Individual Application

Anthem Blue Cross

Reason for Application *(Check one)*

☐ Change your current plan/policy ☐ Add dependent(s) to existing plan/policy

Indicate subscriber's ID Number for existing Anthem Blue Cross plan and/or Anthem Blue Cross Life and Health Insurance Company policy: _____

NOTE: If you are adding a dependent or changing benefit options the effective date will always be the first of the month following approval.

Effective date requested: If your application is approved, Anthem will assign an effective date of coverage. The effective date assigned by Anthem may not be the same date as your requested effective date and requesting an effective date is not a guarantee that coverage will be effective on such date.

Please choose the date you would like your coverage to start: _____/_____/_____ MM/DD/YYYY

IMPORTANT: PREMIUM PAYMENT IS REQUIRED TO BE SUBMITTED WITH YOUR APPLICATION.

Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. Applications received with no premium payment will be returned which may impact your eligibility for coverage. If you have any questions, please call 1-800-333-0912.

1. Primary Applicant Information *(Please print)*

Last Name	First Name	M.I.	Social Security or ID No.* (required)	
Home Address (Must be complete: P.O. Box not acceptable.)**	City		State	ZIP
Mailing Address (If different than above) or P.O. Box Private Mail Box (PMB) No.	City		State	ZIP
Daytime Phone Number / Evening Phone Number	Fax Number		E-mail	

Marital Status
☐ Single ☐ Married ☐ Domestic Partnership

Language Choice (Optional) ☐ English (ENG) ☐ Spanish (SPA) ☐ Korean (KOR) ☐ Chinese (ZHO) (C/M) ☐ Vietnamese (VIE) ☐ Tagalog (TGL) ☐ Other (W09) _____

☐ 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 8).

Please provide your communication method of choice for all underwriting correspondence during the review of your application: ☐ E-mail ☐ Fax ☐ Mail

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

**All information will be mailed to your home address, including billing, private and confidential communications as defined by California law, unless you designate a different address under the "Mailing Address" field above. This will not impact rights you may have to invoke a separate Confidential Communication under the Health Insurance and Portability and Accountability Act ("HIPAA").

2. Choice of Anthem Blue Cross Plan and/or Anthem Blue Cross Life and Health Insurance Company Policy

Family members 19 years of age and older may select a different medical plan/policy by using the FamilyElect℠ option. To do so, refer to the 4-digit codes in parentheses below and indicate your medical benefit options in Section 3B for each family member.

If you want one medical plan/policy for all family members, please select a box below. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will enroll all eligible family members unless otherwise instructed.

☐ I, the Applicant, request that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company not enroll any eligible applicants unless ALL family members qualify.

If you are choosing **Dental** coverage, please complete the appropriate sections that follow.

Medical Benefit Options

Tonik	☐ 5000 (06BK)		
ClearProtection Plus	☐ 3300 (06B4)		
CoreGuard Plus	☐ 750 w Facility Copay (06B6)	☐ 1500 w Facility Copay (06B7)	☐ 2500 w Facility Copay (06B8)
	☐ 3500 (06B9)	☐ 5000 (06BA)	

Agent Name/TIN

2. Choice of Anthem Blue Cross Plan and/or Anthem Blue Cross Life and Health Insurance Company Policy – continued

Primary Applicant's Name _____

Medical Benefit Options

PPO Share	☐ 1000 (06BL)	☐ 3500 (06BX)*	☐ 5000 (06BZ)*
	☐ 7500 (06BY)*		
SmartSense Plus	☐ 2000 Standard Rx (01KC)	☐ 2000 Upgrade Rx (01KG)	☐ 3500 Standard Rx (01KD)
	☐ 3500 Upgrade Rx (01KH)	☐ 6000 Standard Rx (01KE)	☐ 6000 Upgrade Rx (01KJ)
Premier Plus	☐ 1000 (06BD)	☐ 1500 (06BE)	☐ 2500 (06BF)
	☐ 3500 (06BG)	☐ 5000 (06BH)	☐ 6000 (06BJ)

HSA Compatible Plans

Lumenos Plus HSA – Individual Only Policies	☐ 5950 (01KM)		
Lumenos Plus HSA – Family Policies	☐ 5500 Aggregate (01KP)	☐ 7500 Embedded (01KQ)	☐ 11900 Embedded (01KR)

If you have chosen a Health Savings Account (HSA) product, choose the following:

☐ **Yes**, I would like to establish an HSA. Please forward my information to Anthem Blue Cross' banking partner.

☐ **No, I DO NOT** want to establish an HSA. Please **DO NOT** forward my information to Anthem Blue Cross' banking partner.

HMO Plans

HMO	☐ Select HMO (06C2)*	☐ HMO Saver (06C1)*	☐ Individual HMO (06C0)*

Other To apply for a plan/policy not listed, write in the name here:

☐ _____

Dental Benefit Options

PPO Plans	☐ Dental Blue Basic (01PU)	☐ Dental Blue Enhanced (01PW)
	☐ Other _____	
Enhanced Tonik Dental	☐ PPO Dental (DR53)	
DHMO Plan	☐ Dental SelectHMO (ZE7N)†	
	Dental HMO Office Number _____	

Dental Select HMO plans are offered by Anthem Blue Cross. Dental Blue plans are offered by Anthem Blue Cross Life and Health Insurance Company.

* These products are administered by Anthem Blue Cross and are regulated by the California Department of Managed Health Care. All other products are administered by Anthem Blue Cross Life and Health Insurance Company and are regulated by the California Department of Insurance.

† If you are enrolling in any of the Anthem Blue Cross Dental SelectHMO plans, please enter the number of the Dental Office you have chosen in the space above. If I purchase optional dental benefits, I understand that I may have a waiting period for the coverage.

3. List ALL Applicants for Medical/Dental Benefit Options

Primary Applicant's Name_____

For Tonik and Lumenos Plus HSA Individual policies, each member will be enrolled on his/her own policy. All approved applicants will be assigned the same effective date of coverage as long as there is no break in coverage for any applicant.

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn 26).

(List all dependents beginning with the eldest.)

3A. For HMO Use Only Choose a provider for each family member by calling 1-866-297-7647 or from the Provider Directory, which can be found at www.anthem.com/ca

3B. Indicate Medical or Dental Benefit Option Code from Section 2 for each family member *(if different)*

Sex	Last Name First M.I.	Social Security or ID No.* (required)	Late Enrollee**	Birthdate mm/dd/yy	Height ft. in.	Weight lbs.	Select Coverage	PMG/ IPA***	Primary Care Physician (PCP)	Current Patient	3B.
☐ M ☐ F	Primary Applicant		☐ Yes ☐ No	/ /	|		☐ Medical ☐ Dental			☐ Yes ☐ No	
☐ M ☐ F	Spouse/Domestic Partner		☐ Yes ☐ No	/ /	|		☐ Medical ☐ Dental			☐ Yes ☐ No	
☐ M ☐ F	Dependent 1		☐ Yes ☐ No	/ /	|		☐ Medical ☐ Dental			☐ Yes ☐ No	
☐ M ☐ F	Dependent 2		☐ Yes ☐ No	/ /	|		☐ Medical ☐ Dental			☐ Yes ☐ No	
☐ M ☐ F	Dependent 3		☐ Yes ☐ No	/ /	|		☐ Medical ☐ Dental			☐ Yes ☐ No	
☐ M ☐ F	Dependent 4		☐ Yes ☐ No	/ /	|		☐ Medical ☐ Dental			☐ Yes ☐ No	

☐ 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.

My domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.

If a family member's last name is different from the primary applicant's last name, please explain: _____

_____

* *Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

** If an applicant under 19 qualifies as a Late Enrollee, please attach a copy of the completed Late Enrollee Questionnaire.

*** PMG = Participating Medical Group, IPA = Independent Practice Association

INSTRUCTIONS:

Primary Applicant - please complete and return Section 5, Health History page 7a (Primary Applicant) through page 10a (Primary Applicant).

Spouse/Domestic Partner - please complete and return Section 5, Health History page 7b (Spouse/Domestic Partner) through page 10b (Spouse/Domestic Partner).

Dependent 1 - please complete and return Section 5, Health History page 7c (Dependent 1) through page 10c (Dependent 1).

Dependent 2 - please complete and return Section 5, Health History page 7d (Dependent 2) through page 10d (Dependent 2).

If there are no Spouse/Domestic Partner, Dependent 1, or Dependent 2 applicants, you do not need to return Section 5, Health History pages indicated for those applicants.

If there are additional Dependent applicants (Dependent 3 or Dependent 4), please complete copies of Section 5, Health History, write by the page number if it is Dependent 3 or Dependent 4 and return with the other completed sections of the application.

3. List ALL Applicants for Medical/Dental Benefit Options – continued

Primary Applicant's Name_____

1. Has any person listed on this application lived (not traveled) outside the U.S. for the past three (3) consecutive months? ☐ Yes ☐ No

   If yes, who? _____

2. Are all applicants listed on this application legal residents of the United States and residents of the state in which you are applying for coverage? ☐ Yes ☐ No

   If no, who? _____

3. Are all applicants listed on this application United States citizens? ☐ Yes ☐ No

   If no, who _____

   and how many months/years have they resided in the United States? _____ years and _____ months

4. Prior Insurance History

Please answer ALL of the following questions.

Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company credits prior coverage toward the pre-existing period for those applicants who apply for coverage within 63 days after termination of qualifying prior coverage. To obtain credit toward the pre-existing waiting period, please complete the following questions. Pre-existing condition limitations do not apply to applicants under the age of nineteen (19) unless you are adding an applicant under the age of 19 to your coverage which was effective prior to March 23, 2010.

Pre-existing Conditions: For applicants age nineteen (19) and older, no payment will be made for services or supplies for the treatment of a pre-existing condition during a period of six (6) months following your Effective Date. However, we may apply Creditable Coverage to satisfy or partially satisfy the six (6) month period if you become eligible for coverage within 62 days of termination of your qualifying prior coverage (exclusive of any waiting or affiliation period), and you apply with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company no longer than 63 days after termination of your qualifying prior coverage. HMO medical plans do not have a pre-existing waiting period.

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1. Are any applicants eligible for Medicaid or Medicare? ☐ Yes ☐ No

   If yes, who? _____

   Please provide your Medicare or Medicaid Number _____

2. Has any applicant been previously insured by a Anthem Blue Cross plan or Anthem Blue Cross Life and Health Insurance Company policy? ☐ Yes ☐ No

   If yes, indicate Certificate No. _____

3. Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits or unable to work due to disability or receiving Workers' Compensation? ☐ Yes ☐ No

4. Has any applicant had health insurance coverage in the last 63 days? ☐ Yes ☐ No

   If yes, please provide the following information for each applicant below.

Applicant Name(s) OR ☐ All applicants	Insurer Name and Phone Number			Policyholder ID Number
Plan/Policy Name	State	Effective date of Coverage / /	Coverage End Date / /	Type of Coverage ☐ Group ☐ Individual ☐ Other
Reason for Cancellation				
Will you cancel this coverage if approved by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company? ☐ Yes ☐ No				
Applicant Name(s) OR ☐ All applicants	Insurer Name and Phone Number			Policyholder ID Number
Plan/Policy Name	State	Effective date of Coverage / /	Coverage End Date / /	Type of Coverage ☐ Group ☐ Individual ☐ Other
Reason for Cancellation				
Will you cancel this coverage if approved by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company? ☐ Yes ☐ No				

4. Prior Insurance History – continued

Primary Applicant's Name_____

The Health Insurance Portability and Accountability Act (HIPAA)

HIPAA Coverage

For HIPAA applicants, the effective date is determined by the date we receive payment. If payment is not received within 30 days, you will not be enrolled under the HIPAA plan applied for and will have no coverage. If your payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

While I understand that I am applying for an Individual plan/policy, if I do not qualify, I would like to be considered for benefits under HIPAA. . . . . ☐ Yes ☐ No

If yes, please provide the following information:

NOTE: HIPAA plans/polices are not underwritten and rates may be higher than the rates for Individual underwritten Plans/Policies. If you do not qualify for an underwritten individual Plan/Policy and do qualify for HIPAA coverage, Anthem will send to you complete details regarding your HIPAA plan/policy options and rates for each of your HIPAA plan/policy options. In order to enroll on a HIPAA plan/policy you will need to forward payment in the amount of the first month of premium for the selected HIPAA plan/policy. Payment submitted with this application will not be applied to a HIPAA plan/policy and any electronic payment authorization must be resubmitted.

If you have any questions regarding the HIPAA application process, please contact Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company customer service at 1-800-333-0912.

Name of Applicant(s) requesting HIPAA

1. Are you currently covered by or eligible for Medicaid, Medicare, or any other employer-sponsored health insurance benefits, or do you have other health insurance benefits? . . . . . ☐ Yes ☐ No

   If yes, you are not eligible for HIPAA.

2. Have you had a minimum of 18 months of continuous health coverage <u>most recently</u> under an employer-sponsored group health plan, ("employer" includes a governmental entity or church), that ended within the last 63 days for a reason other than fraud or non-payment of premium? . . . . . ☐ Yes ☐ No

   If yes, you will be asked to provide documentation of such coverage, preferably the Certificate of Coverage from your former employer or carrier OR a letter from the employer giving us the following:

   _____ _____/_____/_____ _____/_____/_____
   Name of Applicant | Effective Date *(Mo/Day/Yr)* | End Date *(Mo/Day/Yr)*

   _____ _____
   Name of insurance carrier(s): | Phone No.

   If no, you are not eligible for HIPAA.

3. Were you eligible for continuing coverage under COBRA or Cal-COBRA? . . . . . ☐ Yes ☐ No

   If yes, please provide the following: _____/_____/_____ _____/_____/_____
   Effective Date *(Mo/Day/Yr)* | End Date *(Mo/Day/Yr)*

   If no, please explain: _____

   _____

   If COBRA or Cal-COBRA is not exhausted, you are not eligible for HIPAA.

5. Health History

Primary Applicant's Name_____

Each applicant must complete a separate Health History Questionnaire. Applicants for HIPAA only do not need to complete Section 5. HIPAA law guarantees coverage.

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

NOTICE: Underwriting is the process whereby Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company determines if you are eligible for coverage. As part of this process, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company relies on the information you provide in this application to determine whether you are eligible for coverage. You must provide truthful and complete answers to the following questions to the best of your ability. Even if you have health coverage or had prior coverage with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, you must fully answer all health history questions. In addition to the information you provide in this application, we have the right to obtain and review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, you should not assume or take for granted that we will obtain and review all of your medical records before approving your application. Consistent with California law, if Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company issues coverage to you and later discovers that you committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact, we may rescind your coverage even after the contract has been issued. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may revoke your coverage. (See Rescission of Membership in Section 6).

All questions must be answered or the application will be returned. If you can not answer either "Yes" or "No" for a specific question, check the "Not Sure" box. For example, you can check the "Not Sure" box if you do not understand a medical term being used, are not sure whether you have or had a listed medical condition, cannot remember the exact timeframe when you had a medical condition, when you consulted with a physician, or do not recall or remember the information requested. For any question where you answer either "Yes" or "Not Sure" please provide the information requested in Section 5C. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may need to contact you and ask further questions regarding your "Yes" or "Not Sure" responses in order to process your application.

5A. Health History Questionnaire

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 5C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test, see Section 6 for HIV testing disclosure) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	☐	☐	☐
2. Within the last 5 years have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	☐	☐	☐
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Section 5D)	☐	☐	☐
4a. (This question applies to all females age 13 years and older) Has it been more than 40 days since your last menstrual period?	☐	☐	☐
4b. If you answered yes to 4a, check any reasons that apply			
A. Pregnant	☐	☐	☐
B. Due to birth control method	☐	☐	☐
C. Due to breast feeding	☐	☐	☐
D. Hysterectomy or menopause	☐	☐	☐
5. Are you pregnant or an expectant father, have you entered into a surrogate pregnancy agreement, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	☐	☐	☐
6. Do you have retained hardware, prosthesis or implants?			
A. Breast implants	☐	☐	☐
B. Eye/limb prosthesis	☐	☐	☐
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	☐	☐	☐
D. Joint replacement/internal or external fixations devices (pins, rods, screws, plates) neurostimulators	☐	☐	☐
E. Any other prosthesis or implant (other than dental)	☐	☐	☐

	YES	NO	NOT SURE
7. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Headaches requiring prescription medication	☐	☐	☐
B. Loss of consciousness	☐	☐	☐
C. Sleep apnea/breathing difficulties while sleeping	☐	☐	☐
D. Recurrent fainting, weakness or dizziness	☐	☐	☐
E. Paralysis or chronic limb weakness or numbness/tingling in limbs	☐	☐	☐
F. Chest pain	☐	☐	☐
G. Increased/irregular heart beat	☐	☐	☐
H. Low or high blood pressure	☐	☐	☐
I. High cholesterol	☐	☐	☐
J. Shortness of breath	☐	☐	☐
K. Heartburn (recurrent)	☐	☐	☐
L. Abnormal and/or recurrent bleeding (unrelated to menstruation)	☐	☐	☐
M. Recurrent diarrhea and/or recurrent vomiting	☐	☐	☐
N. Unexplained weight loss	☐	☐	☐
O. Blood, sugar, and/or protein in urine	☐	☐	☐
P. Recurrent pain (including back pain)	☐	☐	☐
Q. Jaundice	☐	☐	☐
R. Mass, cyst(s), or lump(s) in any body part including breast	☐	☐	☐

5A. Health History Questionnaire – continued

Primary Applicant's Name _____

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 5C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
8. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Abnormal Pap smear	☐	☐	☐
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	☐	☐	☐
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)	☐	☐	☐
D. Male infertility	☐	☐	☐
E. Female fertility/infertility	☐	☐	☐
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart valve, circulatory or blood disorder(s)	☐	☐	☐
G. Kidney, bladder or prostate disorder(s)	☐	☐	☐
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	☐	☐	☐
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	☐	☐	☐
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	☐	☐	☐
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	☐	☐	☐
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	☐	☐	☐
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	☐	☐	☐
N. Psoriasis, rosacea, acne or skin disorder(s)	☐	☐	☐
O. Cataract, glaucoma, eye or ear disorder(s)	☐	☐	☐
P. Diabetes, thyroid or endocrine (glandular) disorder(s)	☐	☐	☐
9. Within the last 5 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	☐	☐	☐
10. Within the last 5 years, have you been advised by a health care provider to reduce alcohol intake?	☐	☐	☐
11. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	☐	☐	☐
12. Within the last 5 years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in section 5C.)	☐	☐	☐
A. Obsessive Compulsive Disorder	☐	☐	☐
B. Minor depression	☐	☐	☐
C. Anxiety/panic disorder	☐	☐	☐
D. Attention Deficit Disorder (ADD/ADHD)	☐	☐	☐

	YES	NO	NOT SURE
13. In the last 10 years, have you been diagnosed with, had treatment or treatment recommended for any of the following?			
A. Schizophrenia, Major Depression/BiPolar Disorder	☐	☐	☐
B. Eating disorder	☐	☐	☐
C. Down's Syndrome	☐	☐	☐
D. Autism	☐	☐	☐
E. Cerebral Palsy	☐	☐	☐
14. Within the last 10 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to drug abuse?	☐	☐	☐
15. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	☐	☐	☐
16. Have you ever been diagnosed with hepatitis? (check all types that apply)			
A. Hepatitis A	☐	☐	☐
B. Hepatitis B	☐	☐	☐
C. Hepatitis C, D, E	☐	☐	☐
D. Hepatitis non A - E	☐	☐	☐
17. Have you ever been diagnosed with, or treated for any of the following?			
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment (except HIV treatment)	☐	☐	☐
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma	☐	☐	☐
18. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	☐	☐	☐
19a. Within the last 2 years, have you had any serious illness or serious physical injury not mentioned elsewhere on this application that has not been evaluated by a licensed health practitioner?	☐	☐	☐
19b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	☐	☐	☐
20. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	☐	☐	☐

5B. Other Health Questions

	YES	NO	NOT SURE
21. During the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco?	☐	☐	☐
22. Have you used marijuana within the last 2 years? (if yes, check appropriate box)	☐	☐	☐

☐ less than 4 times per month

☐ 5-7 times per month

☐ 8 or more times per month

	YES	NO	NOT SURE
23. Within the last 10 years, has any applicant used or is now using barbiturates, amphetamines, cocaine, heroin, or other narcotics, except as prescribed by a physician?	☐	☐	☐
24. Have you ever used illegal intravenous (IV) drugs?	☐	☐	☐

25. Please check the appropriate box below based on your average weekly consumption of alcoholic beverages over the past year. (One beverage equals 12 oz beer, 4 oz wine or 1 oz liquor.)

☐ 0 per week ☐ 1-14 per week ☐ 15-26 per week ☐ 27 or more per week

5C. Medical Details

Primary Applicant's Name ____________________

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: ____________________

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 5A and 5B.

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Internal Medicine ☐ Family ☐ Cardiac ☐ Other ________		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State	ZIP
			Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not know if you have the listed condition or symptom
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not understand the question
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Internal Medicine ☐ Family ☐ Cardiac ☐ Other ________		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State	ZIP
			Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not know if you have the listed condition or symptom
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not understand the question
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Internal Medicine ☐ Family ☐ Cardiac ☐ Other ________		
Name of Condition/Illness			Address		Suite No.
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If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
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Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

5C. Medical Details – continued

Primary Applicant's Name _____

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: _____

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 5A and 5B.

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other _____ ☐ Internal Medicine ☐ Cardiac _____	
Name of Condition/Illness			Address	Suite No.
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Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
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Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State / ZIP
			Phone Number	FAX Number *(Optional)*

If you answered "Not Sure" please check the box(es) that apply.

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_____

_____

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant.

☐ **No. of sheets attached**

5D. Prescription Medications

List all medications taken within the last 12 months by any family member listed on this application.

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Physician or Hospital
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone

☐ **Please check box if an additional sheet(s) of paper has been completed for this section.**

5A. Health History Questionnaire

Primary Applicant's Name_____

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

NOTICE: Underwriting is the process whereby Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company determines if you are eligible for coverage. As part of this process, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company relies on the information you provide in this application to determine whether you are eligible for coverage. You must provide truthful and complete answers to the following questions to the best of your ability. Even if you have health coverage or had prior coverage with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, you must fully answer all health history questions. In addition to the information you provide in this application, we have the right to obtain and review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, you should not assume or take for granted that we will obtain and review all of your medical records before approving your application. Consistent with California law, if Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company issues coverage to you and later discovers that you committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact, we may rescind your coverage even after the contract has been issued. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may revoke your coverage. (See Rescission of Membership in Section 6).

All questions must be answered or the application will be returned. If you can not answer either "Yes" or "No" for a specific question, check the "Not Sure" box. For example, you can check the "Not Sure" box if you do not understand a medical term being used, are not sure whether you have or had a listed medical condition, cannot remember the exact timeframe when you had a medical condition, when you consulted with a physician, or do not recall or remember the information requested. For any question where you answer either "Yes" or "Not Sure" please provide the information requested in Section 5C. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may need to contact you and ask further questions regarding your "Yes" or "Not Sure" responses in order to process your application.

5A. Health History Questionnaire

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 5C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test, see Section 6 for HIV testing disclosure) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	☐	☐	☐
2. Within the last 5 years have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	☐	☐	☐
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Section 5D)	☐	☐	☐
4a. (This question applies to all females age 13 years and older) Has it been more than 40 days since your last menstrual period?	☐	☐	☐
4b. If you answered yes to 4a, check any reasons that apply			
A. Pregnant	☐	☐	☐
B. Due to birth control method	☐	☐	☐
C. Due to breast feeding	☐	☐	☐
D. Hysterectomy or menopause	☐	☐	☐
5. Are you pregnant or an expectant father, have you entered into a surrogate pregnancy agreement, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	☐	☐	☐
6. Do you have retained hardware, prosthesis or implants?			
A. Breast implants	☐	☐	☐
B. Eye/limb prosthesis	☐	☐	☐
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	☐	☐	☐
D. Joint replacement/internal or external fixations devices (pins, rods, screws, plates) neurostimulators	☐	☐	☐
E. Any other prosthesis or implant (other than dental)	☐	☐	☐

	YES	NO	NOT SURE
7. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Headaches requiring prescription medication	☐	☐	☐
B. Loss of consciousness	☐	☐	☐
C. Sleep apnea/breathing difficulties while sleeping	☐	☐	☐
D. Recurrent fainting, weakness or dizziness	☐	☐	☐
E. Paralysis or chronic limb weakness or numbness/tingling in limbs	☐	☐	☐
F. Chest pain	☐	☐	☐
G. Increased/irregular heart beat	☐	☐	☐
H. Low or high blood pressure	☐	☐	☐
I. High cholesterol	☐	☐	☐
J. Shortness of breath	☐	☐	☐
K. Heartburn (recurrent)	☐	☐	☐
L. Abnormal and/or recurrent bleeding (unrelated to menstruation)	☐	☐	☐
M. Recurrent diarrhea and/or recurrent vomiting	☐	☐	☐
N. Unexplained weight loss	☐	☐	☐
O. Blood, sugar, and/or protein in urine	☐	☐	☐
P. Recurrent pain (including back pain)	☐	☐	☐
Q. Jaundice	☐	☐	☐
R. Mass, cyst(s), or lump(s) in any body part including breast	☐	☐	☐

(Spouse/Domestic Partner)

5A. Health History Questionnaire – continued

Primary Applicant's Name _____

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 5C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
8. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Abnormal Pap smear	☐	☐	☐
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	☐	☐	☐
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)	☐	☐	☐
D. Male infertility	☐	☐	☐
E. Female fertility/infertility	☐	☐	☐
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart valve, circulatory or blood disorder(s)	☐	☐	☐
G. Kidney, bladder or prostate disorder(s)	☐	☐	☐
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	☐	☐	☐
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	☐	☐	☐
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	☐	☐	☐
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	☐	☐	☐
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	☐	☐	☐
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	☐	☐	☐
N. Psoriasis, rosacea, acne or skin disorder(s)	☐	☐	☐
O. Cataract, glaucoma, eye or ear disorder(s)	☐	☐	☐
P. Diabetes, thyroid or endocrine (glandular) disorder(s)	☐	☐	☐
9. Within the last 5 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	☐	☐	☐
10. Within the last 5 years, have you been advised by a health care provider to reduce alcohol intake?	☐	☐	☐
11. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	☐	☐	☐
12. Within the last 5 years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in section 5C.)	☐	☐	☐
A. Obsessive Compulsive Disorder	☐	☐	☐
B. Minor depression	☐	☐	☐
C. Anxiety/panic disorder	☐	☐	☐
D. Attention Deficit Disorder (ADD/ADHD)	☐	☐	☐

	YES	NO	NOT SURE
13. In the last 10 years, have you been diagnosed with, had treatment or treatment recommended for any of the following?			
A. Schizophrenia, Major Depression/BiPolar Disorder	☐	☐	☐
B. Eating disorder	☐	☐	☐
C. Down's Syndrome	☐	☐	☐
D. Autism	☐	☐	☐
E. Cerebral Palsy	☐	☐	☐
14. Within the last 10 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to drug abuse?	☐	☐	☐
15. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	☐	☐	☐
16. Have you ever been diagnosed with hepatitis? (check all types that apply)			
A. Hepatitis A	☐	☐	☐
B. Hepatitis B	☐	☐	☐
C. Hepatitis C, D, E	☐	☐	☐
D. Hepatitis non A - E	☐	☐	☐
17. Have you ever been diagnosed with, or treated for any of the following?			
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment (except HIV treatment)	☐	☐	☐
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma	☐	☐	☐
18. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	☐	☐	☐
19a. Within the last 2 years, have you had any serious illness or serious physical injury not mentioned elsewhere on this application that has not been evaluated by a licensed health practitioner?	☐	☐	☐
19b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	☐	☐	☐
20. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	☐	☐	☐

5B. Other Health Questions

	YES	NO	NOT SURE
21. During the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco?	☐	☐	☐
22. Have you used marijuana within the last 2 years? (if yes, check appropriate box)	☐	☐	☐

☐ less than 4 times per month

☐ 5-7 times per month

☐ 8 or more times per month

	YES	NO	NOT SURE
23. Within the last 10 years, has any applicant used or is now using barbiturates, amphetamines, cocaine, heroin, or other narcotics, except as prescribed by a physician?	☐	☐	☐
24. Have you ever used illegal intravenous (IV) drugs?	☐	☐	☐

25. Please check the appropriate box below based on your average weekly consumption of alcoholic beverages over the past year. (One beverage equals 12 oz beer, 4 oz wine or 1 oz liquor.)

☐ 0 per week ☐ 1-14 per week ☐ 15-26 per week ☐ 27 or more per week

(Spouse/Domestic Partner)

5C. Medical Details

Primary Applicant's Name ______________________________

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: ______________________________

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 5A and 5B.

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Internal Medicine ☐ Family ☐ Cardiac ☐ Other ________
Name of Condition/Illness			Address / Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City / State / ZIP
			Phone Number / FAX Number *(Optional)*

If you answered "Not Sure" please check the box(es) that apply.

- ☐ Do not understand the medical term(s) used in the question
- ☐ Do not know if you have the listed condition or symptom
- ☐ Do not recall exact time when you consulted a health care provider or were hospitalized
- ☐ Do not understand the question
- ☐ Had the listed condition or symptom but cannot remember when
- ☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care
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Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Internal Medicine ☐ Family ☐ Cardiac ☐ Other ________
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Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

(Spouse/Domestic Partner)

5C. Medical Details – continued

Primary Applicant's Name _____

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: _____

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 5A and 5B.

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
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Name of Condition/Illness			Address	Suite No.
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_____

_____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other _____ ☐ Internal Medicine ☐ Cardiac _____	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State / ZIP
			Phone Number	FAX Number *(Optional)*

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
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Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

_____

_____

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☐ **No. of sheets attached**

5D. Prescription Medications

List all medications taken within the last 12 months by any family member listed on this application.

Family Member	**Medication/Dosage/Frequency** (i.e., Lopressor/100mg/daily)	**Illness for which Medication is Prescribed**	**Date Prescribed** (Mo/Day/Yr)	**Date Discontinued** (Mo/Day/Yr)	**Physician or Hospital**
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone

☐ **Please check box if an additional sheet(s) of paper has been completed for this section.**

5A. Health History Questionnaire

Primary Applicant's Name_____

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NOTICE: Underwriting is the process whereby Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company determines if you are eligible for coverage. As part of this process, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company relies on the information you provide in this application to determine whether you are eligible for coverage. You must provide truthful and complete answers to the following questions to the best of your ability. Even if you have health coverage or had prior coverage with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, you must fully answer all health history questions. In addition to the information you provide in this application, we have the right to obtain and review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, you should not assume or take for granted that we will obtain and review all of your medical records before approving your application. Consistent with California law, if Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company issues coverage to you and later discovers that you committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact, we may rescind your coverage even after the contract has been issued. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may revoke your coverage. (See Rescission of Membership in Section 6).

All questions must be answered or the application will be returned. If you can not answer either "Yes" or "No" for a specific question, check the "Not Sure" box. For example, you can check the "Not Sure" box if you do not understand a medical term being used, are not sure whether you have or had a listed medical condition, cannot remember the exact timeframe when you had a medical condition, when you consulted with a physician, or do not recall or remember the information requested. For any question where you answer either "Yes" or "Not Sure" please provide the information requested in Section 5C. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may need to contact you and ask further questions regarding your "Yes" or "Not Sure" responses in order to process your application.

5A. Health History Questionnaire

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 5C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test, see Section 6 for HIV testing disclosure) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	☐	☐	☐
2. Within the last 5 years have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	☐	☐	☐
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Section 5D)	☐	☐	☐
4a. (This question applies to all females age 13 years and older) Has it been more than 40 days since your last menstrual period?	☐	☐	☐
4b. If you answered yes to 4a, check any reasons that apply			
A. Pregnant	☐	☐	☐
B. Due to birth control method	☐	☐	☐
C. Due to breast feeding	☐	☐	☐
D. Hysterectomy or menopause	☐	☐	☐
5. Are you pregnant or an expectant father, have you entered into a surrogate pregnancy agreement, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	☐	☐	☐
6. Do you have retained hardware, prosthesis or implants?			
A. Breast implants	☐	☐	☐
B. Eye/limb prosthesis	☐	☐	☐
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	☐	☐	☐
D. Joint replacement/internal or external fixations devices (pins, rods, screws, plates) neurostimulators	☐	☐	☐
E. Any other prosthesis or implant (other than dental)	☐	☐	☐

	YES	NO	NOT SURE
7. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Headaches requiring prescription medication	☐	☐	☐
B. Loss of consciousness	☐	☐	☐
C. Sleep apnea/breathing difficulties while sleeping	☐	☐	☐
D. Recurrent fainting, weakness or dizziness	☐	☐	☐
E. Paralysis or chronic limb weakness or numbness/tingling in limbs	☐	☐	☐
F. Chest pain	☐	☐	☐
G. Increased/irregular heart beat	☐	☐	☐
H. Low or high blood pressure	☐	☐	☐
I. High cholesterol	☐	☐	☐
J. Shortness of breath	☐	☐	☐
K. Heartburn (recurrent)	☐	☐	☐
L. Abnormal and/or recurrent bleeding (unrelated to menstruation)	☐	☐	☐
M. Recurrent diarrhea and/or recurrent vomiting	☐	☐	☐
N. Unexplained weight loss	☐	☐	☐
O. Blood, sugar, and/or protein in urine	☐	☐	☐
P. Recurrent pain (including back pain)	☐	☐	☐
Q. Jaundice	☐	☐	☐
R. Mass, cyst(s), or lump(s) in any body part including breast	☐	☐	☐

5A. Health History Questionnaire – continued

Primary Applicant's Name _____

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 5C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
8. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Abnormal Pap smear	☐	☐	☐
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	☐	☐	☐
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)	☐	☐	☐
D. Male infertility	☐	☐	☐
E. Female fertility/infertility	☐	☐	☐
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart valve, circulatory or blood disorder(s)	☐	☐	☐
G. Kidney, bladder or prostate disorder(s)	☐	☐	☐
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	☐	☐	☐
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	☐	☐	☐
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	☐	☐	☐
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	☐	☐	☐
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	☐	☐	☐
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	☐	☐	☐
N. Psoriasis, rosacea, acne or skin disorder(s)	☐	☐	☐
O. Cataract, glaucoma, eye or ear disorder(s)	☐	☐	☐
P. Diabetes, thyroid or endocrine (glandular) disorder(s)	☐	☐	☐
9. Within the last 5 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	☐	☐	☐
10. Within the last 5 years, have you been advised by a health care provider to reduce alcohol intake?	☐	☐	☐
11. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	☐	☐	☐
12. Within the last 5 years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in section 5C.)	☐	☐	☐
A. Obsessive Compulsive Disorder	☐	☐	☐
B. Minor depression	☐	☐	☐
C. Anxiety/panic disorder	☐	☐	☐
D. Attention Deficit Disorder (ADD/ADHD)	☐	☐	☐

	YES	NO	NOT SURE
13. In the last 10 years, have you been diagnosed with, had treatment or treatment recommended for any of the following?			
A. Schizophrenia, Major Depression/BiPolar Disorder	☐	☐	☐
B. Eating disorder	☐	☐	☐
C. Down's Syndrome	☐	☐	☐
D. Autism	☐	☐	☐
E. Cerebral Palsy	☐	☐	☐
14. Within the last 10 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to drug abuse?	☐	☐	☐
15. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	☐	☐	☐
16. Have you ever been diagnosed with hepatitis? (check all types that apply)			
A. Hepatitis A	☐	☐	☐
B. Hepatitis B	☐	☐	☐
C. Hepatitis C, D, E	☐	☐	☐
D. Hepatitis non A - E	☐	☐	☐
17. Have you ever been diagnosed with, or treated for any of the following?			
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment (except HIV treatment)	☐	☐	☐
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma	☐	☐	☐
18. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	☐	☐	☐
19a. Within the last 2 years, have you had any serious illness or serious physical injury not mentioned elsewhere on this application that has not been evaluated by a licensed health practitioner?	☐	☐	☐
19b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	☐	☐	☐
20. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	☐	☐	☐

5B. Other Health Questions

	YES	NO	NOT SURE
21. During the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco?	☐	☐	☐
22. Have you used marijuana within the last 2 years? (if yes, check appropriate box)	☐	☐	☐

☐ less than 4 times per month

☐ 5-7 times per month

☐ 8 or more times per month

	YES	NO	NOT SURE
23. Within the last 10 years, has any applicant used or is now using barbiturates, amphetamines, cocaine, heroin, or other narcotics, except as prescribed by a physician?	☐	☐	☐
24. Have you ever used illegal intravenous (IV) drugs?	☐	☐	☐

25. Please check the appropriate box below based on your average weekly consumption of alcoholic beverages over the past year. (One beverage equals 12 oz beer, 4 oz wine or 1 oz liquor.)

☐ 0 per week ☐ 1-14 per week ☐ 15-26 per week ☐ 27 or more per week

5C. Medical Details

Primary Applicant's Name ______________________

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: ______________________

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 5A and 5B.

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Internal Medicine ☐ Family ☐ Cardiac ☐ Other ______		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State	ZIP
			Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not know if you have the listed condition or symptom
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not understand the question
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Internal Medicine ☐ Family ☐ Cardiac ☐ Other ______		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State	ZIP
			Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not know if you have the listed condition or symptom
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not understand the question
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Internal Medicine ☐ Family ☐ Cardiac ☐ Other ______		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State	ZIP
			Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not know if you have the listed condition or symptom
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not understand the question
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

(**Dependent 1**)

5C. Medical Details – continued

Primary Applicant's Name _____

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: _____

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 5A and 5B.

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other _____ ☐ Internal Medicine ☐ Cardiac _____	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State / ZIP
			Phone Number	FAX Number *(Optional)*

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not understand the question
☐ Do not know if you have the listed condition or symptom
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

_____

_____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other _____ ☐ Internal Medicine ☐ Cardiac _____	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State / ZIP
			Phone Number	FAX Number *(Optional)*

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not understand the question
☐ Do not know if you have the listed condition or symptom
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

_____

_____

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant.

☐ **No. of sheets attached**

5D. Prescription Medications

List all medications taken within the last 12 months by any family member listed on this application.

Family Member	**Medication/Dosage/Frequency** (i.e., Lopressor/100mg/daily)	**Illness for which Medication is Prescribed**	**Date Prescribed** (Mo/Day/Yr)	**Date Discontinued** (Mo/Day/Yr)	**Physician or Hospital**
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone

☐ **Please check box if an additional sheet(s) of paper has been completed for this section.**

5A. Health History Questionnaire

Primary Applicant's Name_____

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

NOTICE: Underwriting is the process whereby Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company determines if you are eligible for coverage. As part of this process, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company relies on the information you provide in this application to determine whether you are eligible for coverage. You must provide truthful and complete answers to the following questions to the best of your ability. Even if you have health coverage or had prior coverage with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, you must fully answer all health history questions. In addition to the information you provide in this application, we have the right to obtain and review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, you should not assume or take for granted that we will obtain and review all of your medical records before approving your application. Consistent with California law, if Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company issues coverage to you and later discovers that you committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact, we may rescind your coverage even after the contract has been issued. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may revoke your coverage. (See Rescission of Membership in Section 6).

All questions must be answered or the application will be returned. If you can not answer either "Yes" or "No" for a specific question, check the "Not Sure" box. For example, you can check the "Not Sure" box if you do not understand a medical term being used, are not sure whether you have or had a listed medical condition, cannot remember the exact timeframe when you had a medical condition, when you consulted with a physician, or do not recall or remember the information requested. For any question where you answer either "Yes" or "Not Sure" please provide the information requested in Section 5C. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may need to contact you and ask further questions regarding your "Yes" or "Not Sure" responses in order to process your application.

5A. Health History Questionnaire

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 5C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test, see Section 6 for HIV testing disclosure) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	☐	☐	☐
2. Within the last 5 years have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	☐	☐	☐
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (if yes, explain in Section 5D)	☐	☐	☐
4a. (This question applies to all females age 13 years and older) Has it been more than 40 days since your last menstrual period?	☐	☐	☐
4b. If you answered yes to 4a, check any reasons that apply			
A. Pregnant	☐	☐	☐
B. Due to birth control method	☐	☐	☐
C. Due to breast feeding	☐	☐	☐
D. Hysterectomy or menopause	☐	☐	☐
5. Are you pregnant or an expectant father, have you entered into a surrogate pregnancy agreement, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	☐	☐	☐
6. Do you have retained hardware, prosthesis or implants?			
A. Breast implants	☐	☐	☐
B. Eye/limb prosthesis	☐	☐	☐
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	☐	☐	☐
D. Joint replacement/internal or external fixations devices (pins, rods, screws, plates) neurostimulators	☐	☐	☐
E. Any other prosthesis or implant (other than dental)	☐	☐	☐

	YES	NO	NOT SURE
7. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Headaches requiring prescription medication	☐	☐	☐
B. Loss of consciousness	☐	☐	☐
C. Sleep apnea/breathing difficulties while sleeping	☐	☐	☐
D. Recurrent fainting, weakness or dizziness	☐	☐	☐
E. Paralysis or chronic limb weakness or numbness/tingling in limbs	☐	☐	☐
F. Chest pain	☐	☐	☐
G. Increased/irregular heart beat	☐	☐	☐
H. Low or high blood pressure	☐	☐	☐
I. High cholesterol	☐	☐	☐
J. Shortness of breath	☐	☐	☐
K. Heartburn (recurrent)	☐	☐	☐
L. Abnormal and/or recurrent bleeding (unrelated to menstruation)	☐	☐	☐
M. Recurrent diarrhea and/or recurrent vomiting	☐	☐	☐
N. Unexplained weight loss	☐	☐	☐
O. Blood, sugar, and/or protein in urine	☐	☐	☐
P. Recurrent pain (including back pain)	☐	☐	☐
Q. Jaundice	☐	☐	☐
R. Mass, cyst(s), or lump(s) in any body part including breast	☐	☐	☐

5A. Health History Questionnaire – continued

Primary Applicant's Name _____

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: _____

ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED. Give complete details in Section 5C for all questions answered "YES" or "NOT SURE."

	YES	NO	NOT SURE
8. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?			
A. Abnormal Pap smear	☐	☐	☐
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	☐	☐	☐
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)	☐	☐	☐
D. Male infertility	☐	☐	☐
E. Female fertility/infertility	☐	☐	☐
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart valve, circulatory or blood disorder(s)	☐	☐	☐
G. Kidney, bladder or prostate disorder(s)	☐	☐	☐
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	☐	☐	☐
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	☐	☐	☐
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	☐	☐	☐
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	☐	☐	☐
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	☐	☐	☐
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	☐	☐	☐
N. Psoriasis, rosacea, acne or skin disorder(s)	☐	☐	☐
O. Cataract, glaucoma, eye or ear disorder(s)	☐	☐	☐
P. Diabetes, thyroid or endocrine (glandular) disorder(s)	☐	☐	☐
9. Within the last 5 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	☐	☐	☐
10. Within the last 5 years, have you been advised by a health care provider to reduce alcohol intake?	☐	☐	☐
11. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	☐	☐	☐
12. Within the last 5 years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in section 5C.)	☐	☐	☐
A. Obsessive Compulsive Disorder	☐	☐	☐
B. Minor depression	☐	☐	☐
C. Anxiety/panic disorder	☐	☐	☐
D. Attention Deficit Disorder (ADD/ADHD)	☐	☐	☐

	YES	NO	NOT SURE
13. In the last 10 years, have you been diagnosed with, had treatment or treatment recommended for any of the following?			
A. Schizophrenia, Major Depression/BiPolar Disorder	☐	☐	☐
B. Eating disorder	☐	☐	☐
C. Down's Syndrome	☐	☐	☐
D. Autism	☐	☐	☐
E. Cerebral Palsy	☐	☐	☐
14. Within the last 10 years, have you participated in a treatment program, consulted with a health care provider, or been diagnosed with, or treated for symptoms related to drug abuse?	☐	☐	☐
15. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	☐	☐	☐
16. Have you ever been diagnosed with hepatitis? (check all types that apply)			
A. Hepatitis A	☐	☐	☐
B. Hepatitis B	☐	☐	☐
C. Hepatitis C, D, E	☐	☐	☐
D. Hepatitis non A - E	☐	☐	☐
17. Have you ever been diagnosed with, or treated for any of the following?			
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment (except HIV treatment)	☐	☐	☐
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma	☐	☐	☐
18. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	☐	☐	☐
19a. Within the last 2 years, have you had any serious illness or serious physical injury not mentioned elsewhere on this application that has not been evaluated by a licensed health practitioner?	☐	☐	☐
19b. Within the last 2 years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	☐	☐	☐
20. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	☐	☐	☐

5B. Other Health Questions

	YES	NO	NOT SURE
21. During the past 12 months, have you regularly smoked cigarettes, cigars, or pipes, or used any other form of tobacco?	☐	☐	☐
22. Have you used marijuana within the last 2 years? (if yes, check appropriate box)	☐	☐	☐

☐ less than 4 times per month

☐ 5-7 times per month

☐ 8 or more times per month

	YES	NO	NOT SURE
23. Within the last 10 years, has any applicant used or is now using barbiturates, amphetamines, cocaine, heroin, or other narcotics, except as prescribed by a physician?	☐	☐	☐
24. Have you ever used illegal intravenous (IV) drugs?	☐	☐	☐

25. Please check the appropriate box below based on your average weekly consumption of alcoholic beverages over the past year. (One beverage equals 12 oz beer, 4 oz wine or 1 oz liquor.)

☐ 0 per week ☐ 1-14 per week ☐ 15-26 per week ☐ 27 or more per week

5C. Medical Details

Primary Applicant's Name ______________________

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: ______________________

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 5A and 5B.

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other ______ ☐ Internal Medicine ☐ Cardiac ______		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State	ZIP
			Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not know if you have the listed condition or symptom
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not understand the question
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other ______ ☐ Internal Medicine ☐ Cardiac ______		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State	ZIP
			Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not know if you have the listed condition or symptom
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not understand the question
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care		
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other ______ ☐ Internal Medicine ☐ Cardiac ______		
Name of Condition/Illness			Address		Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State	ZIP
			Phone Number	FAX Number *(Optional)*	

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not know if you have the listed condition or symptom
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not understand the question
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

____

____

5C. Medical Details – continued

Primary Applicant's Name _____

Responses in sections 5A, 5B, 5C and 5D pertain to the following applicant: _____

Give COMPLETE details in all sections below of any "Yes" or "Not Sure" answers to the questions in Section 5A and 5B.

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other _____ ☐ Internal Medicine ☐ Cardiac _____	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State / ZIP
			Phone Number	FAX Number *(Optional)*

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not understand the question
☐ Do not know if you have the listed condition or symptom
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

_____

_____

Question # and Letter	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	
Date of Onset/Treatment *(Month/Year)*	Date Ended	☐ Still under treatment	Physician Specialty: ☐ Pediatric ☐ Family ☐ Other _____ ☐ Internal Medicine ☐ Cardiac _____	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* /and **Results** *(attach additional pages as needed to provide complete information)*			City	State / ZIP
			Phone Number	FAX Number *(Optional)*

If you answered "Not Sure" please check the box(es) that apply.

☐ Do not understand the medical term(s) used in the question
☐ Do not understand the question
☐ Do not know if you have the listed condition or symptom
☐ Had the listed condition or symptom but cannot remember when
☐ Do not recall exact time when you consulted a health care provider or were hospitalized
☐ Do not recall or remember the information

Please provide any additional information to provide a complete explanation of why you answered "Not Sure" *(attach additional pages as needed to provide complete information).*

_____

_____

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant.

☐ **No. of sheets attached**

5D. Prescription Medications

List all medications taken within the last 12 months by any family member listed on this application.

Family Member	**Medication/Dosage/Frequency** (i.e., Lopressor/100mg/daily)	**Illness for which Medication is Prescribed**	**Date Prescribed** (Mo/Day/Yr)	**Date Discontinued** (Mo/Day/Yr)	**Physician or Hospital**
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone
					Name Phone

☐ **Please check box if an additional sheet(s) of paper has been completed for this section.**

6. Application Understandings, Conditions and Agreement

Primary Applicant's Name_____

To the best of my information and belief, I, the applicant, am solely responsible to review and attest to the completeness and validity of information provided on this application. It is important that you carefully read and fully understand the following:

All Applicants

I, the undersigned, understand that under the Anthem Blue Cross plan and/or Anthem Blue Cross Life and Health Insurance Company policy in which I am enrolling, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician. Contact customer service at 1-866-297-7647 with any questions about the use of network providers and the financial impact of using out-of-network providers.

HIV Testing PROHIBITED:

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

CURRENT HEALTH COVERAGE:

If you currently have health coverage, we strongly recommend that you maintain your current coverage and request an effective date of 60 to 75 days from the date of application. This will help ensure that your application is processed before you surrender your present insurance.

IMPORTANT INFORMATION FOR APPLICANTS UNDER AGE 19 APPLYING FOR MEDICAL COVERAGE:

Applicants under age 19 may be assessed a 20% surcharge for a period not greater than 12 months if the applicant has not had continuous coverage during the 90 day period prior to the date of the application and is not a late enrollee.

Agreement *(all applicants)*

By applying for coverage, I, the undersigned, agree to the following:

1. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may decline my application. No coverage comes into effect until Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company at its discretion.
2. Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company nor any affiliated company shall have any liability to me or anyone else listed on it. If this application is not accepted, neither I nor anyone listed on it will be entitled to benefits or coverage from Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
3. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company underwriting policy or the terms of any Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company coverage.
4. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
5. In no event shall Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company or any affiliated company have any liability to the applicant if the application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by the Medical Underwriting Department of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
6. I understand Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.
7. If I purchase optional dental coverage, I understand that I may have a waiting period for the coverage of major services.
8. I understand that it is mandatory that I notify Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, in writing, immediately if I (the applicant) or any other person for whom coverage is sought received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date. I understand that in this situation, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be denied or delayed or reformed or, for applicants age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, benefits denied due to the illness, injury or condition being treated as a pre-existing condition.

6. Application Understandings, Conditions and Agreement – continued

Primary Applicant's Name_____

9. I understand and agree that I am applying for an individual health coverage policy which is not part of any employer-sponsored plan and the policy, if issued, shall not be used as an employer-sponsored health benefit plan. If the policy is issued, I understand and agree that I am responsible for 100% of the premium and I must ensure that premiums are paid timely. I certify that no employer of any person covered under this policy will pay any premium for this health coverage policy, directly or indirectly, through wage adjustments or otherwise. If my employer has agreed to remit my premium payment to Anthem Blue Cross/Anthem Blue Cross Life and Health on my behalf, my employer will not directly or indirectly contribute to that payment and will only forward to Anthem Blue Cross/Anthem Blue Cross Life and Health my premium payment that is directly funded by the regular wages paid to me by my employer.

10. ☐ By checking this box, I expressly consent to receive calls made by or on behalf of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliated companies, contractors, and vendors that use an automated dialing system or deliver prerecorded messages, including telemarketing sales calls that encourage the purchase of goods or services, to any of the telephone numbers I have provided in this Application. All calls made pursuant to this provision shall be limited to information regarding benefits, services or discounts available under health benefit plans offered or administered by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and its affiliated companies. I also understand that my consent to receive such calls is voluntary and may be discontinued by calling Anthem. The benefits available under health benefit plans offered or administered by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates will not be altered in any way if I do not consent to calls made under this provision.

11. I understand that my domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.

12. When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will be considered and applied only to the individual in question.

13. As part of the W-9 Certification required by the Internal Revenue Service, I certify that the SSN number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

Rescission of Membership

Every applicant age 18 or older acknowledges the following: I have provided true and complete answers to all questions in the application to the best of my knowledge and understand that all answers are important and will be considered in the acceptance or denial of this application. I understand that all information I know, that is responsive to a question on this application, must be provided in my answers consistent with California law. If Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company discovers that you committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is found in this application, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may rescind my plan/policy within the first 24 months from my effective date. I understand this means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will revoke my plan/policy as if it never existed back to the original Effective Date. Rescission may occur even if we review your medical records or seek medical confirmation of your health information as part of our processing of your application.

The primary applicant additionally acknowledges the following: All of my dependents listed on this application who are 18 years of age or older have read this application and have provided complete and accurate information for this application to the best of my knowledge and have signed the application below. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about all applicants, including my children under the age of 18, listed on this application is true and complete. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may deny or rescind the entire plan/policy if it discovers that you committed an act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is found in this application. Enrollees/insureds other than the individual(s) whose information led to the rescission on such plans/policies may be able to obtain coverage as set forth in the section **Eligibility following Rescission**.

I understand that if my plan/policy is rescinded, 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 benefits. I also understand that, consistent with California law, I will be required to pay for any services Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company paid on my behalf and that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will refund any premium paid by me, less my medical expenses that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company paid.

Eligibility following Rescission

For individual plans/policies that have been rescinded, eligible enrollees/insureds other than the individuals whose information led to the rescission on such plans/policies may continue coverage, without medical underwriting, in one of the following ways:

- enroll in a new individual plan/policy that provides equal benefits, or
- remain covered under the individual plan/policy that was rescinded.

In either instance, premium rates may be revised to reflect the number of persons on the plan/policy.

Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will notify in writing all enrollees/insureds of the right to coverage under an individual plan/policy, at a minimum, when it rescinds the individual plan/policy.

Eligible enrollees/insureds who continue coverage as a result of a rescinded plan/policy may be subject to completing the pre-existing condition exclusion period that was not fulfilled on the rescinded plan/policy. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will credit any time that the eligible Insured was covered under the rescinded plan/policy. The time period in the new plan/policy for the pre-existing condition exclusion period will not be longer than the one in the plan/policy that was rescinded.

Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will provide 60 days for enrollees to accept the offered new individual plan/policy and this contract shall be effective as of the effective date of the original plan/policy and there shall be no lapse in coverage.

To the best of my information and belief, I have personally read and attest to the completeness and validity of the information provided on this application. If I am accepted, this application will become part of the plan contract/policy between Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and me. I, and any enrolled family members, agree to abide by the terms of that plan contract/policy. With the exception of minors and persons for whom this application has been interpreted (a signed Statement of Accountability must be attached, see Section 8) all persons applying for coverage agree that they have personally answered all health history questions directed to them. If an Applicant does not read English, the interpreter must sign and submit a Statement of Accountability for interpreting this entire application (see Section 8).

REQUIREMENT FOR BINDING ARBITRATION

YOU AND ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN /POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF 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. ***It is understood that any dispute including disputes relating to the delivery of services under the plan/policy and/or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*** **YOU, ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN YOUR OR ITS INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.**

Applicant/Parent or Legal Guardian	Today's Date	Applicant's Spouse/Domestic Partner	Today's Date
✗		✗	
Applicant's Dependent age 18 or over	Today's Date	Applicant's Dependent age 18 or over	Today's Date
✗		✗	

IMPORTANT: ALL APPLICANTS AGE 18 AND OVER MUST PERSONALLY READ, AGREE TO, SIGN AND DATE THIS APPLICATION.

7. Authorization for Use of Protected Health Information

Primary Applicant's Name_____

NOTE: This form is not required if you are ONLY applying for HIPAA coverage.

By signing below:

I authorize Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, the MIB, Inc. (MIB) and/or insurance support organizations. I further authorize Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company to disclose protected health information it may collect about me to Consumer Reporting Agencies, MIB, Inc. and/or insurance support organizations for the purpose of fraud and abuse detection for this Application and for eligibility for benefits.

YOU HAVE THE RIGHT TO REQUEST HEALTH INFORMATION THAT MIB, INC. MAY HAVE ABOUT YOU AT NO EXPENSE TO YOU BY CALLING 1-866-692-6901.

I also authorize any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans, medical or pharmacy benefit administrators, Consumer Reporting Agencies, MIB, Inc., and/or insurance support organizations to furnish any medical records or health history information concerning me and any family member listed on my Application to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company. This information is needed to determine eligibility for coverage and Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company's acceptance of coverage requested for myself and/or any family members listed on my Application or so that a determination of coverage regarding a claim for specified benefits can be made.

I understand that my application will not be considered if this form is not signed and returned with my completed Application if I am initially applying for acceptance in a medically underwritten health plan/policy offered by Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or signed and returned with my completed Change of Coverage Form if I wish to add a family member or upgrade my coverage in the future. This Authorization will expire 24 months following Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company's acceptance of coverage, if not previously revoked.

I understand that I may revoke this Authorization at any time while Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company is determining eligibility for the coverage requested. To do so, I must submit a completed Authorization Revocation Form to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company. An Authorization Revocation Form is available by calling 1-866-297-7647, going to our website, www.anthem.com/ca, or writing to: Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9041, Oxnard, CA 93031. If I revoke this Authorization after I initially apply for coverage, I understand that I/we will not be considered by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company for acceptance in one of its medically underwritten health plans/policies. If I revoke this Authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. The information disclosed pursuant to this authorization may be subject to redisclosure by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its agents and, in some circumstances, may no longer be protected by federal regulations governing the privacy of health information.

Printed name of Applicant/Member	Signature of Applicant/Member or his/her Legal Representative	Date
	X	

Printed name of Spouse/Domestic Partner or Dependent Child age 18 or over listed on Application	Signature of Spouse/Domestic Partner or Dependent Child* or his/her Legal Representative	Date
	X	

Printed name of Spouse/Domestic Partner or Dependent Child age 18 or over listed on Application	Signature of Spouse/Domestic Partner or Dependent Child* or his/her Legal Representative	Date
	X	

**If listed on your Application or Change Form, your spouse/domestic partner and each dependent child age 18 or over must sign above.*

If a legal representative signs on behalf of the applicant or spouse or domestic partner, a copy of the legal representative's authority must be attached to the application.

A photocopy of this form will be as valid as the original.
You or an authorized representative have the right to receive a copy of this Authorization upon request.

8. Statement of Accountability

Primary Applicant's Name_____

To be completed when the applicant cannot complete the application.

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

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

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English ☐ Applicant is Limited English Proficient

☐ Other (explain): _____

I interpreted 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 interpreted and fully explained the "Application Understandings, Conditions and Agreement," the "Authorization for Use of Protected Health Information" and the "Payment Method."

Signature of Interpreter *(Required)*	Today's Date *(Required)*
✗	

I confirm that the application was interpreted on my behalf.

Signature of Applicant *(Required)*	Today's Date *(Required)*
✗	

Language interpreted (e.g. Spanish):

TO BE COMPLETED BY ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY-APPOINTED AGENT

1. Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting? If yes, please attach explanation. ☐ Yes ☐ No
2. Did you see the proposed subscriber (and spouse/domestic partner, if applying) at the time this application was executed? ☐ Yes ☐ No

   If no, please explain: _____
3. I certify that, to the best of my knowledge and belief, the responses herein are accurate.
4. Please check one of the following and complete the information below:

   ☐ I have not had any interactions whatsoever with this applicant either by phone, e-mail or in person and did not provide any information, advise or assist the applicant in any manner in providing answers or responses to any questions in the application.

   ☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code Section 1389.8(c)/Insurance Code Section 10119.3.

Signature of Agent *(Required)*	Date *(Required)*
✗	

Name of Agent (Print Name)		Agent Street Address / Suite No. / Personal Mail Box (PMB) No.	
Agent ID Number	Sub-Agent ID Number	City/State/ZIP	Location No.
Phone Number	FAX Number	E-mail	

Mail ID Cards to: ☐ Agent ☐ Primary Applicant

PLEASE NOTE: If neither box is checked, the Service Agreement will be mailed directly to the primary applicant.

Agent: Please mail this application to the following address:

Anthem Blue Cross
P.O. Box 9041
Oxnard, CA 93031-9041

OR **Fax to: 1-800-327-9255**

Anthem Blue Cross

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