



P.O. Box 1014, North Haven, CT 06473  
www.anthem.com  
1-866-279-9911

# Anthem Individual Enrollment/Change Application

To Be Completed By Agency / Producer	
Agency Name	_____
Vendor Code #	_____ _____ _____ _____ _____
Producer Signature	_____
Producer Phone #	_____
For Office Use Only	
Effective Date	_____
Firm Division No.	_____

**Contact your Producer to enroll online, or complete all sections of this application.**

**PLEASE USE BLACK OR BLUE INK ONLY AND PRINT CLEARLY**

Please check appropriate item:  New Enrollment  Plan Change  Add/Remove Dependent

<b>1. Applicant Information</b>			Email Address
Name (Last/First/Middle initial)			Home Address (Number and Street)
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth MO. DAY YR.	Social Security Number	City/State/Zip Code
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership (Include "Statement of Domestic Partnership")			Billing Address (If different from Home Address)
Telephone Numbers Daytime: _____ Evening: _____			City/State/Zip Code

<b>2. Membership Choice</b>	<b>Choose one membership type:</b> <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> TWO PERSON <input type="checkbox"/> FAMILY
<b>3. Plan Choice</b> (Please select one deductible option. The Two Person/Family Deductibles are two times the Individual Deductible. All deductible options are calculated per calendar year.)	

<b>BlueCare Direct (HMO)</b>  <input type="checkbox"/> <b>\$1,500/\$3,000</b> (Individual/Two Person or Family Deductible) (Select ONE Drug Maximum) <input type="checkbox"/> \$ 500 Drug Maximum <input type="checkbox"/> \$2,000 Drug Maximum	<b>Century Preferred Direct (PPO)</b>  Check One Deductible Option: <input type="checkbox"/> <b>\$250/\$500</b> (Individual / Two Person or Family Deductible) <input type="checkbox"/> <b>\$1,500/\$3,000</b> (Individual / Two Person or Family Deductible) <input type="checkbox"/> <b>\$5,000/\$10,000</b> (Individual / Two Person or Family Deductible) <input type="checkbox"/> <b>\$10,000/\$20,000</b> (Individual / Two Person or Family Deductible)  Prescription Drug Coverage: YES NO <input type="checkbox"/> <input type="checkbox"/>	<b>Lumenos (PPO)</b> <b>Lumenos Health Savings Account*</b> <input type="checkbox"/> <b>\$1,250/\$2,500</b> deductible (100% In network) <input type="checkbox"/> <b>\$2,500/\$5,000</b> deductible (100% In network) <input type="checkbox"/> <b>\$2,500/\$5,000</b> deductible (80% In network) <input type="checkbox"/> <b>\$5,000/\$10,000</b> deductible (100% In network) *For Health Savings Accounts, complete the following: <input type="checkbox"/> Yes, I would like to establish an H.S.A. with Anthem's banking partner. <b>(SSN required see Section 1)</b> <input type="checkbox"/> No, I do not want to establish an H.S.A. with Anthem's banking partner. <b>Lumenos Health Incentive Account Plus</b> <input type="checkbox"/> <b>\$2,500/\$5,000</b> deductible (80% In network) <b>\$200/\$400 Funding (Individual/Family)</b> <b>Lumenos Health Incentive Account</b> <input type="checkbox"/> <b>\$1,500/\$3,000</b> deductible (80% In network) <input type="checkbox"/> <b>\$2,500/\$5,000</b> deductible (80% In network)
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Recommended for HMO Plan Only. Name of Applicant's Primary Care Physician (PCP) (Refer to www.anthem.com)				Existing Patient
First	Last	City	PCP Provider No.	YES NO
PCP Name:				<input type="checkbox"/> <input type="checkbox"/>

4. Dependent Information	Add	Delete	Social Security Number	Sex	Date of Birth (mm/dd/yy)	(Recommended for the HMO only) Primary Care Physician	(Recommended for the HMO only) PCP ID Number (10 digits)	Existing Patient	Below please indicate name of recognized institution for full time students (Age 19-23)
Spouse / Domestic Partner				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 1				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 2				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 3				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent 4				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No	

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**5. Prior and Other Insurance Information - Please answer ALL of the following questions.**

(A) Do you have any other health insurance policy or certificate in force?  YES  NO

(B) Have you had coverage within 63 days of the application?  YES  NO

If you answered "Yes" to A or B, please provide the following information:

Name of Other Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Type of Coverage  Group  Individual Last Date of Coverage \_\_\_\_\_

If the answer to question (A) is yes, do you intend to replace your current medical or health policy with the policy?

Yes  No

<b>6. Billing Choice (Please Check One)</b>	<input type="checkbox"/> Electronic Fund Transfer - complete section 7 and <b>attach a voided check or savings account deposit slip.</b>	<input type="checkbox"/> Monthly Paper Bill
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**7. Electronic Fund Transfer Authorization (EFT) (Complete if you want your payments deducted directly from your checking or savings account.)**

**I hereby authorize Anthem Blue Cross and Blue Shield to initiate a withdrawal (on or about the 5<sup>th</sup> business day of each month) from my bank account for payment of my premium. The bank account is with the bank named below, which is hereby authorized to withdraw this amount from my account each month.**

Bank Name	Phone Number
Bank Address	City/State/Zip Code
Bank Information: Routing #	Account #
Type of Account: (Check Only One): <input type="checkbox"/> Checking Account (must attach voided check) <input type="checkbox"/> Savings Account (must attach saving account deposit slip)	

**This authorization is to remain in effect until Anthem Blue Cross and Blue Shield has received at least 30 days prior written notification from me of a termination date.**

**8. Effective Date**

If Anthem approves my application, please assign an effective date of \_\_\_\_\_. The effective date must be no earlier than the signature date and no greater than 60 days from the receipt by Anthem of this application. **NOTE: REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE COVERAGE OR ENROLLMENT AS OF THE DATE REQUESTED. Effective date will ultimately be assigned by Anthem Blue Cross and Blue Shield and communicated to you.**

**A completed, signed Health Statement must be enclosed with this completed, signed application. Important: Please attach copies of any certification or other documentation of prior creditable coverage furnished by previous carriers or employers, if available. This will help us process your application.**

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 the following: (a) that all coverage and services are subject to the Exclusions, Limitations and Conditions of the Subscriber Agreement or other Evidence of Coverage document; (b) that no benefits will apply until I receive written approval and confirmation of effective date, and my first month's paid premium has been processed by, Anthem Blue Cross and Blue Shield and; (c) that I will be responsible for notifying the Company of any change in dependent status or change of address. I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or nonpayment of claims for myself or my dependents. I certify that my statements in this form and the attached Health Statement are true and complete to the best of my knowledge and belief.

<b>9. Applicant's Signature</b> (If applicant is under 18, parent or guardian signature required.)	Date / /
<b>Spouse's Signature</b>	Date / /



**CONNECTICUT  
INDIVIDUAL MARKETS HEALTH STATEMENT**

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**APPLICANT AND FAMILY INFORMATION**

**PLEASE USE BLACK OR BLUE INK ONLY**

**PART A  
COMPLETE FOR YOU AND ANY FAMILY MEMBERS APPLYING FOR COVERAGE:**

	FIRST NAME	INITIAL	LAST NAME	HEIGHT	WEIGHT	DATE OF BIRTH	SEX M/F	SOCIAL SECURITY #
APPLICANT				/				
SPOUSE				/				
DEPENDENT				/				
DEPENDENT				/				
DEPENDENT				/				
DEPENDENT				/				

- PART B**
1. IS ANY PERSON TO BE INSURED CURRENTLY ON MEDICARE? YES NO
2. HAS ANYONE HAD HEALTH OR LIFE INSURANCE MODIFIED, POSTPONED OR RATED?  
 PLEASE SUBMIT DETAILS \_\_\_\_\_ YES NO

- PART C**
1. Are you or your spouse or any dependent to be insured currently disabled or unable to perform their normal activities? YES NO
2. Have you or any dependent to be insured been hospitalized, had surgery or been advised to have surgery within the past 5 years for any reason? YES NO
3. Are you or any dependents to be insured currently pregnant, or an expectant parent? YES NO
4. Are you or any dependents currently taking any medication? If yes, please specify medication and condition for which it is used: \_\_\_\_\_ YES NO
5. Do you or any dependents have any conditions or symptoms for which a physician or other medical care provider has not been consulted? YES NO
6. Have you or any dependent had medical expenses in excess of \$5,000 in the last 12 months? YES NO

- PART D**
1. Have you or any dependent to be insured ever had or been told they had, or been medically counseled, consulted or treated for any of the following? (Check **yes** or **no** and **circle the disorder**)
- A. Chest pain, heart attack, heart murmur, heart trouble, rapid, slow or irregular heart beat, other diseases of the heart, circulatory system or blood vessels, varicose veins, phlebitis, anemia or other disorder of the blood? YES NO
  - B. Cancer, tumor or lymph node enlargement? (Indicate type of cancer and location \_\_\_\_\_ ) YES NO
  - C. Sexually transmitted disease? YES NO
  - D. Mental, emotional, nervous disorder, depression, anxiety, psychotherapy or counseling of any kind? YES NO
  - E. Brain disorder, neurologic problems, seizure disorder, any disorder of the central nervous system, stroke or paralysis? YES NO
  - F. Alcohol or drug use, abuse and/or dependency? YES NO
  - G. Medical diagnosis of AIDS (Acquired Immuno Deficiency Syndrome) or ARC (AIDS Related Complex)? YES NO
  - H. Any disorder of the male/female reproductive organs including infertility and complications of pregnancy? YES NO
  - I. Back, neck, bone, joint problems, Lupus, arthritis or autoimmune disorder? YES NO
  - J. Diabetes? If so, specify date of diagnosis, type of treatment, amount of medications (if any): \_\_\_\_\_ YES NO
- 
- K. Any disorder of the stomach, intestines, gallbladder or esophagus? YES NO
  - L. Any disorder of the lungs or respiratory system or Tuberculosis? YES NO
  - M. Any disorder of the kidneys, bladder or urinary tract? YES NO
  - N. Any disorder of the liver or pancreas? YES NO
  - O. Any disorder of the endocrine system or glands? YES NO

