:	
Social Security #:		Date of Birth:	/	Current Age:	Sex: ☐M F ☐
Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	

Are you (check one): ☐ Single ☐ Married ☐ Common Law* ☐ Civil Union* ☐ Legally Separated ☐ Divorced ☐ Under 21

Are you or is anyone in your family American Indian or Alaskan Native? ☐Yes ☐No

* A common law, civil union, or designated beneficiary certification may be required by the carrier

Employer Name and Address:		Work Phone:	

ADDITIONAL APPLICANTS

Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26(older if medically disabled) are applying for coverage. If a dependent child is applying an as individual rather than as part of a family list the child as the primary applicant. If there is not enough space provided, please attach additional family information. **Please sign and date the additional sheet.**

*Social Security Numbers (or document numbers for any legal immigrants) are needed for anyone applying for health insurance, missing numbers will be requested after enrollment

Name (First, MI, Last)	Sex	Social Security #	Relationship	Disabled	Birth Date (MM/DD/YY)	Employer Name and Position
	☐M ☐F		SPOUSE/PARTNER			
	☐M ☐F		☐CHILD ☐STEPCHILD	☐ Yes ☐ No		
	☐M ☐F		☐CHILD ☐STEPCHILD	☐ Yes ☐ No		
	☐M ☐F		☐CHILD ☐STEPCHILD	☐ Yes ☐ No		

Do(es) the child(ren) named within the application live with you at the same physical address shown above? ☐Yes ☐No (if no, complete below)

Child(ren)'s Name:			Mailing Address (If different):				
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Primary Applicant Name:

Name of the Legal Guardian or Parent responsible for carrying health insurance for the child:							
If the primary applicant is under the age of 21 if different from above, provide the name and mailing address of the legal guardian or custodial parent:							
Legal Guardian or Custodial Parent's Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

TOBACCO USE

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."

Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		

MEDICARE/MEDICAID INFORMATION

Is any applicant enrolled in Medicare? ☐Yes ☐No

Name of person covered by Medicare: _____. For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program? ☐Yes ☐No

Name of person covered by Medicaid or other governmental health program: _____. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? ☐Yes No☐

(Dental Coverage in next Section)

Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type

If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted? ☐ Yes ☐ No

Type of Coverage Key: **G** = Group Comprehensive Major Medical; **I** = Individual Comprehensive Major Medical; **MS** = Medicare Supplement; **H** = Hospital Coverage Only; **V** = Vision Coverage Only **O**=Other, please explain:_____

Primary Applicant Name:

CERTIFICATION OF DENTAL INSURANCE COVERAGE (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required provide proof that you have obtained coverage before this policy will be approved

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved. (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)

I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I would like to receive all policy notices, premium notices, and other notices relating to this policy through the supplied email address above. ☐Yes ☐No

I understand I can change this designation at a later date by contacting my carrier directly, and understand it is my responsibility to notify my carrier of any changes to my email address.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	Date Signed:

Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:

Primary Applicant Name:

AGENT/PRODUCER INFORMATION	
This section is to be completed by Agent or Producer.	
Agent / Agency of Record: (for commissions and correspondence)	Writing Agent / Producer:
Name (print):	Name (print):
Agent ID # (NPR):	Agent ID #(NPR):
Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐Yes ☐No As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature.	
Writing Agent Signature	**Date**

DISCLOSURES

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://www.dora.colorado.gov/insurance. For questions regarding coverage or enrollment please see your carrier.

This section may be used to provide additional information that was required in the sections above and did not fit in the space provided.

Signature of Primary Applicant:_____ **Date Signed:** _____

Colorado
Individual Enrollment Application Supplement Form

NOTE: THIS APPLICATION IS ONLY TO BE USED IN CONJUNCTION WITH THE UNIFORM INDIVIDUAL APPLICATION.

PLEASE NOTE: If you are a new customer, you have to send in the premium payment with each application. If you already have an Individual policy with us, you have to pay premium before the requested start date of your plan. Please fill out the Payment Method for Individual Applications Form and send it with your application. If you do not pay premium as above, we will not approve your application. If you need help with this application, please call your insurance agent. If you do not have an insurance agent, call 1 (877) 212-1793. If you have questions about a previously submitted application, please call 1 (855) 383-7249.

Please complete in blue or black ink only.

Section A – Coverage Information

First Name	MI	Last Name	Date of Birth (mm/dd/yyyy)

Effective Date:

As explained below, your effective date of coverage may vary depending on the type and time of enrollment. If the effective date of coverage, as determined by us, is different from the effective date you requested in the application, our determination of the effective date controls.

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 30 days in advance of the qualifying event date.

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/civil union;

☐ Marriage/Domestic Partnership/civil union;

☐ 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).

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, civil union 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.

Are all applicants listed on the Individual Uniform 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 the Individual Uniform Application United States citizens, nationals or present non-citizens? ☐ Yes ☐ No

If **NO**, who? _____

☐ 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 B – 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

☐ $5,000/40% - (1G0P)
☐ $5,400/50% - (1X7C)
☐ $5,800/30% - (1G0R)
☐ $6,250/20% - (1G0X)

Anthem Bronze PPO

☐ $5,200/20% - (1G10)
☐ $6,300/20% - (1X68)
☐ $6,200/30% - (1G0Y)

Anthem Silver PPO

☐ $2,350/20% - (1X76)
☐ $3,200/25% - (1X6N)
☐ $4,000/0% - (1X70)
☐ $4,000/15% - (1X6U)

Anthem Gold PPO

☐ $0/25% - (1X6K)
☐ $1,250/10% - (1X6G)

Anthem Silver Pathway HMO

☐ $1,300/35% - (1G1G)
☐ $2,000/20% - (1G1R)
☐ $2,000/25% - (1G1B)
☐ $2,400/10% - (1G1X)
☐ $2,500/15% - (1G1M)
☐ $3,000/10% - (1G1Y)
☐ $3,200/50% - (1X7M)

Anthem Gold Pathway HMO

☐ $0/30% - (1X7J)
☐ $1,100/10% - (1G24)
☐ $1,500/20% - (1X7F)

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

☐ $6,850/0% - (1G27)

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

☐ $6,850/0% - (1X6E)

Applicants must reside in one of these counties to enroll: La Plata, Montezuma, Summit or Eagle.

Anthem Bronze Mountain Enhanced HMO

☐ $5,000/40% - (1JR7)

Anthem Silver Mountain Enhanced HMO

☐ $2,000/25% - (1JR2)

Anthem Gold Mountain Enhanced HMO

☐ $1,100/10% - (1G2F)

HSA Plans

☐ **Anthem Bronze Pathway HMO 0% for HSA** -(1G0T)
☐ **Anthem Bronze Pathway HMO 25% for HSA** -(1G0V)
☐ **Anthem Bronze PPO 0% for HSA** -(1X64)
☐ **Anthem Bronze PPO 20% for HSA** -(1G0Z)

☐ **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.

☐ **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 (888) 231-5046. 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	

**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 C – 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** - (1FRB)
- ☐ **Anthem Dental Family Enhanced** - (1FRC)
- ☐ **Dental Prime Plan A*** - (1RBR)
- ☐ **Dental Prime Plan B*** - (1RBS)
- ☐ **Dental Prime Plan C*** - (1RBT)

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

- ☐ Applicant only
- ☐ Applicant & Spouse or Domestic Partner only
- ☐ Applicant & all dependent children listed
- ☐ 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*** - (1RY2)

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

- ☐ Applicant only
- ☐ Applicant & Spouse or Domestic Partner only
- ☐ Applicant & all dependent children listed
- ☐ 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 D – Other Health and Dental Coverage

Important information about replacement and duplicate coverage:

Normally you do not require more than one of the same type of policy, but if you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplemental policy. If you are eligible for Medicare due to age or disability, counseling services are available in Colorado to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

If **YES**, please indicate your eligibility:

- ☐ Specified Low Income Medicare Beneficiary (SLMB)
- ☐ Qualified Medicare Beneficiary (QMB)
- ☐ Other Medicaid medical benefits (please explain)_____

Do you, or anyone applying for coverage, currently have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy? ☐ 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 ☐ Group ☐ Individual	Effective Date of Coverage

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

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

If **YES**, do you intend to replace your current accident and sickness insurance with this policy (contract)? ☐ Yes ☐ No

If **YES**, please read the following: According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield or HMO Colorado. Your new policy will provide 10 days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

1) 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?

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

_____ **Additional benefits**

_____ **No change in benefits, but lower premiums**

_____ **Fewer benefits and lower premiums**

_____ **Other** (please specify)

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer or Other Representative* X	Date
Typed Name and address of Issuer or Producer	
Applicants Signature X	Date

*Signature not required for direct response sales.

Premium Reimbursement:

1. Will an employer of fifty (50) or fewer eligible employees be paying for or reimbursing you through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for? ☐ Yes ☐ No

If you answered "yes", please continue. If you answered "no", you may stop.

2. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve (12) months prior to the date of this application? ☐ Yes ☐ No

If the answer to both questions 1 and 2 immediately above is "yes", you may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

If the answer to question 1 is "yes" and the answer to question 2 is "no" , you must submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months.

The affidavit form to be executed by the employer is attached at the end of this form. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier.

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

Please read this section carefully before signing the application.

I understand that under the Anthem plan I have asked for, I will get less benefits if I use an out-of-network provider than if I use an in-network provider.

- I understand that although Anthem takes payment with my application, the sending or receiving of my payment does not mean that coverage has been approved. I understand that, where the law allows, Anthem may decline this application, and that no right is created by this application. If my application is denied, my bank account or credit card will not be charged.
- I agree to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.

- I agree to pay the premium due under the plan. I also agree to pay for any fee or charge Anthem bills me as part of an exchange fee, assessment, uninsured pool or other state or federal program. I agree that my payments will be first applied to such fees or assessments and the balance applied to premium.
- 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 below, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
- I understand that my domestic partner if any, is eligible only in certain cases. I agree that my partner: has been my sole domestic partner for 12 months or more; is mentally competent; is at least 18 years old; is not related to me in any way that would prohibit us from being married under state law; is not married to or separated from anyone else; and 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 certify each Social Security Number listed on this application is correct.

By signing below, I agree that I have read the TERMS and I accept them as a conditions of coverage. I represent that the information on this application are true and accurate to the best of my knowledge and belief. I understand that Anthem is relying on this representation in agreeing to accept this application. I agree that any act, practice, or omission that amounts to fraud or intentional misrepresentation of material fact may result in benefits being denied or my coverage being cancelled.

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.

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 ANYOTHER ISSUES RELATED TO THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

BEFORE COMMENCING ARBITRATION, 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.

IF AN APPLICANT DOES NOT READ ENGLISH, THE TRANSLATOR MUST SIGN AND SUBMIT A STATEMENT OF ACCOUNTABILITY FOR TRANSLATING THIS ENTIRE APPLICATION (SEE SECTION F).

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING, BY THE EXTENT PERMITTED BY STATE OR FEDERAL LAW, TO HAVE ANY AND ALL DISPUTES AGAINST ANTHEM BLUE CROSS AND BLUE SHIELD DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO JURY OR COURT TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS AND ANY OTHER DISPUTES. SIGNATURES REQUIRED.

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 F – Agent/Broker Information

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 FKJMRPKTWZ	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 G – 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 Enrollment 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)***	Today's Date ***(Required)***
X	

I confirm that the application was interpreted on my behalf.

Applicant Signature ***(Required)***	Today's Date ***(Required)***
X	

Employer Affidavit (obtain only if required by Section D of this application)

Employer's Name: _____

Employer's Address: _____

_____

The undersigned officer or principal of the employer identified above certifies that:

1. The employer is a small employer as defined in § 10-16-102(61), C.R.S., with fifty (50) or fewer eligible employees;

2. The employer has not had in place a small group health benefit plan for the twelve (12) months prior to the execution of this affidavit.

3. A false certification may cause the rescission of the employee's individual insurance policy and subject the employer to penalties for perjury and liability to the employee.

Signature X	Date
Typed Name	
Position	

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 – Colorado

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)

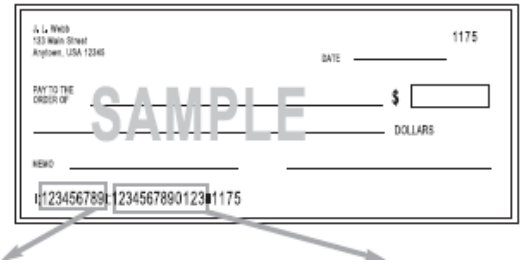
☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ 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.