



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

**2. Membership Choice** Choose one membership type:  INDIVIDUAL  TWO PERSON  FAMILY

**3. Plan Choice** (Please select one deductible option. The Two Person/Family Deductibles are two times the Individual Deductible. All deductible options are calculated per calendar year.)

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

PCP Name:	First	Last	City	PCP Provider No.	Existing Patient YES NO <input type="checkbox"/> <input type="checkbox"/>
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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

**6. Billing Choice (Please Check One)**

Electronic Fund Transfer - complete section 7 and **attach a voided check or savings account deposit slip.**  Monthly Paper Bill

**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):  Checking Account (must attach voided check)  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 / /