



Anthem Blue Cross and Blue Shield
Attn: List Bill Coordinator/KY 0303-A655
13550 Triton Park Boulevard
Louisville, KY 40223-7810
FAX: 502-889-3210

Permission to Provide List Bill Arrangement

By signing this Permission to Provide List Bill Arrangement form, I certify that:

- ✓ I understand I am applying for, or have existing, Individual health coverage through Anthem Blue Cross and Blue Shield (“Anthem”).
- ✓ I acknowledge that I understand, if I am applying for new coverage, I (and my dependents), if any, will be medically underwritten and, if accepted for coverage, I (and my dependents), if applicable, will be issued an Anthem Individual health coverage policy.
- ✓ I further understand that neither Anthem nor my employer (Third Party) intend for the Individual health coverage policy for which I am applying to be employer sponsored coverage.
- ✓ I understand that I am not applying for an employer sponsored health plan and the Individual health coverage policy list billing arrangement is being offered to me as a convenience.
- ✓ I acknowledge I understand that I am responsible for 100% of the premium payment, and I am also responsible to ensure that my premiums are paid.
- ✓ This is Individual coverage. It is not dependant on employment and is guaranteed renewable.
- ✓ Anthem has no obligation to guarantee coverage in the event that coverage lapses due to the List Bill Administrator’s failure to submit payment by the due date.
- ✓ Upon termination of the List Bill Arrangement, Anthem will send future bills to the subscriber monthly.
- By checking this box, I confirm that my employer is **NOT** contributing any money toward my Individual health premium through wage adjustments, reimbursements or otherwise. Only personal monies are being used to pay the premium.

Upon issuance of an Anthem Individual health coverage policy, I hereby give Anthem Blue Cross and Blue Shield permission to send a bill to:

_____ at _____
Third Party Address - Street, City, State and ZIP Code

that includes my Anthem Individual health coverage policy. I understand that my name, Social Security number and/or Subscriber Identification number and the premium I owe for my Individual health coverage policy will be included on the bill referenced above. I further understand that the bill may include the same information applicable to other Anthem Individual health coverage subscribers who agree to this List Bill Arrangement. I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified above. I also understand this authorization is voluntary and that the third party will not condition my treatment, payment, or enrollment or eligibility for benefits on signing this authorization.

I have the right to revoke this authorization at any time by giving written notice of my revocation to the third party. I understand that my revocation will not affect any action taken before my written revocation notice is received. I also understand that information disclosed may be subject to re-disclosure by the recipient in which case it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this authorization.

Expiration Date, If not previously revoked, this authorization will terminate on the earliest of the following dates: The date my coverage ends (only if disclosure requested by insurance company); or upon the termination of employment.

Permission to Provide List Bill Arrangement (continued)

Applicant Name (please print)

Applicant Social Security Number

Applicant's Signature

Date

I have explained the terms and conditions listed above to the List Bill participant, including but not limited to the requirement that no employer contributions may be made directly or indirectly toward the premium through wage adjustments, reimbursement or otherwise. The insured has represented to me that only the insured's personal money is being used to pay the premium.

Writing Agent (please print)

Agent Number

Writing Agent (signature)

Date

Third Party

- Contracts are issued in the subscribers' names because these are contracts between Anthem and the subscriber.
- Refund checks will be made out to the subscriber and mailed to the billing address.
- Third Party and subscriber paperwork must be completed prior to setting up a List Bill Arrangement, no exceptions.
- Each subscriber must be advised that his or her Individual contract does not terminate if employment ends provided the premiums are paid.

Employer must authorize that they do not contribute directly or indirectly through wage adjustments, reimbursements or otherwise to the premium of any employee or such employee's dependent.

Employer Name

Parent Group Number (for existing List Bill only)

Employer Signature

Date

**- IMPORTANT -
DO NOT CANCEL ANY EXISTING HEALTH COVERAGE UNTIL YOU
HAVE BEEN NOTIFIED BY ANTHEM THAT THIS HEALTH COVERAGE IS IN EFFECT**

Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross and Blue Shield of Wisconsin ("BCBSWI") underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation ("CompCare") underwrites or administers the HMO policies; and CompCare and BCBSWI collectively underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

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