Steps To Apply

Step 1: Complete the Colorado Uniform Application

Step 2: Complete the additional Anthem application, including the special enrollment section and payment

Step 3: Scan and email your application(s), including proof of your special enrollment, to help@ihealthagents.com

-or-

Fax to 1 (847) 220-9280

Questions? Call (312) 726-6565.

Information for Applicants Requesting a Special Enrollment Period

Anthem BlueCross BlueShield

When applying to enroll for coverage during a Special Enrollment Period (SEP), an applicant must be eligible to enroll and provide supporting documentation of a qualifying event. Without this documentation the applicant may not be able to enroll.

Please review the list below which outlines examples of what may be used as supporting documentation. Be sure to send in a copy of the documentation supporting the qualifying event when the completed application is submitted or upload a copy of the documentation when submitting an online application.

For paper applications, please submit legible copies of everything and keep all original documents for your personal records, because no documentation will be returned. Please write the applicant's name on the top of each page of the supporting documentation.

After reviewing the information provided, we may request additional documentation to confirm eligibility. Please note that loss of health coverage due to fraud, intentional misrepresentation of a material fact or failure to pay a premium do not constitute qualifying events.

Please note: Anthem will notify the applicant within 14 days of receipt of the application if the applicant did not provide sufficient documentation necessary to verify eligibility for the special enrollment/triggering event requested. The applicant will then have 30 days from that notice to provide us with sufficient documentation to establish eligibility for the special enrollment/triggering event and we will make a determination within 14 days of receiving that documentation.

If you have further questions about qualifying events or the supporting documentation that is required, please call your agent or customer service at 1-855-383-7249.

Supporting documentation by type of qualifying event for all SEP applicants for Anthem Blue Cross and Blue Shield plans in Colorado

Qualifying event	Description and examples of supporting documentation
Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay a premium	**Loss of Minimum Essential Coverage due to change in employment status:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming loss of coverage (date and individuals) and reason for loss of Minimum Essential Coverage (i.e., reduction in employment hours, etc.), **or** • Letter that provides notice of **offer** of COBRA or state continuation benefits **Loss of Minimum Essential Coverage due to loss of dependent eligibility status:** **Due to death:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals), and • Copy of death certificate or obituary **Due to Medicare eligibility:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals), and • Copy of Medicare card or approval letter from Social Security **Due to an over-age dependent:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals) **Due to legal separation, divorce, dissolution of domestic partnership or civil union:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals), and • Divorce decree, legal separation agreement, or notarized/legal termination of domestic partnership or civil union **Loss of Minimum Essential Coverage due to exhaustion of COBRA or state continuation benefits:** • Letter that provides notice of termination of COBRA or state continuation benefits

Qualifying event	Description and examples of supporting documentation
Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay a premium	**Loss of Minimum Essential Coverage due to (permanent) move to new service area:** *Note: Applicant must have had Minimum Essential Coverage for one or more days in the 60 days prior to the permanent move, unless he or she is moving from a foreign country or a United States territory (See below).* • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming loss of coverage (date and individuals). If the minimum essential coverage has not yet been terminated, supporting documentation must show the applicant had minimum essential coverage for one or more days in the 60 days prior to the permanent move **and** • Documentation of applicant's old address and new address (if not present on employer letter or previous carrier documentation) which may be validated by any of the following: — Recent utility bill (electric, water, phone, internet, cable) — Signed residential lease, rental agreement/contract, mortgage or nursing home/assisted living facility residency documentation — A deed showing applicant ownership of property in the new service area — New driver's license with new address in the service area — Receipt of property tax paid — Insurance documents, such as homeowner's, renter's, or life insurance policy or statement — Mail from the Department of Motor Vehicles, such as a driver's license, vehicle registration, or change of address card — State ID — Official school documents, including school enrollment, report cards, or housing documentation — Mail from a government agency to your address, such as a Social Security statement, or a notice from TANF or SNAP agency — Mail from a financial institution, such as a bank statement — U.S. Postal Service change of address confirmation letter — Pay stub showing address — Voter registration card showing name and address — Moving company contract or receipt showing address — Document from the Department of Corrections, jail, or prison indicating recent release or parole, including an order of parole, order of release, or an address certification — If you are homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify your residency. This person must prove their own residency by including one of the documents listed above. — If you are living in the home of another person, like a family member, friend, or roommate, a letter/statement from that person stating you are living with them. This person must prove their own residency by including one of the documents listed above. — Letter from a local non-profit social services provider, certified application counselor, navigator or federally qualified health center that can verify your address. If you are homeless, you can provide a letter from a government entity or not-for-profit organization, including shelters, verifying your address. — Consumers living in rural areas may provide a rural route mail delivery address. The supporting documentation needs to include the name of the applicant along with the residential address listed on the application (the new address), and documentation of the previous address, which should include the applicant's name and the residential address before the move. For **child only applications**, the name of the parent/guardian in the signature section of the application must match the name on the supporting documentation.

Qualifying event	Description and examples of supporting documentation
Legal guardianship or court order	Legal documentation of guardianship that indicates the subscriber or the subscriber's spouse is a guardian of the applicant or court order that indicates the subscriber is required to cover the applicant. Contact us if you are applying for a child only policy.
Gain or become a dependent through birth or adoption/ placement for adoption	**Birth:** Birth certificate **or** medical records from hospital or pediatrician which indicate the names of the parents, the name of the baby, and date of birth. *NOTE: For current Anthem members, a mother's delivery claim may be considered as supporting documentation.* **Adoption/placement for adoption:** Adoption certificate or document establishing placement of a child with applicant for adoption.
Gain a dependent through marriage or domestic partnership or civil union	Certificate of marriage, domestic partnership or civil union. ***NOTE: At least one spouse or domestic partner must either demonstrate that they had Minimum Essential Coverage or that they lived in a foreign country or US territory for one or more days in the 60 days prior to the date of the marriage or domestic partnership.***
Applicants moving to the U.S. from a foreign country or U.S. territory	∘ Documentation of the move (including date of move) which may be validated by a passport, VISA, or airplane ticket, **and** ∘ Documentation of the new address which may be validated by any of the following: — Signed residential lease, rental agreement/contract, mortgage — A deed showing applicant ownership of property in the new service area — If you are homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify your residency. This person must prove their own residency by including one of the documents listed above. — If you are living in the home of another person, like a family member, friend or roommate, a letter/statement from that person stating you are living with them. This person must prove their own residency by including one of the documents listed above. — Letter from a local non-profit social services provider, certified application counselor, navigator, or federally qualified health center that can verify your address. If you are homeless, you can provide a letter from a government entity or not-for-profit organization, including shelters, verifying your address. ∘ **And** one additional supporting document of new address which may be validated by one of the following in the applicant's name: — Recent utility bill (electric, water, phone, internet, cable) — New driver's license with new address in the service area — Receipt of property tax paid — Insurance documents, such as homeowner's, renter's, or life insurance policy or statement — Mail from the Department of Motor Vehicles, such as a driver's license or vehicle registration — State ID — Official school documents, including school enrollment, report cards, or housing documentation — Mail from a government agency to your address, such as a Social Security statement, or a notice from TANF or SNAP agency — Mail from a financial institution, such as a bank statement — Pay stub showing address or letter/employment contract from employer — Voter registration card showing name and address — Moving company contract or receipt showing address

Qualifying event	Description and examples of supporting documentation
Release from incarceration	Papers from local, state or federal department of corrections or prisons showing the applicant's date of legal discharge
Death of a family member enrolled under current coverage	∘ Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming coverage (date and individuals), **and** ∘ Copy of death certificate or obituary
An individual, who was not previously a citizen, a national, or a lawfully present individual, gains such status	Change in status validated by any of the following: ∘ Valid U.S. passport or passport card. ∘ Valid I-551, permanent resident card (issued by the Department of Homeland Security/ U.S. citizenship and immigration services). Non-expiring I-551 (issued 1977-1989) cards are acceptable. ∘ U.S. Certificate of Naturalization (federal form N-550). ∘ Certificate of U.S. Citizenship (federal form N-560). ∘ Employment Authorization Document. ∘ Unexpired foreign passport with a valid unexpired U.S. visa affixed accompanied by the approved I-94 form documenting the applicants most recent admittance into the U.S.
Current policy does not renew on a calendar year basis (renews on a date other than January 1)	Information from previous carrier (recent billing statement, ID card, renewal letter) confirming coverage (date and individuals) and renewal date of coverage.
Victim of domestic abuse or spousal abandonment, who seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment	Statement that the applicant(s) (which can include any dependent or unmarried victim within the same household) is currently enrolled in creditable coverage with the perpetrator of the abuse or abandonment. The statement can be provided to us over the phone or via email. Please call us to confirm if this is your qualifying event.
Originally determined to be eligible for Medicaid or the Child Health Plan Plus (CHP+) but later determined to be ineligible after open enrollment has ended	Copy of the determination of eligibility, and later determination of ineligibility for Medicaid or CHP+.
Material error in plan benefits, service area or premium influenced the applicant's decision to purchase their current plan	Letter from Connect for Health (for on-exchange plans) or the Division of Insurance (for off-exchange plans) determining and explaining the material error as a qualifying event.
Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events	A letter from the applicant and an official form such as a letter or other supporting documentation from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected.

Division of Insurance

COLORADO UNIFORM INDIVIDUALAPPLICATION FOR MAJOR MEDICAL HEALTH BENEFIT PLANS

This form is designed for an individual's initial application for coverage. Please contact your carrier with questions regarding this form

Federal financial assistance may be available for coverage purchased through Connect for Health Colorado. If purchasing coverage through Connect for Health Colorado, you will need to provide additional information for determination of eligibility for federal financial assistance. Further informationmay be found at www.connectforhealthco.com.

COVERAGE INFORMATION

Application Type:	☐ New Coverage ☐ Change/Modification to Existing Coverage ☐ Open Enrollment ☐ Special Enrollment*
Requested Effective Date:	_____/_____/_____(MM/DD/YYYY)

* Proof of eligibility for special enrollment will be required – information on eligibility for special enrollment periods is available at: www.dora.colorado.gov/DOI/HealthApp

PRIMARY APPLICANT/INSURED INFORMATION

Instructions: Please type or print using black or blue ink. Please fill out the entire application for each person for whom coverage is being sought. If a person is currently enrolled in Medicare, this application should not be completed for that enrolled individual. If additional pages are needed to fully complete this application please attach, sign, and date each page.

First Name:		Middle Initial:		Last Name:	
Social Security #:		Date of Birth:	/	Current Age:	Sex: ☐ M F ☐
Physical Address:				City:	
County:		State:		Zip:	
Mailing Address (If different):				City:	
County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:	

Are you (check one): ☐ Single ☐ Married ☐ Common Law* ☐ Civil Union* ☐ Legally Separated ☐ Divorced ☐ Under 21

Are you or is anyone in your family American Indian or Alaskan Native? ☐ Yes ☐ No

* A common law, civil union, or designated beneficiary certification may be required by the carrier

Employer Name and Address:		Work Phone:	

ADDITIONAL APPLICANTS

Complete ONLY if your spouse/partner, and/or child(ren) under the age of 26(older if medically disabled) are applying for coverage. If a dependent child is applying an as individual rather than as part of a family list the child as the primary applicant. If there is not enough space provided, please attach additional family information. **Please sign and date the additional sheet.**

*Social Security Numbers (or document numbers for any legal immigrants) are needed for anyone applying for health insurance, missing numbers will be requested after enrollment

Name (First, MI, Last)	Sex	Social Security #	Relationship	Disabled	Birth Date (MM/DD/YY)	Employer Name and Position
	☐ M ☐ F		SPOUSE/PARTNER			
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		
	☐ M ☐ F		☐ CHILD ☐ STEPCHILD	☐ Yes ☐ No		

Do(es) the child(ren) named within the application live with you at the same physical address shown above? ☐ Yes ☐ No (if no, complete below)

Child(ren)'s Name:			Mailing Address (If different):				
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

Primary Applicant Name:

Name of the Legal Guardian or Parent responsible for carrying health insurance for the child:							
If the primary applicant is under the age of 21 if different from above, provide the name and mailing address of the legal guardian or custodial parent:							
Legal Guardian or Custodial Parent's Name:		Mailing Address (If different):					
City:		County:		State:		Zip:	
Home Phone:		Alternate Phone:		Email:			

TOBACCO USE

Please answer the following questions to the best of your knowledge. 45 CFR 147.102(a)(1)(iv) "For purposes of this section, tobacco use means use of tobacco on average four or more times per week within no longer than the past 6 months. This includes all tobacco products, except that tobacco use does not include religious or ceremonial use of tobacco. Further, tobacco use must be defined in terms of when a tobacco product was last used."

Has anyone named in this application used tobacco or smokeless tobacco during the past 6 months? If yes, provide the information requested below.

Name of Person	Used Tobacco Products	If Yes, check all that apply	Duration	Frequency
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		
	☐ Yes ☐ No	☐ Cigarettes ☐ Chewing Tobacco ☐ Pipe/Cigars		

MEDICARE/MEDICAID INFORMATION

Is any applicant enrolled in Medicare? ☐Yes ☐No

Name of person covered by Medicare: _____. For this applicant, please stop here, this insurance may duplicate existing Medicare coverage.

Is any applicant enrolled in Medicaid, CHIP+, or other governmental health program? ☐Yes ☐No

Name of person covered by Medicaid or other governmental health program: _____. For this applicant, please be aware that obtaining individual health insurance may affect this individual's Medicaid status.

CURRENT MEDICAL COVERAGE

Do you, your spouse/partner, or your dependent child(ren) listed in this application currently have health insurance? ☐Yes No☐

(Dental Coverage in next Section)

Name	Carrier Name	Effective Date of Coverage (MM/DD/YY)	Termination Date of Coverage (MM/DD/YY)	Coverage Type

If any applicant has current health coverage, will that applicant cancel current coverage if this applicant is accepted? ☐ Yes ☐ No

Type of Coverage Key: **G** = Group Comprehensive Major Medical; **I** = Individual Comprehensive Major Medical; **MS** = Medicare Supplement; **H** = Hospital Coverage Only; **V** = Vision Coverage Only **O**=Other, please explain:_____

Primary Applicant Name:

CERTIFICATION OF DENTAL INSURANCE COVERAGE (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)	
Pediatric dental coverage is a required essential health benefit. The plan you select may not include pediatric dental coverage. Do you have pediatric dental coverage under another plan?	☐ Yes ☐ No Note: you may be required provide proof that you have obtained coverage before this policy will be approved

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Application, and I certify on behalf of my eligible family dependents and myself that the answers contained in this Application are complete and accurate to the best of my knowledge.

I understand that my answers, together with any supplements or additional pages, are the basis for the certificate or policy that is issued. I agree that no insurance will be effective until the date specified by the carrier on the certificate or policy.

I understand that my signature constitutes an attestation that I have obtained the required pediatric dental coverage under a separate policy, and may be required to provide proof of this pediatric dental policy prior to this policy being issued and approved. (Certification of dental insurance coverage is not required when purchasing coverage through Connect for Health Colorado)

I understand that any intentional misrepresentation relied upon by the carrier may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy or certificate, it is determined that I or a family member made an intentional misrepresentation in this application.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance carrier for the purpose of defrauding or attempting to defraud the carrier. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance carrier or agent of an insurance carrier who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I understand that I may request a copy of this Application. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document, or the information contained herein, will become a part of the contract when coverage is approved and issued.

I would like to receive all policy notices, premium notices, and other notices relating to this policy through the supplied email address above. ☐Yes ☐No

I understand I can change this designation at a later date by contacting my carrier directly, and understand it is my responsibility to notify my carrier of any changes to my email address.

Signature of Primary Applicant/Parent or Legal Guardian for Child-Only Plans	Date Signed:

Complete this section if someone assisted you in the completion of this Application	
The following person assisted me in completing the Application:	Please explain the assistant's relationship to you and your family:

Primary Applicant Name:

AGENT/PRODUCER INFORMATION	
This section is to be completed by Agent or Producer.	
Agent / Agency of Record: (for commissions and correspondence)	Writing Agent / Producer:
Name (print): Independent Health Agents	Name (print): Ryan Kennelly
Agent ID # (NPR):14924332	Agent ID #(NPR): 8478911
Agent replacement questions: Will this policy replace any existing accident and sickness insurance policy(s)? ☐Yes ☐No As the Writing Agent/Producer, I acknowledge that I am responsible to personally interact with the primary applicant submitting this application in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefits summary document or other plan literature.	
Writing Agent Signature	**Date**

DISCLOSURES

This document is a publication of the Colorado Division of Insurance. If you have questions about the content of this document please contact our offices at 303-894-7499 or visit our website at http://www.dora.colorado.gov/insurance. For questions regarding coverage or enrollment please see your carrier.

This section may be used to provide additional information that was required in the sections above and did not fit in the space provided.

Signature of Primary Applicant:_____ **Date Signed:** _____

Anthem BlueCross BlueShield

Primary applicant name: _____

Welcome

Colorado Individual Application Supplement Form

Thanks for choosing us. We're glad you're here.

If you have any questions while filling out this form, give us a call at 1 (877) 212-1793. But if you've worked with an agent or broker, contact them first.

About this form

NOTE: THIS APPLICATION IS ONLY TO BE USED IN CONJUNCTION WITH THE UNIFORM INDIVIDUAL APPLICATION.

Use this form to apply for **new** medical, dental or vision coverage or to **change** existing coverage with Anthem Blue Cross and Blue Shield (Anthem).

You can apply or change coverage:

1. **During the annual Open Enrollment period**
   The earliest your coverage can start is the 1st of the year. Your coverage will start based on when we receive your complete application (including payment). If we get it:
   - Between the 1st and 15th day of the month, coverage is effective the 1st day of the following month.
   - Between the 16th and last day of the month, coverage is effective the 1st day of the second following month.
2. **Due to a qualifying event** (such as getting married, having a baby, etc.)
   When you're done with this form, fill out **Appendix A: Special Enrollment,** which includes information about when coverage starts.
3. **For new dental and vision**
   - For new dental and vision coverage you can apply any time during the year.
   - If you apply with medical, your effective dates will match.
   - If you apply without medical, your coverage will start based on when we receive your complete application (including payment). If we get it between the 1st and last day of the month, coverage is effective the 1st day of the following month.

Tips when filling out this form

1. Answer all questions. Print using blue or black ink only. And please write clearly.
2. You can also apply online at **anthem.com**.
3. Refer to your Health Plan Guide for plan and enrollment details. Don't have a copy? Ask your agent or contact us.
4. If you're enrolling in a medical plan, you must choose a Primary Care Physician (PCP). View a list of doctors for your plan on **anthem.com** or call us. If you don't choose a PCP, we'll pick one close to you.

Some Frequently asked questions

1. **Do I need to include a payment?**
   Yes. We can't complete your application without your first month's premium payment. Without it, your enrollment will be delayed. Don't worry though – we won't charge your card or cash your check or money order until you've been enrolled.
2. **What if I already have coverage with another company?**
   Don't cancel your other coverage yet – your health coverage is too important. We'll contact you when you're approved. Then you'll need to cancel your other coverage.
3. **Why do you need my Social Security Number?**
   The IRS requires us to collect it. It won't be shared unless required by law. If you enroll in a health savings account (HSA) compatible plan with us, we may give it to our HSA banking partner.

Colorado Individual Application Supplement Form

Please indicate the reason you are submitting this application for medical:
☐ Open Enrollment
☐ Special Enrollment Period – must also complete Appendix A

Step 1: Who is applying?

Primary Applicant ☐ New coverage ☐ Change coverage ☐ Add dependent to existing coverage ID No. _____

Last Name (Legal Name)	**First Name (Legal Name)**	**M.I.**	**Date of birth** (mm/dd/yyyy)

Legal resident of CO ☐ Yes ☐ No

Preferred written language ☐ English (ENG) ☐ Spanish (SPA) **Preferred spoken language** ☐ English (ENG) ☐ Spanish (SPA)

☐ 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".

Primary Care Physician (PCP)	**PCP ID**	**Current patient** ☐ **Yes** ☐ **No**	**Medical group ID**

Coverage(s) Selected ☐ Medical ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse/Domestic Partner and/or Dependent coverage eligibility

Eligibility

Are any applicants currently incarcerated (with more than 60 days left to serve before release) as a result of a conviction? (not just pending disposition of charges)
☐ No ☐ Yes **If yes, who?**

Are you covered for medical assistance through the state Medicaid program
☐ No ☐ Yes **If yes,** please indicate your eligibility:
☐ Specified Low Income Medicare Beneficiary (SLMB)
☐ Qualified Medicare Beneficiary (QMB)
☐ Other Medicaid medical benefits (please explain) _____

Step 2: What coverage would you like?

Medical Plans

Choose only one medical plan.
If you selected an HMO product, be sure to select a Primary Care Physician (PCP) in Step 1.

HMO plans are only available in certain counties. See your Health Plan Guide for details. Applicants must reside in one of these counties to enroll in Mountain Enhanced HMO plans: Archuleta, La Plata, Montezuma, Summit or Eagle.

Anthem Bronze	**Anthem Silver**	**Anthem Gold**
☐ Mountain Enhanced HMO 5000 (1JR7) ☐ Mountain Enhanced HMO 5000 for HSA (2VDE) ☐ Mountain Enhanced HMO 6300 for HSA (2VDF) ☐ Pathway HMO 5000 (1G0P) ☐ Pathway HMO 5400 (1X7C) ☐ Pathway HMO 5800 (1G0R) ☐ Pathway HMO 5000 for HSA (1G0V) ☐ Pathway HMO 6300 for HSA (1G0T)	☐ Mountain Enhanced HMO 2000 (1JR2) ☐ Core Mountain Enhanced HMO 5300 (2K4L) ☐ Core Pathway HMO 5300 (2EP8) ☐ Pathway HMO 1650 (1G1G) ☐ Pathway HMO 2000 (1G1B) ☐ Pathway HMO 2500 (1G1M) ☐ Pathway HMO 5150 (2VD2) ☐ Pathway HMO 5750 (2VD8) ☐ Pathway HMO 6100 (2VDR) ☐ Pathway HMO 6200 (2VDX)	☐ Mountain Enhanced HMO 1100 (2VE7) ☐ Pathway HMO 1100 (2VE3)

Anthem Catastrophic Only available to applicants under age 30, unless otherwise qualified. Catastrophic plans are only available if you reside in certain counties. See your Health Plan Guide for details.

☐ Pathway HMO 7350 (1G27) ☐ PPO 7350 (2KVD)

Health Savings Account (HSA) Enrollment If you chose an HSA compatible plan, you have the option to setup a health savings account.

☐ Yes, I'd like to establish an HSA with Anthem's banking partner. (Please make sure you entered Social Security numbers in Step 1)

Current (existing) coverage

If you already have health care coverage, please don't cancel it until you are effective with us.

Important information about replacement and duplicate coverage:

Normally you do not require more than one of the same type of policy, but if you purchase this policy, you may want to evaluate your existing health 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 Supplemental policy. If you are eligible for Medicare due to age or disability, counseling services are available in Colorado to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

☐ One or more of the applicants currently have health care coverage (Please fill out the info below)

People with coverage (Write ALL if everyone)	**Existing health care coverage company**	**ID number(s)**

Will you be terminating this coverage if approved for Anthem coverage? ☐ No ☐ Yes
If Yes, do you intend to replace your current accident and sickness insurance with this policy (contract)? ☐ No ☐ Yes
If Yes, please read the following: According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield or HMO Colorado. Your new policy will provide 10 days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Dental Plans

Dental coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits).
Choose a dental plan and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Dental plan option	**Prior & other dental coverage** It's important we know.	
☐ Anthem Dental Family Value (2J4Y) ☐ Anthem Dental Family (1FRB) ☐ Anthem Dental Family Enhanced (1FRC) ☐ Dental Prime A (1RBR) ☐ Dental Prime B (1RBS) ☐ Dental Prime C (1RBT)	☐ I currently have dental coverage (please fill out the info below) ☐ I previously had dental coverage ☐ I previously had orthodontia coverage	
	People with coverage (write ALL if everyone applying):	
	Prior or other dental coverage company:	**Effective date** (when this coverage started)
	ID Number:	**Last date of coverage** (if applicable)

Will you be terminating this coverage if approved for Anthem coverage? ☐ No ☐ Yes

If Yes, do you intend to replace your current dental insurance with this policy (contract)? ☐ No ☐ Yes

If Yes, please read the following: According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield or HMO Colorado. Your new policy will provide 10 days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all dental coverage you now have. If, after due consideration, you find the purchase of this dental coverage is a wise decision you should evaluate the need for other dental coverage you have that may duplicate this policy.

Vision Plan

Vision coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a vision plan and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Vision plan option

☐ Blue View Vision Bundled (1RY2)
☐ Blue View Vision Enhanced (2SUJ)
☐ Blue View Vision Plus (2SUK)
☐ Blue View Vision Value (2SUL)

Statement to applicant by issuer or producer

For Non-Health Benefits Plans: If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Applicant's Signature	**Date**

*Signature not required for direct response sales.

Premium Reimbursement

Will an employer of one hundred (100) or fewer eligible employees be paying for or reimbursing you through wage adjustment or a health reimbursement arrangement for any portion of the premium on the policy being applied for? ☐ No ☐ Yes
If you answered Yes, please continue. If you answered no, you may stop.

Did the employer have a small group health benefit plan providing coverage to any employee in the twelve (12) months prior to the date of this application? ☐ No ☐Yes

If the answer to both questions 1 and 2 immediately above is "yes", you may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

If the answer to question 1 is "yes" and the answer to question 2 is "no", you must submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months.

The affidavit form to be executed by the employer is attached at the end of this form. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier.

Step 3: Please read and sign

Important legal information

I, the undersigned, understand that under the Anthem 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.

- I must send my first (initial) premium with this application, but it does not mean coverage has been approved. I'm applying for the coverage I chose on this form. To the extent permitted by law, Anthem has the right to accept or decline this application, and that there are no guarantees of any kind just because I filled out this form. If my application is denied, my bank account or credit card will not be charged, and if I paid with a money order, it will be returned to me.
- I'm responsible to let Anthem know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- I agree to pay the premium due. I also agree to pay for any fee or charge Anthem bills me as part of an exchange fee, assessment, uninsured pool or other state or federal program. I agree that my payments will be first applied to such fees or assessments and the balance applied to premium.

- Anthem may change check payments to electronic Automated Clearinghouse (ACH) debit transactions. If this happens, my original check will be destroyed. This charge will appear on my bank statement but my check won't be given to my financial institution or sent back to me. This charge 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. All checking transactions will remain secure, and my payment by check means I agree to these terms.
- I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
- I'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, billing, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.
- I certify that each Social Security number listed on this application is correct.
- 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 at least 18 years of age; 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.
- I acknowledge that I have read the Important Legal Information section, and I agree to the coverage conditions. I state 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 act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).

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. This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

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 any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered in this application, Anthem may revoke my coverage. This means Anthem may cancel membership as if it never existed. Also, after approval for membership, if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact 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 and me. I agree to abide by the terms of that contract.

REQUIREMENT FOR BINDING ARBITRATION:

I UNDERSTAND AND AGREE THAT ANY AND ALL DISPUTES BETWEEN ANTHEM AND ME MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE 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. ANTHEM AND I AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN OUR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT ANTHEM AND I 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 ANYOTHER ISSUES RELATED TO THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

BEFORE COMMENCING ARBITRATION, THE PARTY SEEKING ARBITRATION MUST HAVE EXHAUSTED ALL LEVELS OF APPEAL AND REVIEW SET FORTH IN THE CERTIFICATE. ANY SUCH ARBITRATION WILL BE GOVERNED BY THE PROCEDURES AND RULES ESTABLISHED BY THE AMERICAN ARBITRATION ASSOCIATION. THE LAW OF THE STATE IN WHICH THE POLICY WAS ISSUED AND DELIVERED TO THE POLICYHOLDER SHALL GOVERN THE DISPUTE. THE DECISION IN ARBITRATION IS BINDING UPON BOTH ANTHEM AND ME. THE AWARD GIVEN IN ARBITRATION MAY BE ENFORCED OR REVIEWED IN ANY COURT THAT HAS PROPER JURISDICTION. IN THE EVENT ANY PERSON SUBJECT TO THIS ARBITRATION CLAUSE INITIATES LEGAL ACTION OF ANY KIND, THE OTHER PARTY MAY APPLY FOR A COURT OF COMPETENT JURISDICTION TO ENJOIN, STAY OR DISMISS ANY SUCH ACTION AND DIRECT THE PARTIES TO ARBITRATE IN ACCORDANCE WITH THIS PROVISION. THE QUESTION OF WHAT DISPUTES ARE SUBJECT TO THIS ARBITRATION CLAUSE SHALL BE DETERMINED BY THE ARBITRATOR.

IF AN APPLICANT DOES NOT READ ENGLISH, THE TRANSLATOR MUST SIGN AND SUBMIT A STATEMENT OF ACCOUNTABILITY FOR TRANSLATING THIS ENTIRE APPLICATION (SEE APPENDIX B).

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING, BY THE EXTENT PERMITTED BY STATE OR FEDERAL LAW, TO HAVE ANY AND ALL DISPUTES AGAINST ANTHEM BLUE CROSS AND BLUE SHIELD DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO JURY OR COURT TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS AND ANY OTHER DISPUTES. SIGNATURES REQUIRED.

By signing this application, I certify that the premium for my coverage will not be paid by a provider of health care services, hospital, non-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entity with a direct or indirect financial interest in the benefits of the contract/policy or an employer that offers coverage under an employer health plan. I understand that if a third party is paying my premium, Anthem may decline to accept such premium payment if it is made by a person or entity from which it is not required by law to accept.

Please sign below

	Primary Applicant (or legal representative)	Date
	Spouse / Domestic Partner (or legal representative)	Date
	Dependent Child (age 18 or over)	Date
	Dependent Child (age 18 or over)	Date
	Dependent Child (age 18 or over)	Date

Did an agent help you? Make sure they fill out this section.

Agent (or broker) Certification All fields required.

I have listed above any policies I sold the applicant which are current and any policies I sold in the past five (5) years.I certify to the best of my knowledge, the responses herein are accurate.

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s)(check one):

☐ Additional benefits ☐ No change in benefits, but lower premiums ☐ Fewer benefits and lower premiums

☐ Other (please specify) _____

Agent/Broker Signature	**Date**

Agent Name (Please print clearly)
Ryan Kennelly

(A) Writing Agent TIN / SSN (Encrypted TIN is ok)	*** (B) Writing Agent/Agency/General Agency TIN (**Encrypted TIN is ok)
FCHPGQLTNZ	CFGKJHJRTY

Agent Address	**City**	**State**	**ZIP**

Agent Phone No.	**Agent Fax No.**	**Agent Email**
(312) 588-9915	847-220-9280	ryan@ihealthagents.com

* **Field (A)** - Always provide your Writing Agent TIN/SSN. **Field (B)** - If you are a Direct Agent, with no relationship to an Agency, also enter your Agent TIN/SSN in Field (B). If this policy is sold through an Agency without a General Agency, enter the selling Agency TIN in Field (B); if this policy is sold through a General Agency, enter the General Agency TIN in Field (B).

Here's what's next.

1) Can you check a few items? When incorrect, they're the most frequent reasons for delays in enrollment.
    - Your name and address information should be clear and readable
    - You've included your first month's premium payment
    - Everyone 18 and older signed this form
    - If enrolling due to a qualifying event, you've completed Appendix A: Special Enrollment

2) All good? Send this to us by mail to Anthem Blue Cross and Blue Shield, P.O. Box 659960, San Antonio, TX 78265-9146 or by fax to 1 (800) 848-2512.

3) We'll be in touch in the next few weeks. If you have questions before then, call us at 1 (855) 383-7249.

Thank you!

Appendix A: Special Enrollment

If you're applying for coverage due to a qualifying event, please fill out this section along with your application.

Qualifying event date	
Date of qualifying event	For Loss of Coverage, this is the last date of existing or prior coverage. For all other events, please enter the date based on the qualifying event.

You must apply for coverage within 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
☐ **1. Marriage/Civil Union or Domestic Partnership** Got married, entered in a civil union, or in a domestic partnership that becomes eligible for coverage (see step 3 for description of domestic partnership eligibility)	First day of the month after we receive your complete application
☐ **2. Birth or Adoption** Had a baby, adoption of a child or placement of a child with you for adoption	**Select an effective date:** ☐ Same as the event date ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application* ☐ First day of month after the event date
☐ **3. Court Order or Guardianship** Required by a court order to provide an eligible child(ren) coverage, including a child support order, filed an application for appointment of guardianship of a child or appointment of guardianship of a child	**Select an effective date:** ☐ Same as the event date ☐ Based on when we receive your complete application*
☐ **4. Death** Death of a family member enrolled under current coverage	**Select an effective date:** ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application*
☐ **5. Immigration** Immigration status changed ☐ **6. Other qualifying event** If you can't find your situation, contact your agent/broker or call us. We can only enroll based on events defined by state and/or federal law	Based on when we receive your complete application*

You must apply for coverage within 60 days before or 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
7. Loss of coverage: Lost or will lose Minimum Essential Coverage: ☐ Involuntary loss of coverage (for any reason except non-payment of premium or fraud) ☐ A legal separation or divorce ☐ Moved to a new service area. Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move.	First day of the month after we receive your complete application.
☐ **8. Permanent Move** Moved to U.S. from a foreign country or a U.S. territory ☐ **9. Non-calendar renewal** Current policy does not renew on a calendar year basis (renews on a date other than January 1) ☐ **10. Jail or prison** Released from jail or prison (incarceration)	Based on when we receive your complete application*

* If the coverage date is based on when we receive your complete application then if we receive it:
- Between the 1st and 15th day of the month, coverage is effective the 1st day of the following month.
- Between the 16th and the last day of the month, coverage is effective the 1st day of the second following month.

Almost there! We need a bit more info.

We need supporting documentation for your qualifying event, such as a letter or official form from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected. If you're applying because you've lost your coverage, we need to know the reason why coverage was lost, and it must be included in the supporting documentation. In all instances, we might need additional documentation to confirm eligibility.

Give us or your agent a call if you have any questions.

Appendix B: Statement of Accountability

Statement of Accountability Fill out when applicant cannot complete application.

Note: Interpreter must be 18 years or older to translate the application of 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: _____

Language interpreted

☐ Spanish ☐ Chinese ☐ Korean ☐ Tagalog ☐ Vietnamese ☐ Other _____

I also interpreted and fully explained the "Important legal information "and the "Payment Method".

Signature of Interpreter (required)	**Date** (required)

I confirm that the application was interpreted on my behalf

Signature of Applicant (required)	**Date** (required)

Appendix C: Employer Affidavit

Complete if required based on Premium Reimbursement section of this application

Employer's Name:
Employer's Address:

The undersigned officer or principal of the employer identified above certifies that:
1. The employer is a small employer as defined in § 10-16-102(61), C.R.S., with one hundred (100) or fewer eligible employees;
2. The employer has not had in place a small group health benefit plan for the twelve (12) months prior to the execution of this affidavit.
3. A false certification may cause the rescission of the employee's individual insurance policy and subject the employer to penalties for perjury and liability to the employee.

Signature	**Date**
Typed Name	
Position	

Payment Methods for Individual Applications

Anthem BlueCross BlueShield

Applicant/Member name	Primary applicant's Social Security number

Anthem Blue Cross and Blue Shield (Anthem) will accept monthly payments made on behalf of applicants/members **if the payment is made by the following persons or entities:** The Ryan White HIV/AIDS Program; other federal and state government programs that provide monthly payments and cost-sharing support for specific individuals; Indian tribes tribal organizations and urban Indian organizations; or a relative or legal guardian on behalf of an applicant/member.

Unless required by law, Anthem does not accept monthly payments from third parties that are not listed above. Examples of third parties from whom Anthem will not accept monthly payments include, but are not limited to, insurance brokers and/or agents, doctors, hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entities with a direct or indirect financial interest in the benefits of the contract/policy and employers that offer coverage under an employer health plan. Note: As allowed by law, Anthem reserves the right to decline monthly payments from third parties.

I authorize Anthem to debit the bank account listed or charge the credit/debit card listed for my first monthly payment on or after the day that my coverage is approved. By signing this form, I understand that the amount of the first payment may change from what I was told because my coverage has not been approved yet. In addition if I select Option 1 or Option 2 below, I understand that my future payments may vary as a result of change(s) I make once enrolled, including but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified according to my plan/policy. In addition, I understand if changes I make are close to the auto withdrawal date, Anthem may not be able to notify me before the withdrawal is made. **I agree to pay any service charge that Anthem may bill me because the debit/charge was not honored.** I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to reset the automatic monthly payments.

Please choose how you want to pay your monthly payments for all of your plans. Put a check in the box for either Option 1, Option 2 or Option 3.

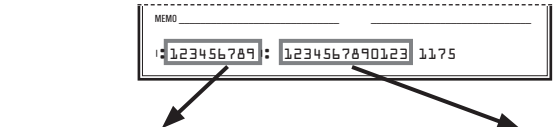
☐ **Option 1 Bank Account Authorization: Have your first and future monthly payments automatically deducted from your bank account.**

All of your monthly payments will be taken out of the **bank account** you check below.

Checking account: ☐ Business ☐ Personal
Savings account: ☐ Business ☐ Personal

Enter the requested debit date from your bank account ____ (1st to 6th of each month). If no date is requested your monthly payments will be debited on the first of each month.

Write the routing and account numbers that are on your check here: →



9-digit bank routing number	Bank account number

I authorize Anthem to automatically debit the **bank account** listed above each month to make my monthly payments. I agree that **Anthem's rights with each debit are the same as if the debit was a check that I signed.** I understand monthly payments will be made on the day I've indicated or within 5 business days thereafter. I authorize Anthem to automatically debit my account (and to make corrections to previous debits). This authority stays in effect until I let Anthem know that I no longer want them to debit my account by giving them a 30-day advance written notice. I understand that if my bank does not allow Anthem to debit my account for any reason, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to reset the automatic monthly payments.

Authorized signature (as it appears on bank's records)	Printed bank account holder's name (as it appears on account)	Date (MM/DD/YY)
X		

☐ **Option 2 Credit/Debit Card Authorization: Have your first and future monthly payments automatically charged to your credit/debit card.**

Complete the information below.

Enter the requested charge date for your credit/debit card ____ (1st to 6th of each month).

I authorize Anthem to automatically charge my **credit/debit card** listed below each month to make my monthly payments. I understand monthly payments will be made on the day I've indicated or within 5 business days thereafter. I authorize Anthem to charge my credit/debit card until I let them know that I no longer want them to charge my credit/debit card by giving them a 30-day advance written notice. I agree that Anthem, in honoring the monthly payments charged to my credit/debit card, is not responsible for any fees charged by my bank. I understand that if any Anthem credit/debit transaction is not honored, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to reset the automatic monthly payments.

Anthem accepts ☐ **Visa** **or** ☐ **MasterCard** **(Note to applicant: Please check one.)**

Card number	Expiration date ____ (MM/YY)	
Billing address for this credit/debit card	City	ZIP code

Authorized signature (as it appears on card)	Printed card holder's name (as it appears on card)	Date (MM/DD/YY)
X		

See page two for *Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.*

Payment Methods for Individual Applications

Anthem BlueCross BlueShield

Applicant/Member name	Primary applicant's Social Security number

☐ **Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.**

Choose one of the ways below that you would like to pay only your first monthly payment.

☐ Check (enclose your paper check with application) ☐ Electronic check (fill out section A below) ☐ Credit/Debit card (fill out section B below)

A. Electronic check: Instead of sending us a paper check, you can use an electronic check that allows Anthem to take the money right from your bank account to make your first payment on the day that your coverage is approved. You will not get the check back from your bank. (We will not keep this information on file or use it for any future payments.) Please fill out this information.

Printed account holder name	Routing number	Account number	Amount of first payment
			$

B. Credit/Debit card: I allow Anthem to charge the credit or debit card I listed below one time for my first monthly payment. This payment will cover the first monthly payment for all of the plans I have with Anthem.

Anthem accepts ☐ Visa or ☐ MasterCard (Note to applicant: Please check one.)

Card number	Expiration date (MM/YY)

Billing address for this credit/debit card	City	ZIP code

I authorize Anthem to debit/charge the bank account or credit/debit card listed above **to make my first monthly payment only.**

I agree that Anthem will not have to pay any fees that my bank may charge because my electronic check or credit/debit card was rejected even if I can no longer continue coverage. I understand that **this is a one-time payment and that I am responsible for making sure Anthem receives my future monthly payments after this first payment.**

Authorized signature (as it appears on bank account/card)	Printed bank account/card holder's name (as it appears on account/card)	Date (MM/DD/YY)
X		