



Your Individual Application Kit is enclosed

Here is a checklist to review before you return your application.

- Print clearly and complete the application in blue or black ink.
- If you make any changes while completing this form (for example, if you cross out something you wrote), be sure to **initial and date** those changes.
- If any **corrections** are needed or if the form is incomplete, the application may have to be returned to you, or we may try to call you, to obtain the necessary information. In that case, we will record your information on a form that will be attached to your application.
- You may request an effective date of the 1st or 15th of the month, unless you are requesting continuous coverage. Continuous coverage is defined as no lapse between the cancellation date of your current coverage and the effective date of the Anthem Blue Cross and Blue Shield (“Anthem”) coverage for which you are applying. Your application must be received by Anthem by the requested effective date in order to secure that date.
- The primary applicant and spouse, if applicable, must sign and date the application (bottom of page 10).**
- List the height and weight for each applicant.
- List the date of birth for each applicant.
- If you have had creditable health coverage in the past 63 days, please fill out Section I to apply for preexisting credit. Creditable Coverage is defined as prior coverage from a group plan, Medicare, Medicaid, health plan for active military personnel, including CHAMPUS, Indian Health Service, state risk pool, Federal Employees Health Benefits Program, state children’s health insurance program, public health plan, U.S. Government plans, foreign health plans, individual insurance policy or Peace Corps service. Prior coverage does not count as Creditable Coverage if there was a break of 63 days or more prior to applying for this coverage.
- Select the plan, deductible amount, Rx option and any applicable riders requested.
- Answer all health history questions in Section K. Failure to do so will delay the processing of your application.
- If you answered “yes” to any of the health history questions, give complete details on page 9.
- For Automatic Bank Draft, complete the Authorization located in Section H and include a **voided check**. We cannot accept deposit slips. (Your account will be drafted from the assigned effective date to the current billing date if your application is approved by Underwriting.)
- The initial premium is required with the application. Please provide your credit card authorization or bank draft per the instructions in Section H. If you pay by check, include your Social Security number on the front of the check, and affix the check to the front of the application.
- If you do not qualify for our regular plan because of your health, you might still qualify as a result of the **Health Insurance Portability and Accountability Act of 1996**. See Section 1, “HIPAA Eligibility and Program Selection,” on page 2. Individuals who qualify for HIPAA coverage are guaranteed acceptance. The benefits under your chosen HIPAA plan are the same regardless of whether you are a HIPAA or non-HIPAA member of that plan. The premium for a HIPAA plan is considerably higher than the premium for our regular plan.
- If you are enrolled in **both** Part A or Part B of Medicare, you are not eligible to apply for our regular individual products. If you are enrolled in **either** Part A or Part B of Medicare, you are not eligible to apply for a HIPAA program.

If you need assistance filling out the application, please contact your agent.

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

HIPAA Eligibility and Program Selection

To be eligible for a HIPAA program, you and any dependents listed on this application must meet all of the following requirements. (For more information, please refer to the enclosed sheet titled "HIPAA Information.") Complete the next 5 statements. Any time you check "Yes," write the name of each family member, including yourself, who meets that requirement.

1. I and any dependents listed have had at least 18 months of creditable coverage without a break in continuous coverage of more than 63 consecutive days.
 No, this is not true.
 Yes, this is true for: _____

 2. The most recent coverage that I and any listed dependents had was through a group, church or government health plan (other than Medicare, Medicaid or a State Health Insurance Pool) and it was not canceled due to fraud or failure to pay premiums.
 No, this is not true.
 Yes, this is true for: _____

 3. If I and any dependents listed were eligible for COBRA and/or state Continuation Coverage, we elected that coverage. In addition, we will have used up all of that coverage as of the date our HIPAA coverage becomes effective.
 No, this is not true.
 Yes, this is true for: _____
- If you and/or any dependents listed were not offered COBRA and/or advised of state Continuation Coverage, check "Yes" above and write the names here: _____
4. Neither I nor any dependents listed are eligible for coverage under a group plan, Medicare or Medicaid.
 No, this is not true.
 Yes, this is true for: _____

 5. Neither I nor any dependents listed have any other health coverage.
 No, this is not true.
 Yes, this is true for: _____

Not eligible: Any persons for whom you checked "No" in one or more of the 5 statements above are **not** eligible for a HIPAA program. For those persons, please continue to Section A.

Eligible: Any persons for whom you checked "Yes" for all 5 statements above **are** eligible for a HIPAA program. *They will be guaranteed acceptance and will not have any exclusions or any waiting periods for coverage of any preexisting conditions. But the premium will be higher than for a regular program. (If maternity coverage is purchased, it may not begin until after one year.) Please complete either A or B, below:*

A. I and any eligible dependents listed are applying only for a HIPAA program, with the options checked below:

- Options: Blue Access 100, \$1000 deductible, 100/60 coinsurance, Rx \$15/\$30/\$60/25% Optional Maternity Rider
 Blue Access 80, \$1000 deductible, 80/60 coinsurance, Rx \$15 Generic only Optional Maternity Rider
 Blue Preferred HMO 90, Rx \$15/\$30/\$60/25% Rx \$15 Generic only

Effective date options: Date application was received by Anthem Blue Cross and Blue Shield **or**
 Requested effective date:* _____ (mo/day/yr)

**The date you request must be the same as, or later than, the date your other coverage ended, but cannot be prior to our receipt of this application. If you completed A, please continue to Sections B, C, D, E, F, G, H, I, J, K, L, M, and N. In Section E, do not select a regular program. In Section B, you do not need to complete the height and weight information. You do not have to complete Sections A and E. Along with this application, submit your certification or a completed Attestation Form (provided on the enclosed "HIPAA Information" sheet).*

B. I and any eligible dependents listed qualify for a HIPAA program, but I am also applying for one of the regular programs (in Section E), which I understand may have waiting periods for coverage of preexisting medical conditions. I understand that, if I am accepted for the regular program, I/we will be enrolled in a HIPAA program. Also, if Anthem requires additional medical information, I/we will be enrolled in a HIPAA program while eligibility for a regular program is determined. If I am accepted in a regular program, but any health conditions and/or family member(s) are excluded, I understand that I and/or my family member(s) have the option of remaining in a HIPAA program. My/our effective date of coverage will be either the end date of my other coverage or the date Anthem received my completed application, whichever is later.

Missouri Individual Enrollment Application



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

Section A – Coverage Information

Application Type (select one): Change Anthem Individual policy coverage Add dependent(s) to current coverage
 New Coverage Policy No. _____ Policy No. _____

Effective date requested: If your application is approved, your coverage can start on the 1st or 15th of the month after the date we receive your application. **Please choose the date you would like your coverage to start:** Month _____ 1st 15th
 Or, if you are requesting continuous coverage or a future effective date, please enter the desired effective date: Date ____ / ____ / ____ MM/DD/YY
 Note: Please see cover page of application to see if you qualify for continuous coverage. You must enter the cancellation date of your current coverage in Section I.

Section B – Applicant Information

Risk Tier	Last Name	First Name	MI	Social Security Number*
Home Address (street and P.O. Box if applicable)				
City		State	Zip	County
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Height (Ft. / In.) /	Weight	Sex M F	Age
Date of Birth / /		Daytime Phone Number () ()		
Evening Phone Number () ()		E-mail (This information will not be shared with any third party.)		
Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		Tobacco Use: Have you used tobacco in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If cigarettes, how many do you smoke per day? _____		

Contraceptive Coverage Option: If your application is accepted, benefits for contraceptive drugs and devices may be included in your health care coverage unless you check the box below. (Checking this option will not affect your premium.)
 For moral, ethical or religious reasons, I do not want benefits for contraceptive drugs and devices for myself or any family members.

Section C – Spouse Information

Risk Tier	Last Name	First Name	MI	Relationship Spouse
Social Security Number*				
Height (Ft. / In.) /		Weight	Sex M F	Age
Date of Birth / /		Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		Tobacco Use: Have you used tobacco in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If cigarettes, how many do you smoke per day? _____		

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 unmarried children, or your spouse's unmarried children (to the end of the calendar year in which they turn 19 or to the end of the calendar year in which they turn 24 if they qualify as full-time students). (List all dependents beginning with the eldest.)

Risk Tier	First, MI (last name if different)	Relationship to Applicant	Social Security Number	Sex	Age	Date of Birth mm/dd/yyyy	Height Ft. / In.	Weight Lbs.	FT student
		Child		M F			/		Y N
		Child		M F			/		Y N
		Child		M F			/		Y N
		Child		M F			/		Y N

Risk Tier Key: Super Preferred (SP) Preferred (P1) Standard (S1), (S2) Modified (M1)

*This information is used for internal purposes only and will not be disclosed.

Anthem Blue Cross and Blue Shield is the trade name RightCHOICE® Managed Care, Inc. (RIT) and Healthy Alliance® Life Insurance Company (HALIC) use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC. RIT and HALIC are independent licensees of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Section E – Medical Coverage Select one plan, deductible, Rx option and any optional riders.

BLUE ACCESS CHOICE

(Only available to residents of the following counties: Franklin, Jefferson, St. Charles, St. Francois, St. Louis City, St. Louis, and Warren)

Blue Access Choice Value

Deductible (choose one)

- \$2,000 \$3,000
 \$5,000 \$10,000

Rx Options (choose one)

- \$15/\$30/\$60/25% (\$500 deductible)
 \$15 Generic only (\$500 maximum)
 Discount only

Blue Access Choice Economy

Deductible (choose one)

- \$1,000 \$1,500
 \$2,500 \$5,000

Rx Options (choose one)

- \$15/\$30/\$60/25% (\$500 deductible)
 \$15 Generic only (\$500 maximum)
 Discount only

Blue Access Choice 80[†] (deductibles—choose one)

- \$500 \$1,000 \$2,500 \$5,000 \$7,500

Blue Access Choice 90[†] (deductibles—choose one)

- \$250 \$500 \$1,000 \$2,500

Blue Access Choice 100[†] (deductibles—choose one)

- \$500 \$1,000 \$2,500 \$5,000 \$7,500 \$10,000

[†]Blue Access Choice 80/90/100 Rx Options/Riders

(Rx default is \$15 generic)

- \$15/\$30/\$60/25% \$15 Generic only
 \$15/\$30/\$60/25% (\$500 deductible) Optional Maternity Rider

BLUE ACCESS

(See brochure for service area.)

Blue Access Value

Deductible (choose one)

- \$2,000 \$3,000
 \$5,000 \$10,000

Rx Options (choose one)

- \$15/\$30/\$60/25% (\$500 deductible)
 \$15 Generic only (\$500 maximum)
 Discount only

Blue Access Economy

Deductible (choose one)

- \$1,000 \$1,500
 \$2,500 \$5,000

Rx Options (choose one)

- \$15/\$30/\$60/25% (\$500 deductible)
 \$15 Generic only (\$500 maximum)
 Discount only

Blue Access 80[†] (deductibles—choose one)

- \$500 \$1,000 \$2,500 \$5,000 \$7,500

Blue Access 90[†] (deductibles—choose one)

- \$250 \$500 \$1,000 \$2,500

Blue Access 100[†] (deductibles—choose one)

- \$500 \$1,000 \$2,500 \$5,000 \$7,500 \$10,000

[†]Blue Access 80/90/100 Rx Options/Riders

(Rx default is \$15 generic)

- \$15/\$30/\$60/25% \$15 Generic only
 \$15/\$30/\$60/25% (\$500 deductible) Optional Maternity Rider

- Blue Preferred HMO 90** Select one Rx option: \$15/\$30/\$60/25% \$15 Generic only

Section F – Dental Coverage

Anthem[®] Dental BlueSM

- Yes, I wish to add dental coverage (at an extra cost per individual)

If Yes, select ONE coverage type (applies to individuals listed on this application only):

- Applicant only Applicant, Spouse, and all dependent children listed
 Applicant & Spouse only Applicant & all dependent children listed

- Yes, if myself or any listed family member are declined for medical coverage, still enroll **all members selected above, if eligible.**

Section G – Term Life Insurance

Blue Preferred Term Life

- Yes, in addition to my medical coverage, I wish to apply for Term Life Insurance (at an extra cost per individual).

Provide information below.

Applicants must meet Anthem's Underwriting Guidelines to qualify for Term Life Insurance Coverage. Applicants under the age of one year are not eligible for Life Insurance. All Term Life policies terminate at age 65.

Applicants	Coverage Amount (select one)	Beneficiary**	Relationship	Beneficiary Street Address City/State/ZIP code
<input type="checkbox"/> Applicant	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000*	Primary:		
		Contingent:		
<input type="checkbox"/> Spouse	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000*	Primary:		
		Contingent:		
<input type="checkbox"/> Child(ren)	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000*	Primary:		
		Contingent:		

*The \$50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to \$25,000.

**If a beneficiary is not listed and a policy is issued, death benefits will be paid in accordance with the Beneficiary Provision of the Policy.

Section H – Billing Options

Frequency (select one)

- Monthly Quarterly
 Semi-annually Annually

Initial Premium (required)

- Bank Draft (see below)
 Check Enclosed (If paying by check, make the check payable to ABCBS.)
 Credit Card (see below)

Total amount enclosed/charged \$ _____

Method (select one)

- HOME**—Bills will be sent to your home billing address unless a separate billing address is listed below.

Name Address (street and P.O. Box if applicable) City State Zip

- AUTOMATIC BANK DRAFT** (automatic premium withdrawals)—your premium will be deducted on the same day of the month as your assigned effective date. (You **MUST** attach a **blank voided check**)

Deduct money from my/our account for (check one):

- My first payment only \$ _____ My first and ongoing payments
 My ongoing payments only (first payment made by other method)

I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. I understand that this authorization is in effect until I notify Anthem in writing that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals if they wish to do so.

Account holder's name (please print)

X

Account holder's signature (if other than the applicant)

X

Staple
blank, voided check here

Staple
blank, voided check here

- IF PAYING BY CREDIT CARD:** A credit card can be used only for this initial premium payment. If your application is accepted, you will be billed for future payments or you can call us to change to automatic bank withdrawal. Your credit card will not be charged unless you are approved for coverage. Please complete all the fields below.

Credit card information —

Cardholder's Name (as shown on the credit card): _____

Cardholders' Address: _____

If applicant is using the credit card of another cardholder: By signing this form, applicant represents and warrants that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for this payment and any charges accruing to it.

Type of Credit Card: VISA MasterCard Discover
 American Express

Authorization: I authorize Anthem Blue Cross and Blue Shield to charge the credit card indicated for the amount specified in **Initial Premium**.

Credit Card Number: _____

Applicant's Signature:

X

Expiration Date (month/year): _____ / _____

- NEW LIST BILL**—Billing through third-party (This option must have prior approval and requires separate List Bill forms to be completed and submitted with this application).

- CHANGE TO EXISTING LIST BILL** List Bill Arrangement Number: _____

Section I – Other Health Coverage

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

Did you or your eligible dependents have creditable coverage within the past 63 days? YES NO (you may be eligible for preexisting credit).
The following information must be completed in order for credit to be given. Please provide the previous 18 months of 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)		Reason for cancellation
Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Effective Date of Coverage	Cancellation Date of Coverage

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

Complete this section if you've had more than one carrier in the last 18 months (attach a separate sheet if necessary).

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

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

Section J – Healthy Lifestyle (optional)

You and your spouse may qualify for a better rate based on your lifestyle. Complete the section below if you would like to be considered for this special rate.

	Applicant		Spouse	
1. Have you been a non-tobacco user for three years or longer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you exercise regularly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you in excellent health with no ongoing medical conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Section K– Health History (IMPORTANT: This section has two steps)

Step 1: All applicants must answer all questions.

Questions 1–19: In his/her lifetime, have you or a listed family member had a symptom of, or been advised of, diagnosed with or treated for, any of the following conditions by a medical professional? Please circle all conditions that apply (such as Allergies).

	YES	NO		YES	NO
1. Alcoholism/Drug Dependency—Habit or have been convicted of driving while intoxicated or under the influence of a controlled substance.	<input type="checkbox"/>	<input type="checkbox"/>	11. Irregular heart beat, Mitral Valve Prolapse (MVP) or heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
2. Disease or disorders of the blood or circulatory system including anemia	<input type="checkbox"/>	<input type="checkbox"/>	12. Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Chronic <input type="checkbox"/> Alcoholic <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>
3. Cancer (skin or internal)	<input type="checkbox"/>	<input type="checkbox"/>	13. Kidney disease or disorders, including kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
4. Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	14. Liver disorders or disease (including Cirrhosis)	<input type="checkbox"/>	<input type="checkbox"/>
5. Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	15. Lung disorders or lung disease, including Emphysema, Tuberculosis, or Chronic Obstructive Pulmonary disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>
6. Diabetes or hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	16. Multiple Sclerosis, Amyotrophic Lateral Sclerosis (Lou Gehrig's) or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
7. Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	17. Muscular Dystrophy, Parkinson's Disease, Myotonia, or Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>
8. Epilepsy or seizure <input type="checkbox"/> Grand Mal <input type="checkbox"/> Petit Mal <input type="checkbox"/> Other Date of last seizure (mm/yyyy) _____	<input type="checkbox"/>	<input type="checkbox"/>	18. Disease or disorders of the Pancreas	<input type="checkbox"/>	<input type="checkbox"/>
9. Heart disease, disorder or heart surgery	<input type="checkbox"/>	<input type="checkbox"/>	19. Disease or disorders of the Spine or disc(s)	<input type="checkbox"/>	<input type="checkbox"/>
10. Heart attack, Angina, Aneurysm, Stroke or Transient Ischemic Attack (TIA)	<input type="checkbox"/>	<input type="checkbox"/>			

(continued)

Section K– Health History (continued)

Questions 20–45: Within the past 5 years, have you or a listed family member had a symptom of, or been advised of, diagnosed with or treated for, any of the following conditions by a medical professional? Please circle all conditions that apply (such as Allergies).

	YES	NO		YES	NO
20. Arthritis, Lupus or Gout	<input type="checkbox"/>	<input type="checkbox"/>	35. Migraines, chronic pain, fatigue, fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
21. Asthma or Allergies	<input type="checkbox"/>	<input type="checkbox"/>	36. Other nervous or mental conditions, including depression, bipolar disorder, obsessive-compulsive disorder, schizophrenia, mental retardation, or Alzheimer's	<input type="checkbox"/>	<input type="checkbox"/>
22. Attention Deficit Disorder (ADD/ADHD)	<input type="checkbox"/>	<input type="checkbox"/>	37. Organ transplant	<input type="checkbox"/>	<input type="checkbox"/>
23. Autism	<input type="checkbox"/>	<input type="checkbox"/>	38. Disease or disorder of the prostate	<input type="checkbox"/>	<input type="checkbox"/>
24. Anxiety, stress	<input type="checkbox"/>	<input type="checkbox"/>	39. Disease or disorder of the male or female reproductive system	<input type="checkbox"/>	<input type="checkbox"/>
25. Disease or disorders of the Bladder or Urinary Tract System	<input type="checkbox"/>	<input type="checkbox"/>	40. Neck pain or disorder, back pain or disorder or any treatment or evaluation for chiropractic treatment.	<input type="checkbox"/>	<input type="checkbox"/>
26. Bone, muscle or nerve diseases or disorders	<input type="checkbox"/>	<input type="checkbox"/>	41. Genital Warts, Herpes Simplex II, or other sexually transmitted disease(s)	<input type="checkbox"/>	<input type="checkbox"/>
27. High cholesterol/triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	42. Any disease or disorder of skin (acne, psoriasis) or nail fungus	<input type="checkbox"/>	<input type="checkbox"/>
28. Cyst, tumor growth, lymph node or gland disorder	<input type="checkbox"/>	<input type="checkbox"/>	43. Disease or disorders of the stomach or intestines (including ulcers, colitis or gastroesophageal reflux disease (GERD), and Irritable Bowel Syndrome)	<input type="checkbox"/>	<input type="checkbox"/>
29. Disease or disorders of the eyes, ears, nose, or throat, including sleep apnea	<input type="checkbox"/>	<input type="checkbox"/>	44. Surgery for obesity or any eating disorders	<input type="checkbox"/>	<input type="checkbox"/>
30. Disease or disorders of the gallbladder, including gallstones	<input type="checkbox"/>	<input type="checkbox"/>	45. Hyperthyroidism, hypothyroidism, goiter or other thyroid disease or disorders	<input type="checkbox"/>	<input type="checkbox"/>
31. Hernia <input type="checkbox"/> Hiatal <input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>			
32. Hypertension or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>			
33. Implant(s), prosthetic device(s), internal fixation device(s), retained hardware (i.e. pins, wires, screws, shunts, stents, pacemaker or valve replacements)	<input type="checkbox"/>	<input type="checkbox"/>			
34. Disease or disorders of the joints (hip, knees, shoulders, etc.)	<input type="checkbox"/>	<input type="checkbox"/>			

	YES	NO
46. Within the past 5 years , has any person to be covered had any of the following symptoms: unexplained weight loss, night sweats, persistent fever or cough, malaise, prolonged fatigue, chronic/recurrent skin rashes or lesions, recurrent episodes of diarrhea, lymph node enlargement, or unexplained recurrent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
47. Within the past 5 years , has any person to be covered been treated for, diagnosed by or consulted a physician, psychotherapist, counselor, or any other provider, for any illness, injury or medical abnormality not stated in questions 1–46?	<input type="checkbox"/>	<input type="checkbox"/>
48. Within the past 5 years , has any person to be covered had abnormal results in any of the following tests: blood work, laboratory results, X-Ray, EKG, blood flow studies, MRI scan, or CAT scan, for conditions you have not already described in this application?	<input type="checkbox"/>	<input type="checkbox"/>
49. Within the past 5 years , has any person to be covered had surgery, been confined in a hospital, or been treated in an emergency room for conditions you have not already described in this application?	<input type="checkbox"/>	<input type="checkbox"/>
50. In his or her lifetime , has any person to be covered ever tested positive for Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) or other immune system disorder?	<input type="checkbox"/>	<input type="checkbox"/>
51. Is any person to be covered currently taking medication or been prescribed medication by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
52. Currently are you, your spouse, or any dependent child(ren), even if not named in this application, an expectant parent?	<input type="checkbox"/>	<input type="checkbox"/>
Name/Relationship _____ Due Date: _____		
53. Has any person applying for coverage applied for disability or have a condition that is currently covered by Worker's Compensation?	<input type="checkbox"/>	<input type="checkbox"/>

Name/Relationship _____ Date: _____

Reason _____

Section K– Health History (continued)

54. Name, address and phone number of personal physician.

_____ Phone No. _____

55. Date last seen by physician: _____ Reason: _____

STEP 2: If you answered “YES” to any of the health history questions, give complete details (see the example below)

Question Number of “YES”	Patient First Name	Physician Name & Telephone (with area code)	Specific Diagnosis & Treatment	Name & Dosage of Medication & Dates of Use		Duration of Condition		Was Surgery Performed?		Description of Surgery/ Procedures & Date(s)	Current Status
				Begin mm/yy	End mm/yy	Begin mm/yy	End mm/yy	YES	NO		
Example #27	Mary	Dr. John Doe 555-555-1000	Tonsillitis	Amoxicillin 250 mg. 4x day 8/2002 9/2002		8/2002	9/2002	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy 09/2002	Good
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		

Section L – Application Agreement (Please read carefully.)

Please read this section carefully before signing the application.

1. I understand that it is mandatory that I notify Anthem, in writing, immediately if I (the applicant) or any other person for whom coverage is sought has a symptom of, or been advised of, diagnosed with or treated for any illness, injury or condition after the date I sign this application but before my coverage approval date. I understand that in this situation, Anthem has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members’ coverage might be rescinded, or delayed, or reformed or benefits denied due to the illness, injury or condition being treated as a preexisting condition.
2. I understand that sending my initial premium with this application, and the receipt of my payment by Anthem, does not mean that coverage has been approved. I understand that if my application is denied, my bank account or credit card will not be charged.
3. If my request for coverage is being handled by a producer, I understand that the producer is not authorized to waive a complete answer to any question in the application, pass on insurability, make or alter any contract or waive any of Anthems’ other rights or requirements.
4. I may not assign any payment under my Anthem program. I am applying for the coverage selected on this application. I understand that any premium quote provided is preliminary and review of my application by medical underwriting may change the premium or result in a denial of coverage. 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.

Section L – Application Agreement (continued)

5. **I understand that preexisting conditions are limited to 12 months after enrollment for conditions in existence within 12 months immediately prior to my enrollment for which medical advice, diagnosis, care or treatment was recommended or received. Pregnancy is considered a preexisting condition.*** (Does not apply to HIPAA and HMO programs.)
6. If the plan I purchase offers maternity coverage, and I purchase that coverage, I understand that 1) these benefits apply only to me or my covered spouse and not to any dependent child and 2) these benefits will not begin until after my membership has been in effect for one year. (Does not apply to Blue Preferred HMO 90.) **Note:** If a female applicant/spouse is approved for coverage, this waiting period will be waived if she is transferring directly from group coverage through Anthem that was in effect for 12 months or more with no break in coverage.
7. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
8. 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.
9. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
10. **I understand agree I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.**
11. If I purchase optional dental coverage, I understand that I will have a six-month waiting period for coverage of Basic services and a 12-month waiting period for coverage of Major services. *(For a description of Basic and Major services, please refer to your Marketing materials.)*
12. By signing this application I represent that I understand that Anthem Life has the right to deny my application for Term Life Coverage, and if it does, I will be notified in writing. I understand that if Anthem Life declines this coverage, no benefits will be payable. I understand that I alone am responsible for reading and accurately completing this application, and I must communicate any changes to my status. I also understand that all other conditions of my medical application apply for the life application.
13. I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem in accepting this application. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).
If tobacco use question in Section B or Section C is answered “NO”, I understand that the signature(s) below will attest to non-tobacco usage for the past 12 months.
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.

Signature of Applicant <i>(or Custodial Parent's or Guardian's signature if applicant is under age 18)</i> X	Date
Signature of Spouse <i>(if to be covered)</i> X	Date

Section M – Agent Certification

Agent Signature X	Date
Agent Name (please print)	Agent Email Address
Agent No.	Agent Phone No.
	Agent Fax No.



Anthem Blue Cross and Blue Shield is the trade name RightCHOICE[®] Managed Care, Inc. (RIT) and Healthy Alliance[®] Life Insurance Company (HALIC) use to do business in most of Missouri. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC. RIT and HALIC are independent licensees of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.