Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: (818) 987-5000 Fax: (818) 776-9865

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction or paper bill).

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy

18375 Ventura Blvd. # 226

Tarzana, CA 91356

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.

If you have questions please contact our office at: (818) 987-5000

Thank you for choosing...

Anthem

Individual Enrollment Application—Colorado

Anthem

The following are offered by Anthem Blue Cross and Blue Shield: BluePreferred PPO plans, HSA-qualified high-deductible health PPO plans, RightPlan PPO 40 plans, short-term PPO plans, dental PPO and term life products.

Applicant Social Security or ID Number

Promotion Code

Reason for Application (Check one)

☐ New enrollment(s) ☐ Changing your current Anthem Blue Cross and Blue Shield plan
☐ Adding dependent(s) to existing plan (indicate subscriber's ID number for existing plan: _____)

1. Applicant Information (please print)

Primary Applicant Last Name **First Name** **M.I.**	Marital Status ☐ Single ☐ Married	Spouse Social Security or ID Number
Home Address (must be complete; P.O. box not acceptable)	Maiden Name of Applicant/Spouse	
City State ZIP Code	Contact Phone Number a.m. p.m.	
Mailing Address (*if different than above*) or P.O. Box Personal Mail Box (PMB) Number	Fax Number	If possible, do you want e-mail notification? ☐ Yes ☐ No
City State ZIP Code	E-mail Address	
Has any person listed on this application lived (not traveled) outside the U.S. for the past three consecutive months? ☐ Yes ☐ No		
When information is sent to you, we may be able to send it in a language other than English. What language would you prefer? *(optional)* ☐ English ☐ Spanish		

2. Choice of Anthem Blue Cross and Blue Shield Individual Coverage

You may select a different health plan for each family member by using the FamilyElect option. To do so, refer to the four-digit health plan codes in parentheses below and indicate your health care coverage choices in Section 3B for each family member. Would you like all family members on one bill? ☐ Yes ☐ No

If you want one health plan for all family members, please select a box below.
Anthem Blue Cross and Blue Shield will enroll all eligible family members unless otherwise instructed.

☐ I, the applicant, request that Anthem Blue Cross and Blue Shield not enroll any eligible applicants unless ALL family members qualify.

If you are choosing **dental** coverage or **term life insurance**, please complete the appropriate sections that follow.

HEALTH AND DENTAL COVERAGE

☐ BluePreferred 500/5000 (BK84)	☐ High-deductible Health Plan 1250 100% (CQ95)	☐ High-deductible Health Plan 3000 80% (CR03)
☐ BluePreferred 1000/5000 (BK85)	☐ High-deductible Health Plan 2000 100% (CQ96)	☐ High-deductible Health Plan 4000 100% (CR04)
☐ BluePreferred 2000/5000 (BK86)	☐ High-deductible Health Plan 2500 100% (CQ97)	☐ High-deductible Health Plan 5000 100% (CR05)
☐ BluePreferred 500/10,000 (BK88)	☐ High-deductible Health Plan 3000 100% (CQ98)	☐ RightPlan PPO 40-No Rx (DL93)
☐ BluePreferred 1000/10,000 (BK89)	☐ High-deductible Health Plan 1250 80% (CQ99)	☐ RightPlan PPO 40-Generic Rx (DL94)
☐ BluePreferred 2000/10,000 (BK90)	☐ High-deductible Health Plan 2000 80% (CR00)	☐ RightPlan PPO 40-Comprehensive Rx (DL95)
☐ BluePreferred 3000/10,000 (CQ94)	☐ High-deductible Health Plan 2500 80% (CR02)	☐ Anthem Blue Individual PPO Dental Plan (DE12)

3. List ALL Applicants for Health/Dental Coverage

Please include health plan code in Section 3B.
If a family member's last name is different than the primary applicant's, please explain: _____
For RightPlan PPO 40, each member will be enrolled on his/her own policy.

MUST BE ACCURATE

Sex	**Last Name** **First Name** **M.I.**	**Social Security or ID Number**	**Birthdate**	**Height**	**Weight**	**Dental Coverage**	**3B.** Indicate health plan code from Section 2 for each family member (if different)
☐ M ☐ F	Primary Applicant		/ /			☐ Yes ☐ No	
☐ M ☐ F	Spouse		/ /			☐ Yes ☐ No	
☐ M ☐ F	Dependent		/ /			☐ Yes ☐ No	
☐ M ☐ F	Dependent		/ /			☐ Yes ☐ No	
☐ M ☐ F	Dependent		/ /			☐ Yes ☐ No	

I understand that all children listed above who are between the ages of 19 through 24 must either reside with me or be financially dependent on me. Initial: ____

4. Anthem Blue Preferred Term Life™ Insurance

TERM LIFE COVERAGE

Applicants and/or any dependents who are approved for health coverage will also qualify for Anthem Life insurance at an additional charge. Applicants under the age of one year are not eligible for life insurance. **DO NOT SUBMIT PREMIUM FOR LIFE INSURANCE.**

Family Member Name	Birthdate mm/dd/yyyy	Amount of Benefit Circle One	Beneficiary Name	Beneficiary Social Security Number	Relationship	Allocation	% of Allocation
	/ /	$15,000, $25,000, $50,000				Primary Contingent	%
	/ /	$15,000, $25,000, $50,000				Primary Contingent	%
	/ /	$15,000, $25,000, $50,000				Primary Contingent	%
	/ /	$15,000, $25,000, $50,000				Primary Contingent	%

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

If a beneficiary is not listed on the policy, death benefits will be paid according to the beneficiary provision in the policy.

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5. Prior Insurance History—Please answer ALL of the following questions.

Anthem Blue Cross and Blue Shield credits prior coverage toward the pre-existing period for applicants who apply and are accepted for coverage and who request an effective date within 90 days after termination of qualifying prior coverage as required by law. To obtain credits for the pre-existing period, please complete the following:

A. Do you currently have health care coverage? ☐ Yes ☐ No
B. Have you had coverage in the last 90 days? ☐ Yes ☐ No
C. Were you insured within the last 63 days? ☐ Yes ☐ No
D. If applicable, do you intend to replace your current accident and sickness insurance with this policy? ☐ Yes ☐ No
E. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No
   a. as a specified low income medicare beneficiary (SLMB)
   b. as a qualified Medicare beneficiary (QMB)
   c. for other Medicaid health care benefits

Additional Prior Coverage Information

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

If you answered "Yes" to any of the above, please provide the following information:

Certificate/Policyholder Number	Plan Name	State	Most Recent Coverage Start Date	Type of Policy
Applicant Names			Date Policy Paid Through	
Certificate/Policyholder Number	Plan Name	State	Most Recent Coverage Start Date	Type of Policy
Applicant Names			Date Policy Paid Through	

Applicant Social Security or ID Number

6. Health History

6A. Health History Questionnaire—**ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.**
Give **COMPLETE** details for any "Yes" answers below in Section 6B on the following page.

1. Has any applicant had a physical exam or any diagnostic test or screening test such as blood tests, X-rays, CAT scans, MRIs, mammograms, etc. within the past 60 days? ☐ Yes ☐ No
2. Has any applicant discussed or been advised to have testing, treatment, therapy or surgery that has not yet been completed? ☐ Yes ☐ No
3. Has any applicant been prescribed or taken any prescribed medication within the past 12 months except for birth control pills or short-term (10 days or less) antibiotics? ☐ Yes ☐ No
4. Has it been more than 40 days since any female applicant's last menstrual period? ☐ Yes ☐ No
   Name(s): _____ ☐ Applicant/spouse ☐ Dependent
   If yes, explain _____
5. Has any applicant been diagnosed, treated, evaluated for or experienced any male/female genital/gynecological or reproductive problem(s), including infertility, prostatitis, endometriosis or abnormal PAP within the past five years? ☐ Yes ☐ No
6. Has any applicant been evaluated or treated for or experienced breast cysts or lumps within the past two years? ☐ Yes ☐ No
7. Is any applicant an expectant parent? ☐ Yes ☐ No
8. Has any applicant had or been treated for herpes, HPV or any other sexually transmitted disease (STD) within the past five years? ☐ Yes ☐ No
9. Has any applicant been treated for any mental, emotional or behavioral disorder, including anorexia, attention deficit disorder or depression, within the past 10 years? ☐ Yes ☐ No
10. Has any applicant been hospitalized within the past 10 years for any mental, emotional or behavioral disorder? ☐ Yes ☐ No
11. Has any applicant been diagnosed with or treated or evaluated for symptoms related to alcoholism and/or use or abuse of alcohol within the past 10 years? ☐ Yes ☐ No
12. Has any applicant used illegal drugs, IV drugs or been treated for drug abuse within the past 10 years? ☐ Yes ☐ No
13. Has any applicant been diagnosed with or treated or evaluated for or experienced any of the following within the past six months?
    - A. Allergy injections ☐ Yes ☐ No
    - B. Increased and/or irregular heartbeat ☐ Yes ☐ No
    - C. Heartburn (recurrent) and/or reflux ☐ Yes ☐ No
    - D. Paralysis ☐ Yes ☐ No
    - E. Abnormal bleeding ☐ Yes ☐ No
    - F. Recurrent diarrhea and/or excessive vomiting ☐ Yes ☐ No
    - G. Unexplained weight loss ☐ Yes ☐ No
    - H. Loss of consciousness and/or fainting ☐ Yes ☐ No
    - I. Blood and/or sugar in urine ☐ Yes ☐ No
    - J. Persistent and/or intense pain ☐ Yes ☐ No
14. Does any applicant have any implants or prostheses? ☐ Yes ☐ No
15. Has any applicant been diagnosed with or incurred charges, received treatment, had treatment recommended, consulted a health care professional, or taken prescription drugs for any of the following within the past 10 years:
    - A. AIDS/ARC; evaluated for or recommended ANTIVIRAL treatment ☐ Yes ☐ No
    - B. Heart/circulatory/bleeding disorders, including chest pain, hypertension, high cholesterol ☐ Yes ☐ No
    - C. Diabetes or other endocrine (glandular) disorders ☐ Yes ☐ No
    - D. Kidney/gall bladder/stomach/intestinal disorders, including colitis, diverticulitis, GERD or ulcers ☐ Yes ☐ No
    - E. Hepatitis and/or liver disorders ☐ Yes ☐ No
    - F. Hernia/hemorrhoid/rectal disorders ☐ Yes ☐ No
    - G. Muscle/bone/tendon/joint/back/injuries or disorders ☐ Yes ☐ No
    - H. Multiple sclerosis, migraine headaches, convulsions, Parkinson's disease or other brain/nervous disorders ☐ Yes ☐ No
    - I Congenital heart or other birth defects/congenital disorders ☐ Yes ☐ No
    - J. Emphysema, asthma, bronchitis or other respiratory disorders ☐ Yes ☐ No
16. Has any applicant had or been treated for cancer or a malignant tumor within the past 10 years? ☐ Yes ☐ No
17. In the past 10 years has any applicant been diagnosed with or incurred charges, received treatment, had treatment recommended, consulted a health care professional or taken prescription drugs for any condition(s) not listed elsewhere on this application? ☐ Yes ☐ No
18. Has any applicant been hospitalized or treated in the emergency room within the past 12 months (except for pregnancy)? ☐ Yes ☐ No
19. In the past 12 months, has/is any applicant considered/considering any hospitalization or medical or surgical treatment? ☐ Yes ☐ No
20. Has any applicant smoked cigarettes, cigars or pipes or used chewing tobacco within the past 12 months? ☐ Yes ☐ No

Family member's name(s):

I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I have personally reviewed and answered all health questions correctly. I understand that if I provided incomplete or false material information, Anthem Blue Cross and Blue Shield may cancel my membership as if it never existed, and I will be personally responsible for all medical and pharmacy claims.

Initial _____

Applicant Social Security or ID Number

6B. Other Health Questions

Professional Services

Give COMPLETE details in all sections below for any "Yes" answers to the questions in Section 6A.

	Name of Family Member (as identified on physician record)	Name of Hospital, Clinic and/or Person Providing Care	Phone number
Date Treatment Started (month/year)	Date Ended	☐ Still Under Treatment	
Name of Condition/Illness			
Results of Treatment Rendered (i.e., X-ray, lab, surgical procedure, prescribed medications, etc.)			

	Name of Family Member (as identified on physician record)	Name of Hospital, Clinic and/or Person Providing Care	Phone number
Date Treatment Started (month/year)	Date Ended	☐ Still Under Treatment	
Name of Condition/Illness			
Results of Treatment Rendered (i.e., X-ray, lab, surgical procedure, prescribed medications, etc.)			

	Name of Family Member (as identified on physician record)	Name of Hospital, Clinic and/or Person Providing Care	Phone number
Date Treatment Started (month/year)	Date Ended	☐ Still Under Treatment	
Name of Condition/Illness			
Results of Treatment Rendered (i.e., X-ray, lab, surgical procedure, prescribed medications, etc.)			

	Name of Family Member (as identified on physician record)	Name of Hospital, Clinic and/or Person Providing Care	Phone number
Date Treatment Started (month/year)	Date Ended	☐ Still Under Treatment	
Name of Condition/Illness			
Results of Treatment Rendered (i.e., X-ray, lab, surgical procedure, prescribed medications, etc.)			

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. **Number of sheets attached**

6C. Prescription Medications

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

Applicant Social Security or ID Number

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (mm/dd/yy)	Date Discontinued (mm/dd/yy)	Name, Phone Number of Physician or Hospital
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____

7. The Health Insurance Portability and Accountability Act (HIPAA)

If you can answer "yes" to all of the following statements, you may meet the definition of a "federally eligible individual." To qualify as a "federally eligible individual," you must answer yes to all of the following:

1. In the past 18 months, I have had creditable coverage, the most recent of which was under a group health plan (including a government plan or church plan).
   If "yes," group name _____ Telephone number _____
2. I am **NOT** eligible for coverage under a group health benefit plan, Medicare or Medicaid and do **NOT** have other health benefit plan coverage.
3. My most recent coverage was **NOT** terminated as a result of nonpayment of premium or fraud.
4. If offered, I accepted continuation coverage and exhausted such benefits (i.e., State Continuation Coverage or COBRA).

Date State Continuation or COBRA coverage ended (Month/Day/Year) _____

Names of members covered _____

Do you or anyone on this application qualify for HIPAA? ..... ☐ Yes ☐ No

Names of qualified applicant(s)

1) _____

2) _____

3) _____

4) _____

8. Application Understandings, Conditions and Agreement

Applicant Social Security or ID Number

IMPORTANT: It is important that you carefully read and fully understand the following. All applicants age 18 and over must personally read, agree to and sign the following.

I, the undersigned, understand that under the Anthem Blue Cross and Blue Shield plan for which I am applying, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use an in-network hospital or physician.

Effective Date

REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING WILL BE COMPLETED BEFORE THE DATE REQUESTED.

☐ If Anthem Blue Cross and Blue Shield approves my application, please assign an effective date of _____.
The effective date must be after the signature date but not greater than 75 days from the signature date on this application.

☐ If Anthem Blue Cross and Blue Shield approves my application, please assign an effective date of the first day after Anthem Blue Cross and Blue Shield approval.
Please note: If you are changing existing Anthem coverage, your effective date will always be the first of the month following approval.

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

Agreement

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

1. Anthem Blue Cross and Blue Shield may decline my application. No coverage comes into effect until Anthem approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Anthem 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 nor any affiliated company shall have any liability to me or anyone else listed on it, except for the obligation to return the money submitted with this application. If this application is not accepted, I will not be entitled to benefits or coverage from Anthem.
3. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross and Blue Shield underwriting policy or the terms of any Anthem 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 Blue Shield or any affiliated company have any liability to the applicant if the application is not approved, except for the obligation to return the money submitted with this application if this 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 Anthem.
6. I understand Anthem Blue Cross and Blue Shield may use any information prior to the effective date of coverage in considering my application, including medical conditions that occur after my signature and before the original effective date.
   I agree to update Anthem in writing with any additional medical history which relates to any of the preceding questions and of which I became aware after the date of this application, but before the effective date of coverage.

Rescission of Membership

I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if I provided incomplete or false material information, Anthem Blue Cross and Blue Shield may revoke my coverage. This means Anthem may cancel membership as if it never existed. Also, after approval for membership, if incomplete or false material information is discovered by Anthem that was not provided to Anthem prior to the effective date of the policy, the plan may revoke coverage.

I understand that if my coverage is revoked, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for enrollment. I also understand that I may be required to pay for any claims that were paid while a member and that Anthem will refund all amounts paid by me except amounts owed to Anthem.

I have personally read and completed this application. If I am accepted, this application will become part of the contract between Anthem Blue Cross and Blue Shield and me. I agree to abide by the terms of that contract.

***Requirement for Binding Arbitration*:**

I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF AND ANTHEM BLUE CROSS AND BLUE SHIELD OR ITS AFFILIATE, INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS COLORADO LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND ANTHEM BLUE CROSS AND BLUE SHIELD OR ITS AFFILIATES ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. ANTHEM BLUE CROSS AND BLUE SHIELD OR ITS AFFILIATES AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR POLICY.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE VOLUNTARILY AGREEING TO HAVE ANY DISPUTE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL
***Signature (Required)* – IMPORTANT: All applicants over age 18 must sign and date. A parent or legal guardian must sign and date if applicant is under 18.**

Applicant/Parent or Legal Guardian	Today's Date	Applicant's Spouse	Today's Date
Applicant's Dependent, Age 18 or Older	Today's Date	Applicant's Dependent, Age 18 or Older	Today's Date

Applicant Social Security or ID Number

9. Payment Method (Premium payment required. Please choose from A or B.)

A. Please choose from the options below for your initial premium payment:

☐ Paper Check* ☐ Electronic Check *(complete Section 9E)* ☐ Credit/Debit Card *(complete Section 9D)*

B. Please choose from the following options for future payments.

☐ Monthly Checking Account Automatic Premium Payment *(complete Section 9C)* ☐ Monthly Credit/Debit Card *(complete Section 9D)* ☐ Bi-monthly Paper Billing

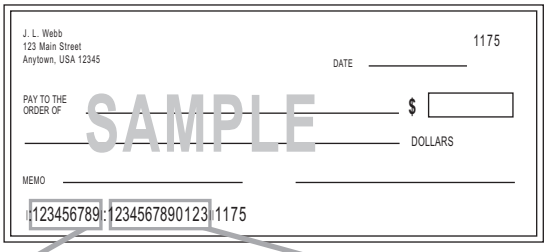
☐ Monthly Paper Billing ☐ Quarterly Paper Billing—submit the three-month premium

9C. Monthly Checking Account Automatic Premium Payment

By providing your check information to the right, you authorize us to electronically debit your bank account. If you have not sent in an initial premium payment from choice A, your bank account will be debited one month's premium the day after approval. This will include all products selected, including dental and/or life. Subsequent premium amounts will be debited on the day you request below.

Requested debit day: ☐☐ **(1st to 28th of each month)**
If no date is requested, your premiums will be debited on the first of each month.

Provide your routing and account numbers here.



As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during underwriting, and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross and Blue Shield to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross and Blue Shield premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from monthly checking account automatic premium payment and will be billed monthly.

You will incur a $25 service charge for any withdrawal not honored.

Authorized Signature *(as it appears in the financial institution's records)*	Account Holder Name PRINT	Date
X		

9D. Monthly Credit/Debit Card

As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the initial payment amount may vary as a result of change(s) during underwriting, and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

☐Visa ☐ MasterCard ☐Discover

Card Number: Expiration Date: Cardholder ZIP Code:

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐/☐☐ ☐☐☐☐☐–☐☐☐☐

(13 or 16 digits)

Authorized Signature *(as it appears on the credit card)*	Cardholder Name *(as it appears on the credit card)* PRINT	Date
X		

9E. Electronic Check

In lieu of sending a paper check, we can submit this same information electronically. You will need to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

Account Holder Name PRINT	Bank Routing Number	Account Number	Amount	Check Number
			$	

** By sending your paper check, you authorize us to convert your check to an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.*

10A. Determination of Self-employed Business Group of One

Applicant Social Security or ID Number

1. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees? . . . . . Self ☐ Yes ☐ No
   . . . . . Spouse ☐ Yes ☐ No
2. Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage? . . . . . Self ☐ Yes ☐ No
   . . . . . Spouse ☐ Yes ☐ No
3. Do you have gross income from your self-employment or sole proprietorship as indicated on federal Internal Revenue Service forms 1040, Schedule C, F or SE, or other forms recognized by the federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out the past three years? Note: "Substantial part of your income" means income derived from business activities of the business group of one that are sufficient to pay for the annual premiums for the business group of one's health benefit plan. . . . . Self ☐ Yes ☐ No
   . . . . . Spouse ☐ Yes ☐ No
4. Do you work a minimum of 24 hours a week on a permanent basis? . . . . . Self ☐ Yes ☐ No
   . . . . . Spouse ☐ Yes ☐ No

I (print name), _____, attest that the answers to the questions about self-employed business group of one in the above section are true and correct.

Signature of Applicant	**Date**

Spouse's Statement

I (print name), _____, attest that the answers to the questions about self-employed business group of one in the above section are true and correct.

Signature of Spouse (if applying for coverage)	**Date**

If you or your spouse answered "Yes," to all four questions above, please complete section B.

10B. If you waive coverage for a family member who will not be covered under this policy, you must list the other coverage for the dependent and when it became effective.

Full Name	Name of Other Coverage	Effective Date of Other Coverage (mm/dd/yy.)
Spouse		
Dependent		
Dependent		

10C. I, (print name) _____, meet the definition for a self-employed business group of one as attested to in the Determination of Self-employed Business Group of One, Section A of this application. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic or other small group health benefit plan from a small employer carrier for a period of three years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three-year period. I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, the carrier's overall cost and utilization trends, the underwriting methodology used to evaluate individual coverage, my age, my family size, and a factor that reflects the cost of care where I live. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier's overall cost and utilization trends ("index rate"), my age, my family size, and a factor that reflects the cost of care where I live. I have been given a Colorado Health Plan Description Form showing the benefits under Colorado's small group Standard Health Benefit Plans. I have also been given a Colorado Health Plan Description Form for the plan for which I am applying. Applicant's Statement

TO BE COMPLETED BY YOUR ANTHEM BLUE CROSS AND BLUE SHIELD-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 might have a bearing on the risk? ☐ Yes ☐ No
   If yes, please attach explanation.
2. Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed? ☐ Yes ☐ No
   If no, please explain: _____

To the extent not already identified in Section 3 of this application, I have listed in an attachment to this application any other accident or sickness policies I have sold to the applicants in the past five years. With respect to those policies listed on the attachment, I will also identify those that are currently in force.

Signature of Agent *(required)*	Date *(required)*
X	

3. **Breakdown of Funds Collected:**
   Total Health Funds $ _____
   Total Dental Funds $ _____
   Total Funds Collected $ _____

4. Was the term life insurance option selected? *(If yes, first term life insurance payment will be billed.)* ☐ Yes ☐ No

Name of Agent (print name)		Agent Street Address Suite Number/Personal Mail Box (PMB) Number	
Oleg Skurskiy		18375 Ventura Blvd. # 226	
Agent ID Number	Sub-agent ID Number	City/State/ZIP Code	Location Number
BCLNGNPVMZ		Tarzana, CA 91356	
Phone Number	Fax Number	E-mail Address	
(818) 987-5000	(818) 776-9865	oleg@askoleg.com	

Mailing Address: **Agent:** Please mail this application to the following address: **Anthem Blue Cross and Blue Shield • P.O. Box 173334 • Denver, CO 80217-9411**

Applicant Social Security or ID Number									

Authorization for Use of Protected Health Information

By signing below:

I authorize Anthem Blue Cross and Blue Shield, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield, to obtain any medical records (but not including psychotherapy notes) from any physicians, hospitals and/or other health care providers concerning my care and the care of any family member listed on my Individual Enrollment Application.

I also authorize any physicians, hospitals and/or other health care providers to furnish any medical records (but not including psychotherapy notes) concerning my care and the care of any family member listed on my Individual Enrollment Application to Anthem Blue Cross and Blue Shield, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield. This information is needed to determine eligibility for the coverage requested for myself and/or any family members listed on my Individual Enrollment Application.

I understand that the entities indicated above may request medical records for up to the past 10 years, and this information will be used to determine whether I and my listed family members are eligible for enrollment in the coverage requested.

I understand that this form must be signed and returned with my completed Individual Enrollment Application if I am initially applying for enrollment in a medically underwritten health plan offered by Anthem Blue Cross and Blue Shield or its affiliate, Anthem Life 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. This authorization will expire when determination is completed regarding my/our eligibility for coverage.

I understand that I may revoke this authorization at any time while Anthem Blue Cross and Blue Shield is determining eligibility for the coverage requested. To do so, I must submit a completed Authorization Revocation Form to Anthem Blue Cross and Blue Shield. An Authorization Revocation Form is available by writing to: Anthem Blue Cross and Blue Shield, P.O. Box 173334, Denver, CO 80217-9411. 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 Blue Shield for enrollment in one of its medically underwritten health plans. 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.

Printed Name of Applicant/Member	Signature of Applicant/Member or His/Her Personal Representative	Date

Printed Name of Spouse or Dependent Child Age 18 or Over Listed on Application	Signature of Spouse/Dependent Child* or His/Her Personal Representative	Date

Printed Name of Spouse or Dependent Child Age 18 or Over Listed on Application	Signature of Spouse/Dependent Child* or His/Her Personal Representative	Date

**If listed on your Individual Enrollment Form, your spouse and each dependent child age 18 or over must sign above.*

If this authorization is signed by a personal representative on behalf of the applicant/member, spouse and/or dependent child(ren), the representative must complete the following:

Printed Name of Personal Representative	Relationship to Applicant/Member, Spouse and/or Dependent Child(ren)	Date

A photocopy of this form will be as valid as the original.
You have the right to receive a copy of this authorization upon request.