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| | |
|--|----------------|
| Send to: Andrew J. Friesner | From: |
| Company: Chaser Insurance Group | Date: |
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Urgent
 Reply ASAP
 Please comment
 Please review
 For your information

Total pages, including cover:

Comments:

I look forward to helping you in any way that I can and please feel free to contact me with any questions. I hope the following information is helpful in your health insurance search. Also, please use this page as a cover page to fax over the attached application included on the following pages. With this information, we are able to help you navigate through the open enrollment process.

Thanks,
Andy Friesner

Anthem Blue Cross and Blue Shield Update on New Ohio Open Enrollment Plans

HIPAA-HIC Open Enrollment Plans are no longer available as of January 1, 2010

In the last quarter 2009, Ohio House Bill 1 caused several changes to health care offerings for Open Enrollment. A summary of those changes is included in this article and updates on the Department of Insurance requirements and rules are reflected in this update. Please be aware of the following changes:

Effective January 1, 2010, Anthem Blue Cross and Blue Shield no longer offers the HIPAA-HIC (basic and standard) Open Enrollment plans in Ohio. The HIPAA CMM Basic and Standard options (now called CMM Basic and CMM Standard for Open Enrollment) continue to be available.

- Current HIPAA HIC & CMM members who enrolled prior to 1/1/2010 will continue to have a 6/1 renewal date. New members enrolling after 1/1/2010 will renew on their anniversary date.

There is a now an Open Enrollment page on anthem.com that will provide additional detail on Anthem's Open Enrollment offering including links to brochures, rate sheets, application forms, and instructions for enrolling in the program. Click here to access: www.anthem.com/ohioopenenrollment

- New rates for 2010 will be located on the website on January 1, 2010, but please note the open enrollment website will not be available for your use until then.

There are two types of HIPAA Eligible applicants to the CMM Open Enrollment plans: Federally Eligible Individuals (FEI) and Non Federal Eligible (Non FEI). The definitions of FEI and Non FEI are included in the [Ohio Open Enrollment Brochure](#) .

1. Federally Eligible Individuals - meets the federally eligible requirements

- **Will continue to receive credit for prior coverage**
- **Will not have to wait 90 days**
- **Will not have a pre-existing condition waiting period imposed**

2. Non Federal Eligible Individuals - are individuals who do not qualify for group conversion or cannot qualify for our underwritten products (Formerly Public Open Enrollment enrollees). They will be able to enroll anytime during the year beginning January 1, 2010. Enrollment requirements include:

- **A 90 day waiting period between the application received date and the effective date**
- **Coverage will include a 12 month pre-existing condition waiting period**
- **A 270 day waiting period for the maternity benefit on the CMM Standard plan**

If you have further questions, please see the [Ohio Open Enrollment Brochure](#) which includes a benefit comparison, visit the www.anthem.com/ohioopenenrollment, contact Broker Services at **1-800-742-8199** or agency.services@anthem.com, or your Regional Sales Manager



Cincinnati Area Grouping: Butler, Clermont, Hamilton, Warren Counties

| Att Age | HIPAA CMMI | | HIPAA CMM | |
|---------|-------------|---------------|-------------|---------------|
| | Basic | | Standard | |
| | \$1,000 | | \$750 | |
| | Single Male | Single Female | Single Male | Single Female |
| 0 | 246.83 | 246.83 | 334.47 | 334.47 |
| 1 | 246.83 | 246.83 | 334.47 | 334.47 |
| 2 | 221.34 | 221.34 | 299.94 | 299.94 |
| 3 | 221.34 | 221.34 | 299.94 | 299.94 |
| 4 | 221.34 | 221.34 | 299.94 | 299.94 |
| 5 | 221.34 | 221.34 | 299.94 | 299.94 |
| 6 | 221.34 | 221.34 | 299.94 | 299.94 |
| 7 | 221.34 | 221.34 | 299.94 | 299.94 |
| 8 | 221.34 | 221.34 | 299.94 | 299.94 |
| 9 | 221.34 | 221.34 | 299.94 | 299.94 |
| 10 | 221.34 | 221.34 | 299.94 | 299.94 |
| 11 | 221.34 | 221.34 | 299.94 | 299.94 |
| 12 | 221.34 | 221.34 | 299.94 | 299.94 |
| 13 | 228.05 | 268.29 | 309.02 | 363.56 |
| 14 | 228.05 | 268.29 | 309.02 | 363.56 |
| 15 | 228.05 | 268.29 | 309.02 | 363.56 |
| 16 | 228.05 | 268.29 | 309.02 | 363.56 |
| 17 | 228.05 | 268.29 | 309.02 | 363.56 |
| 18 | 228.49 | 291.54 | 309.63 | 395.07 |
| 19 | 228.49 | 291.54 | 309.63 | 395.07 |
| 20 | 228.49 | 291.54 | 309.63 | 395.07 |
| 21 | 214.18 | 296.91 | 290.24 | 402.34 |
| 22 | 214.18 | 296.91 | 290.24 | 402.34 |
| 23 | 214.63 | 303.17 | 290.85 | 418.82 |
| 24 | 217.76 | 311.22 | 295.09 | 421.73 |
| 25 | 220.44 | 319.27 | 298.72 | 432.63 |
| 26 | 223.13 | 326.87 | 302.36 | 442.93 |
| 27 | 225.81 | 334.92 | 305.99 | 453.84 |
| 28 | 230.73 | 347.44 | 312.66 | 470.81 |
| 29 | 235.20 | 360.40 | 318.72 | 488.38 |
| 30 | 242.36 | 376.95 | 328.41 | 510.80 |
| 31 | 247.27 | 389.91 | 335.08 | 528.37 |
| 32 | 252.19 | 403.33 | 341.74 | 546.55 |
| 33 | 264.27 | 421.66 | 358.10 | 571.39 |
| 34 | 276.79 | 439.55 | 375.07 | 595.63 |
| 35 | 289.31 | 457.88 | 392.04 | 628.47 |
| 36 | 301.83 | 476.21 | 409.00 | 645.32 |
| 37 | 314.79 | 494.10 | 426.57 | 669.55 |
| 38 | 332.68 | 513.33 | 450.81 | 695.61 |
| 39 | 358.17 | 542.39 | 485.35 | 734.99 |
| 40 | 376.50 | 555.81 | 510.19 | 753.17 |
| 41 | 395.28 | 575.03 | 535.64 | 779.23 |
| 42 | 414.06 | 593.82 | 561.09 | 804.68 |
| 43 | 439.55 | 614.38 | 595.63 | 832.55 |
| 44 | 460.56 | 628.69 | 624.11 | 851.94 |
| 45 | 485.60 | 646.13 | 658.04 | 875.57 |
| 46 | 516.01 | 673.86 | 699.24 | 913.14 |
| 47 | 535.69 | 686.82 | 725.90 | 930.71 |
| 48 | 562.07 | 693.53 | 761.65 | 939.80 |
| 49 | 599.63 | 714.10 | 812.55 | 967.67 |
| 50 | 620.64 | 731.98 | 841.03 | 991.91 |
| 51 | 664.02 | 760.60 | 899.81 | 1,030.69 |
| 52 | 707.84 | 788.77 | 959.19 | 1,068.86 |
| 53 | 746.29 | 813.37 | 1,011.30 | 1,102.19 |
| 54 | 799.50 | 852.72 | 1,083.40 | 1,155.51 |
| 55 | 847.80 | 876.86 | 1,148.94 | 1,188.23 |
| 56 | 884.02 | 897.88 | 1,197.92 | 1,216.71 |
| 57 | 920.68 | 918.89 | 1,247.61 | 1,245.19 |
| 58 | 956.45 | 942.15 | 1,296.08 | 1,276.69 |
| 59 | 992.67 | 964.95 | 1,345.16 | 1,307.60 |
| 60 | 1,034.71 | 988.65 | 1,402.12 | 1,339.71 |
| 61 | 1,079.48 | 1,011.90 | 1,450.60 | 1,371.22 |
| 62 | 1,107.14 | 1,034.71 | 1,500.28 | 1,402.12 |
| 63 | 1,145.15 | 1,058.85 | 1,551.79 | 1,434.84 |
| 64 | 1,183.61 | 1,083.00 | 1,603.90 | 1,467.56 |

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The premium information provided in this tool is for illustrative purposes only. Actual premiums will be determined following completion and review of the application.

Ohio Open Enrollment Options



Basic Comprehensive Major Medical (CMM) and Standard Comprehensive Major Medical (CMM) Plans

| Schedule of Benefits | Basic CMM | Standard CMM |
|--|--|--|
| Benefit Period | Calendar Year | Calendar Year |
| Dependent Age | To age 25 | To age 25 |
| Out-of-Pocket Limit for Coinsurance There is no family out-of-pocket limit for coinsurance; each covered person must meet his/her own out-of-pocket maximum. | • \$5,000 per covered individual (does not include deductible) | • \$5,000 per covered individual (does not include deductible) |
| Deductible There is no family deductible; each covered person must meet his/her own deductible. | • \$1,000 per covered individual | • \$750 per covered individual |
| Coinsurance | 50% coinsurance ² for all covered services listed unless indicated otherwise, none after the out-of-pocket limit is reached. | 30% coinsurance ² for all covered services listed unless indicated otherwise, none after the out-of-pocket limit is reached. |
| Deductible/Copayment | Deductible applies to all services. Emergency room care requires an additional copayment ¹ of \$75 per visit, which is waived if admitted to the hospital. | Deductible applies to all services. Emergency room care requires an additional copayment ¹ of \$75 per visit, which is waived if admitted to the hospital. |
| Pre-existing Period | None for Federally Eligible Individuals (FEIs). If you are not a Federally Eligible Individual (non-FEI), there is a 12-month pre-existing condition waiting period. See the definition of FEI and non-FEI further on in this brochure. | None for Federally Eligible Individuals (FEIs). If you are not a Federally Eligible Individual (non-FEI), there is a 12-month pre-existing condition waiting period. See the definition of FEI and non-FEI further on in this brochure. |
| Maternity Services | Not covered, except for complications of pregnancy. | Payable for all covered services (after 270 day waiting period for non-FEIs). |
| Payment Maximums | | |
| • Benefit Period Maximum | <ul style="list-style-type: none"> • \$50,000 for all covered services (includes amounts applied to any maximum specified below): • \$2,500 for Prescription Drugs • \$550 for Outpatient Psychiatric Care and Outpatient Substance Abuse Services combined with a maximum of \$50 per visit • \$2,000 for Inpatient Psychiatric Care Services and Inpatient Substance Abuse Services combined • \$5,000 for Skilled Nursing Facility, Home Health Care and Hospice Services combined • 20 visits for Outpatient Physical Therapy Services with a maximum allowance of \$40 per visit • 10 visits for Spinal Manipulation Services with a maximum allowance of \$25 per visit | <ul style="list-style-type: none"> • \$2,500 for Prescription Drugs • \$550 for Outpatient Psychiatric Care and Outpatient Substance Abuse Services combined with a maximum of \$50 per visit • \$2,000 for Inpatient Psychiatric Care Services and Inpatient Substance Abuse Services combined • \$5,000 for Skilled Nursing Facility, Home Health Care and Hospice Services combined • 20 visits for Outpatient Physical Therapy Services with a maximum allowance of \$40 per visit • 10 visits for Spinal Manipulation Services with a maximum allowance of \$25 per visit |
| • Lifetime Maximum | <ul style="list-style-type: none"> • \$100,000 per member aggregate for Tissue and Human Organ Transplants combined • \$5,000 per member for Inpatient and Outpatient Psychiatric Care and Substance Abuse Services combined | <ul style="list-style-type: none"> • \$1,000,000 per member for all covered services (includes amounts applied to any maximum specified below) • \$100,000 per member for Tissue and Human Organ Transplants combined • \$10,000 per member for Inpatient and Outpatient Psychiatric Care and Substance Abuse Services combined • \$3,000 per member for maternity services |

¹ Copayment does not apply to deductible or out-of-pocket limit

² Services subject to calendar-year deductible

Application Process: You can apply for our coverage by completing an Ohio Open Enrollment Options Application. If you need assistance, contact your agent or call the toll-free customer service number and an agent will assist you. Please complete the application in its entirety and be sure to include all appropriate signatures.

Completed applications should be mailed to:

Anthem Blue Cross and Blue Shield
P.O. Box 37810
Louisville, KY 40233-7810

You will receive a letter advising of the approval or denial of your application. If approved, your identification card and information on how to obtain your Policy will be sent in a separate mailing.

Payment can be submitted with the application by check, automatic bank draft or credit card. No payments will be processed until your application has been approved for coverage.

If you do not submit payment with the application or apply for automatic bank draft, you will receive a bill in the mail.

- If you are an FEI, your bill will be mailed immediately upon enrollment. The first payment will be due by your effective date.
- If you are a non-FEI member, there is a 90-day waiting period prior to your effective date. Your bill will be mailed approximately 20 days prior to your effective date and will be due on your effective date.

Payment can be made by check or calling customer service to make a one-time payment by phone. Automatic bank draft payments can be set up at enrollment or by contacting customer service after you are enrolled.

Ohio Open Enrollment Options Application for CMM Plans



ASSIGNED EFFECTIVE DATE (DO NOT WRITE IN THIS AREA.)

Please complete in blue or black ink only.

| Section A – Applicant Information | | | | | |
|--|-----------------------------|--|------------|-----|-------------------------|
| Last Name | | First Name | | MI | Social Security Number* |
| Home Address (street and P.O. Box if applicable) | | | | | |
| City | | | State | Zip | County |
| Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married | Height (Ft. / In.) / | Weight | Sex M F | Age | Date of Birth / / |
| Daytime Phone Number () | Evening Phone Number () | E-mail* If possible, do you want E-mail notification? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Are all applicants listed on this application United States citizens? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| If NO, who? _____ and how many years/months have they resided in the United States? _____ years and _____ months | | | | | |

| Section B – Spouse or Domestic Partner Information | | | | | |
|---|-------------------------|------------|------------|-----|---|
| Last Name | | First Name | | MI | Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner |
| Social Security Number* | Height (Ft. / In.) / | Weight | Sex M F | Age | Date of Birth / / |
| Is your spouse or domestic partner a legal resident of the United States and a resident of the state in which you are applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |

| Section C – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary.) | | | | | | | |
|--|------------------------------|----------------------------|-----|-----|-----------------------------|---------------------|----------------|
| Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your unmarried children, or your spouse or domestic partner's unmarried children (to the end of the calendar month in which they turn 25). (List all dependents beginning with the eldest.) | | | | | | | |
| First, MI (last name if different) | Relationship to Applicant | Social Security Number* | Sex | Age | Date of Birth mm/dd/yyyy | Height Ft. / In. | Weight Lbs. |
| | Child | | M F | | | / | |
| | Child | | M F | | | / | |
| | Child | | M F | | | / | |
| | Child | | M F | | | / | |
| | Child | | M F | | | / | |

*This information is used for internal purposes only and will not be disclosed.

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| | | | |
|---|----------------------------|---|-----|
| Section D – Medical Coverage | | | |
| Comprehensive Major Medical (CMM) <input type="checkbox"/> Basic <input type="checkbox"/> Standard | | Select Type of health coverage: <input type="checkbox"/> Single <input type="checkbox"/> Parent/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> Child(ren) <input type="checkbox"/> Couple | |
| Section E – Eligibility and Prior Coverage Information (This section must be fully completed.) | | | |
| Was your last coverage through an employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the following: | | | |
| Contract Holder's Name | | Identification Number | |
| Employer's Name | | Telephone number (include area code) () | |
| Employer's Address (street and P.O. Box if applicable) | City | State | Zip |
| Effective Date of Coverage | | Cancellation Date of Coverage | |
| Were you/are you eligible for COBRA/State Continuation benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the following: | | | |
| COBRA/State Continuation Effective Date | | COBRA/State Continuation Expiration Date | |
| Have you elected and exhausted COBRA or state continuation benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Are you eligible for Medicare or Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Are you currently covered under any other health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please complete the following: | | | |
| Contract Holder's Name | | Identification Number | |
| Name of Current Coverage | | Telephone number (include area code) () | |
| Address of Current Coverage (street and P.O. Box if applicable) | City | State | Zip |
| If family, list all persons covered under the plan. | | | |
| Type of Coverage and Policy Number | Effective Date of Coverage | Cancellation Date of Coverage | |
| Are you or any person to be covered currently confined to a health care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |

Section F – Billing Options

| | | |
|--|--|---|
| Frequency (select one) <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually | Initial Premium (required) <input type="checkbox"/> Bank Draft (see below) <input type="checkbox"/> Check Enclosed (If paying by check, make the check payable to ABCBS.) <input type="checkbox"/> Credit Card (see below) | Total amount enclosed/charged \$ _____ |
|--|--|---|

Method (select one)
 HOME—Bills will be sent to your home billing address unless a separate billing address is listed below.

| | | | | |
|------|---|------|-------|-----|
| Name | Address (street and P.O. Box if applicable) | City | State | Zip |
|------|---|------|-------|-----|

AUTOMATIC BANK DRAFT (automatic premium withdrawals)—your premium will be deducted on the same day of the month as your assigned effective date. (You **MUST** attach a **blank** voided check)

Deduct money from my/our account for (check one):

- My first payment only \$ _____ My first and ongoing payments
 My ongoing payments only (first payment made by other method)

I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. I understand that this authorization is in effect until I notify Anthem in writing that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals if they wish to do so. I understand that a service charge will be incurred for any withdrawal not honored.

| | |
|--|--|
| Account holder's name (please print) X | Account holder's signature (if other than the applicant) X |
|--|--|

Staple
blank, voided check here

Staple
blank, voided check here

IF PAYING BY CREDIT CARD: A credit card can be used only for the initial premium payment.

Credit card information —

Cardholder's Name (as shown on the credit card): _____ Cardholders' Address: _____

If applicant is using the credit card of another cardholder: By signing this form, applicant represents that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for this payment and any charges accruing to it.

Type of Credit Card: VISA MasterCard Discover American Express

Credit Card Number: _____ **Expiration Date (month/year):** _____

Authorization: I authorize Community Insurance Company to charge my VISA, MasterCard, Discover or American Express credit card for the initial premium payment. If the review of my application results in a different premium than the quote generated by the system, I also authorize Community Insurance Company to charge my VISA, MasterCard, Discover or American Express credit card for this difference if necessary.

I agree that Community Insurance Company is fully protected in honoring any credit card payments. I further agree that if any credit card payment is dishonored, with or without cause, intentionally or inadvertently, Community Insurance Company is under no liability whatsoever, including any fees imposed by my bank, if my credit card is rejected even though such dishonor results in termination of coverage.

Applicant's Signature:
X

Section G – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application. For the purposes of this application, a Non-Federally Eligible Individual is a person who does not have any other health coverage and is not eligible to be covered under any private or government sponsored program, including but not limited to state continuation coverage, COBRA, Medicare and Medicaid.

1. I understand that it is mandatory that I notify Anthem, in writing, immediately if I (the applicant) or any other person for whom coverage is sought is or becomes eligible for any other health coverage including any private or government sponsored program, such as state continuation coverage, COBRA, Medicare or Medicaid or I or any other person for whom coverage is sought becomes confined to a health care facility because of chronic illness, permanent injury or other infirmity after the date I sign this application but before my coverage effective date. I understand that in these situations, Anthem has the right to review my application again, using the new information and that, as a result, my coverage/family members' coverage might be rescinded, or delayed, or reformed or benefits denied due to the other coverage, illness, injury or condition being treated as a preexisting condition.
2. 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 may not assign any payment under my Anthem program. I am applying for the coverage selected on this application. I understand that any premium quote provided is preliminary and review of my application may change the premium or result in a denial of coverage. 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. I understand that if my application is denied, my bank account or credit card will not be charged.
3. If I am a Non-Federally Eligible Individual, I understand that I have a 90 day waiting period before my coverage begins. I also understand that pre-existing conditions are limited to 12 months after enrollment for conditions in existence within 6 months immediately prior to my enrollment for which medical advice, diagnosis, care or treatment was recommended or received. Pregnancy is considered a pre-existing condition for Non-Federally Eligible Individuals and I understand if I select the Comprehensive Major Medical standard plan I have a 270 day waiting period before any maternity benefits are covered.
4. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
5. I understand Anthem may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. 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.
6. 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 Regulation and Ohio law, I have the 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.
7. 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; and he or she does not have any other health coverage and is not eligible to be covered under any private or government sponsored program, including but not limited to state continuation coverage, COBRA, Medicare and Medicaid.
8. 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.

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

- 9. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
- 10. 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 significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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.

| | | |
|------------------|--|------|
| SIGN HERE | Signature of Applicant <i>(or Custodial Parent's or Guardian's signature if applicant is under age 18)</i> X | Date |
| | Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) X | Date |
| | Signature of Dependent Child(ren) age 18 or over (if to be covered) X | Date |

Section H – Agent Certification

To be completed by your Anthem-appointed agent:
I certify to the best of my knowledge and belief, the responses herein are accurate.

| | | | |
|-----------------------------|----------------|--|------|
| Agent Signature X | | Date | |
| Agent Name (please print) | | Agent Street Address/Suite No./Personal Mail Box (PMB) No. | |
| Agent ID No. | City/State/Zip | County Code | Area |
| Agent Phone No. | Agent Fax No. | Agent Email Address | |
| GA (if applicable) | | GA code (if applicable) | |

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Authorization for Use of Protected Health Information

The following authorization must be signed by all of the following persons if they are applying for coverage or changing existing coverage:

- the applicant;
- the applicant's spouse or domestic partner; and
- any Dependent Child age 18 or over.

If the authorization is not signed by all of the persons listed above who are seeking coverage, the application may be returned to you as incomplete or acted upon without regard to any person whose required signature was not included. This Authorization will expire 24 months following Community Insurance Company acceptance of coverage, if not previously revoked.

By signing below: I authorize Community Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Community Insurance Company, to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, 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 Community Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Community Insurance Company. This information is needed to determine eligibility for coverage and Community Insurance Company's acceptance of coverage requested for myself and/or any family members listed on my Application or so that a determination of coverage regarding a claim for specified benefits can be made.

This authorization is subject to revocation at any time by written notice to Anthem except to the extent that Anthem has already taken action in reliance on this authorization. If I revoke this authorization after I initially apply for coverage, I understand that I/we will not be considered for coverage. 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. I understand that if my and/or my family's information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans governed by federal privacy regulations. A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

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

**If listed on your application or change form, your spouse/domestic partner and each dependent child age 18 or over must sign above.
If a legal representative signs on behalf of the applicant or spouse or domestic partner, a copy of the legal representative's authority must be attached to the application.*

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