

# Ohio Blue Short Term<sup>SM</sup> Individual Enrollment Application

(Provided through a Group Trust Insurance Policy)



Please print clearly in ink, or type.

Section A – Applicant Information						
Last name of applicant			First name		Middle initial	
Home address: Street			City		State	ZIP code
County		Home phone (include area code)			Social Security Number*	
Date of birth / /	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Height (Ft./In.) /	Weight (Lbs.)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
Are all persons applying for coverage legal residents of the United States and residents of the state in which you are applying for coverage? (If No, attach a copy of your green card or visa.) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No						

Section B – Coverage Desired													
Deductible level desired:		Type of coverage desired:			Term (months):								
<input type="checkbox"/> \$250	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$2,500	<input type="checkbox"/> Single	<input type="checkbox"/> Parent/Children	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
Effective date requested: If your application is approved, your coverage can start on any day of the month after the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.													
Please choose the date you would like your coverage to start: ____/____/____ MM/DD/YYYY													
During the term of this plan, will you or any dependent become eligible for Medicare, turn age 65, or will any dependent turn age 25 or no longer be eligible for coverage? (Dependents are eligible to the end of the calendar month in which they turn 25. When no longer eligible, dependents may apply for their own temporary coverage.) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No													
If Yes, who? _____													

Section C – Dependent Information								
Applicant information must be completed for all dependents (if any) for whom coverage is being requested. An eligible dependent may be your spouse, domestic partner, your unmarried children, or your spouse's or domestic partner's unmarried children (to the end of the calendar month in which they turn age 25). (List all dependents beginning with the eldest.)								
First name	Middle initial	Last name (if different from applicant)	Social Security Number*	Height Ft./In.	Weight Lbs.	Birthdate mm/dd/yyyy	Sex	Relationship to applicant
							M <input type="checkbox"/> F <input type="checkbox"/>	
							M <input type="checkbox"/> F <input type="checkbox"/>	
							M <input type="checkbox"/> F <input type="checkbox"/>	
							M <input type="checkbox"/> F <input type="checkbox"/>	
If there are additional dependents, please attach a separate page with all requested information.								

## Section D – Other Coverage Information

Will this coverage replace a previous short-term or temporary plan? .....  Yes  No

**If Yes, previous identification number:** \_\_\_\_\_ **Policy expiration date:** \_\_\_\_\_

Do you or any person to be covered now have an active health coverage policy? .....  Yes  No

**If Yes, expiration date** (This coverage cannot be issued while any other coverage is in force.): \_\_\_\_\_

Are you currently applying for any other coverage with us? .....  Yes  No

Did you or your eligible dependents have creditable coverage within the past 63 days? .....  Yes  No

## Section E – Health History Questions

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.

Is any applicant currently pregnant (includes positive pregnancy test within the last 30 days), an expectant father, or in the process of adoption or surrogate pregnancy? .....  Yes  No

**If Yes, who?** \_\_\_\_\_

Has any applicant been diagnosed with or treated for AIDS or ARC? .....  Yes  No

**If Yes, provide the name of each person:** \_\_\_\_\_

Has any applicant been advised by a healthcare provider to have testing (excluding HIV or AIDS), examination, evaluation, treatment, therapy, or surgery that has not yet been completed? .....  Yes  No

**If Yes, who?** \_\_\_\_\_

**Specify condition(s):** \_\_\_\_\_

Is any applicant a candidate for or recipient of an organ or bone marrow transplant? .....  Yes  No

**If Yes, provide the name of each person:** \_\_\_\_\_

Within the last 30 days, has any applicant been admitted to an inpatient hospital or surgical facility? .....  Yes  No

**If Yes, who?** \_\_\_\_\_

**Specify condition(s):** \_\_\_\_\_

Within the last 5 years, has any applicant been diagnosed with or received treatment for heart, lung, blood (e.g. Hemophilia, leukemia), blood vessel, kidney, liver, brain, nerve or immune system disorders (excluding HIV or AIDS), diabetes, cancer, stroke, heart attack, high blood pressure, ulcerative colitis, Crohn's Disease, or alcohol abuse or drug abuse? .....  Yes  No

**If Yes, who?** \_\_\_\_\_

**Specify condition(s):** \_\_\_\_\_

## Section F – Significant Terms, Conditions and Authorizations (TERMS)

1. I understand that it is mandatory that I notify Community Insurance Company (Anthem), 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, or the date underwriting approves, whichever is later. I understand that in this situation, Anthem has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be denied or delayed, or reformed or benefits denied due to the illness, injury or condition being treated as a preexisting condition.
2. I may not assign any payment under my Anthem program.
3. I understand that sending my initial premium with this application, and the receipt of my payment by Anthem, does not mean that coverage has been approved. I understand that if my application is denied, my bank account or credit card will not be charged.
4. If my request for coverage is being handled by a producer, I understand that the producer is not authorized to waive a complete answer to any question in the application, pass on insurability, make or alter any contract or waive any of Anthems' other rights or requirements.
5. I am applying for the coverage selected on this application.
6. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application.
7. I understand that any premium quote provided is preliminary and review of my application by medical underwriting may change the premium or result in a denial of coverage.
8. I understand the preexisting conditions in existence within 24 months immediately prior to my enrollment, for which medical advice, diagnosis, care or treatment was recommended or received, are not covered. Pregnancy is considered a preexisting condition.
9. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.

**Section F – Significant Terms, Conditions and Authorizations (TERMS) (continued)**

10. I understand Anthem may convert my payments by check to an electronic Automated Clearinghouse (ACH) debit transaction. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem automatic debit process and will only occur each time I send a check to Anthem. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
11. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
12. I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
13. I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is mentally competent; he or she is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
14. I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 C.F.R. Parts 160 and 164) and the Ohio Revised Code § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.
15. I authorize Community Insurance Company (Anthem), or an agent, subsidiary or affiliate that has a business associate contract with Anthem, 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, and/or insurance support organizations. 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, 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, or an agent, subsidiary or affiliate that has a business associate contract with Anthem.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage.

I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief and I understand they are being relied on by Anthem in accepting this application. Any material misrepresentation or omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or a claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative.

**Thank you for choosing Anthem Blue Cross and Blue Shield.**

Signature of Applicant (for applicants age 18 or older) <b>X</b>	Date
Signature of Spouse or Domestic Partner (if to be covered) <b>X</b>	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) <b>X</b>	Date

**Do not cancel your present health coverage until you receive written notification from Anthem Blue Cross and Blue Shield that your new coverage is in force.**

**Section G – Agent Certification**

To be completed by your Anthem-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? .....  Yes  No
2. **I certify to the best of my knowledge and belief, the responses herein are accurate.**

Agent's Signature <b>X</b>		Date	
Agent's Name (please print)		Agent Address/ Suite No. / Personal Mail Box (PMB) No.	
Agent ID No.	City	State	Zip
Agent Phone No.	Agent Fax No.	Agent Email Address	
GA (if applicable)		GA code (if applicable)	

**IMPORTANT: No person, including an employee or agent of Anthem Blue Cross and Blue Shield, has the authority to change or omit any of the questions or statements on this application.**

# Payment Methods for Individual Short Term Health Coverage Ohio



Please complete in blue or black ink.

Applicant Name:	Primary Applicant's Social Security Number:
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Monthly premium amount: \$ \_\_\_\_\_ Full premium amount: \$ \_\_\_\_\_

I want to avoid a monthly fee of \$10 by paying the full premium now.

**PLEASE TELL US HOW YOU WILL PAY YOUR FULL PREMIUM:**

- Credit/Debit Card (complete Section B)
- One-time Electronic Bank Payment (complete Section C)
- Check or Money Order attached (make payable to Anthem Blue Cross and Blue Shield)\*

I understand the first month's premium is required with my application and I will be charged an additional \$10 for each bill if I do not pay the full premium now.

**PLEASE TELL US HOW YOU WILL PAY YOUR FIRST PREMIUM:**

- Automatic Bank Payment (complete Section A)  
If you choose this option, you must also select the Automatic Bank Payment option for future premiums.
- Credit/Debit Card (complete Section B)
- One-time Electronic Bank Payment (complete Section C)
- Check or Money Order attached, including additional \$10 fee (make payable to Anthem Blue Cross and Blue Shield)\*

**PLEASE TELL US HOW YOU WILL PAY YOUR FUTURE PREMIUMS:**

- Automatic Bank Payment (complete Section A)
- Bill me for future premiums. (Bills will be sent to the address on your application unless a different address is listed below.)

Name	Address	
City	State	ZIP

\* When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic fund transfer, funds will be withdrawn from your account as soon as the day of approval, and you will not receive your check back from your financial institution.

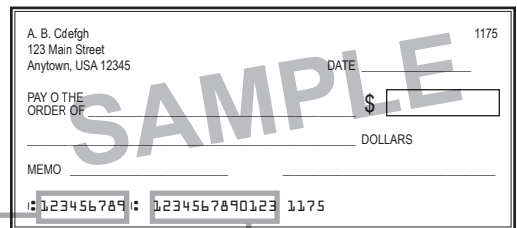
**A. Automatic Bank Payment –**  
If you have selected this option for your initial payment, your bank account may be debited the applicable month's premium as soon as the day of approval. I hereby authorize Anthem to initiate a withdrawal the same day of the month as my assigned effective date from the bank account named below.

**Provide your Bank Account Information here:**

- Checking Account
- Savings Account (account number will be different than that of checking account). Check with your financial institution to be sure automatic recurring deductions are allowed against this account.

**Provide your Bank Account Information here:**

9-Digit Bank Routing Number	Bank Account Number
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I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions (and corrections to premium deductions) from the bank account indicated and the designated financial institution to debit the same account. **I understand that the initial premium amount may vary as a result of change(s) during the underwriting process.** I understand that Anthem's rights with each premium deduction are the same as if I submit a check signed by me. This authorization is in effect until I provide Anthem thirty (30) days written notice that I no longer desire this service, and Anthem and the designated financial institution have the right to discontinue the premium deductions if they wish to do so. **I also understand that a service charge may be incurred for any withdrawal not honored.**

Authorized Signature (as it appears on the financial institution's records) <b>X</b>	Account Holder Name (Please PRINT)	Date
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**PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.**

