Ohio
Change of Coverage Application

(as provided through a Group Trust Insurance Policy)

Use only for upgrade of medical benefits or risk review. **This form cannot be used to add members not currently covered. This form cannot be used to *just* add Dental or Life – you must be making Medical Coverage changes to use Sections F and G.** Please complete in blue or black ink only. Do not write in shaded areas, these are for Sales/Producers use only.

Section A – Coverage Information

Anthem individual policy coverage

Identification Number _____

Effective month requested:

_____

Your renewal date will remain the same day of the month as your existing policy.

Section B – Applicant Information

Risk Tier	Last Name	First Name	MI	Social Security Number*

Home Address (street and P.O. Box if applicable)

City	State	ZIP	County

Marital Status ☐ Single ☐ 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? ☐ Yes ☐ No (This information will not be shared with any third party.)

Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? ☐ Yes ☐ No

Section C – Spouse or Domestic Partner Information

Risk Tier	Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner

Social Security Number*	Height (Ft. / In.) /	Weight	Sex M F	Age	Date of Birth / /

Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? ☐ Yes ☐ No

Section D – Child Dependent(s) Information

(All fields required. Attach a separate sheet if necessary.)

Dependent information must be completed for all child dependents (if any) currently covered under this coverage. An eligible dependent may be your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 28). (List all dependents beginning with the eldest.) This form cannot be used to add members not currently covered.

Risk Tier	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			/	
		Child		M F			/	

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

Section E – Medical Coverage

☐ ***I wish to change my existing coverage:***

Plan Name, In-Network Coinsurance, Deductible Options	Optional Benefits
Select ONE Plan…then select ONE Individual Deductible and any optional benefits. Total Family Deductible will be two (2) times the amount shown.	
☐ **SmartSense® Plus** (50% coinsurance) ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,500 (30% coinsurance) ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $3,500 ☐ $5,000 ☐ $10,000	☐ **Upgrade Drug Coverage**
☐ **Premier Plus** (20% coinsurance) ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $1,500 - no office visit copay (0% coinsurance) ☐ $2,500 ☐ $3,500 ☐ $5,000 ☐ $10,000 ☐ $2,500 - no office visit copay	☐ **Upgrade Drug Coverage** ☐ **Add Maternity Coverage** (available on $2,500 or higher deductible options)
☐ **CoreShare** (50% coinsurance) ☐ $750 ☐ $1,500 ☐ $2,500 ☐ $3,500 ☐ $5,000 (0% coinsurance) ☐ $7,500 ☐ $10,000 ☐ $15,000 ☐ $25,000	

HSA Compatible Plans

Select ONE Plan…then select ONE Deductible (Individual/Family) and any optional benefits.

☐ **Lumenos® HSA Plus** (50% coinsurance) ☐ $1,500/3,000 (20% coinsurance) ☐ $1,750/3,500 (0% coinsurance) ☐ $1,500/3,000 ☐ $2,500/5,000 ☐ $3,500/7,000 ☐ $5,500/11,000	

☐ **YES**, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Anthem's banking partner. (Please fill in your Social Security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Anthem's banking partner.

Section F – Dental Coverage (Must be making Medical Coverage changes to add/change Dental Coverage)

☐ Change plan to (at an extra cost per individual):

☐ **Dental Blue® Basic 100** ☐ **Dental Blue® Essential 100** ☐ **Dental Blue® Essential 200**

Select ONE coverage type (applies to individuals listed on this application only):

☐ Applicant only ☐ Applicant, Spouse /Domestic Partner, and all dependent children listed

☐ Applicant and Spouse /Domestic Partner only ☐ Applicant and all dependent children listed

☐ Keep existing plan

Section G – Term Life Insurance (Must be making Medical Coverage changes to add/change Life Coverage)

Blue Preferred® Term Life ☐ Yes, please continue my life coverage.

Do you, the applicant, own an existing life policy or annuity contract? ☐ Yes ☐ No (Answer by checking one)
If you answered "Yes" to the above question, inform the agent, who will provide you an "Important Note: Replacement of Life Insurance or Annuities," which you must read and complete.

By applying for this proposed life policy, do you intend to replace, discontinue or change any existing life policy or annuity contract? {box} Yes {box} No (Answer by checking one)

☐ Yes, in addition to my medical coverage, I wish to apply for Term Life Insurance (at an extra cost per individual).

☐ Yes, I want to change my coverage amount–see below.
Provide information below.
Applicants must meet Anthem's Underwriting Guidelines to qualify for Term Life Insurance Coverage. Applicants under the age of one year are not eligible for Life Insurance.
All Term Life policies terminate at age 65.

Applicants	Coverage Amount (select one)	Beneficiary**	Relationship	Beneficiary Street Address City/State/ZIP code
☐ Applicant	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		
☐ Spouse	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		
☐ Child(ren)	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		

*The $50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to $25,000.
****If a beneficiary is not listed** and a policy is issued, death benefits will be paid in accordance with the Beneficiary Provision of the Policy.

Section H – Billing Options ☐ Keep billing the same ☐ Change billing as indicated below

Frequency (select one)

☐ Monthly ☐ Quarterly

☐ Semi-annually ☐ Annually

Initial Premium **Total amount enclosed/charged $ _____**

☐ Bank Draft (see below)

☐ Check Enclosed (If paying by check, make the check payable to Anthem Blue Cross Blue Shield.)

☐ Credit Card (see below)

☐ No Payment Enclosed

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 and warrants 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 Anthem Blue Cross and Blue Shield to charge the credit card indicated for the amount specified in* ***Initial Premium.***

Applicant's Signature:
X

☐ **NEW LIST BILL** — Billing through third-party (This option must have prior approval and requires separate List Bill forms to be completed and submitted with this application.)

☐ **CHANGE TO EXISTING LIST BILL** List Bill Arrangement Number: _____

Section I – Health History (Attach a separate sheet if necessary.)

When answering questions on this enrollment application, the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

	YES	NO
1. Has any enrolled family member been hospitalized, seen a physician or other health care provider or taken any prescription medication within the last six months? If yes, please provide name of applicant and details below.	☐	☐
2. Are you or your spouse/domestic partner (whether currently enrolled or not) an expectant parent?	☐	☐
3. Has any enrolled member been advised to seek treatment, have surgery or testing (excluding HIV and AIDS)? If yes, please provide name of applicant and details below.	☐	☐
4. Has any enrolled member used tobacco products within the past 12 months?	☐	☐
If yes, please give name		
5. FEMALES ONLY – Please provide the following information (Applicable to ALL females listed on this application)		
Do you menstruate?	☐	☐
Has it been more than 40 days since your last menstrual period? If yes, please give reason	☐	☐

Section J – Significant Terms, Conditions, and Authorizations (Please read carefully.)

Please read this section carefully before signing the application.

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 receives medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage approval date. I understand that in this situation, Anthem has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be delayed or reformed or, for applicants age nineteen (19) and older, benefits denied due to the illness, injury or condition being treated as a preexisting condition.**
2. I may not assign any payment under my Anthem program.
3. I am applying for the coverage selected on this application.
4. I understand that any premium quote provided is preliminary and review of my application by medical underwriting may change the premium or result in a denial of coverage.
5. 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.
6. **For applicants age nineteen (19) and older, I understand that preexisting conditions are limited to 12 months after enrollment for conditions in existence within six months immediately prior to my enrollment for which medical advice, diagnosis, care or treatment was recommended or received. Pregnancy is considered a preexisting condition.**
7. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
8. 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.
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 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.
11. **I understand I am applying for individual health coverage (under Anthem's Group Trust) 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.**
12. If I purchase optional dental coverage, I understand that I will have a six-month waiting period for coverage of Basic services and a 12-month waiting period for coverage of Major services. (For a description of Basic and Major services, please refer to your marketing materials.)
13. If the plan I purchase offers a maternity rider, and I purchase the maternity rider, I understand that: 1) these benefits apply only to me or my covered spouse or domestic partner and to any dependent child and 2) these benefits will not begin until after my membership has been in effect for 270 days.
14. By signing this application I certify that I understand that Anthem Life has the right to deny my application for Term Life Coverage, and if it does, I will be notified in writing. I understand that if Anthem Life declines this coverage, no benefits will be payable. I understand that I alone am responsible for reading and accurately completing this application, and I must communicate any changes to my status. I also understand that all other conditions of my medical application apply for the life application.
15. 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 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).

    If tobacco use question in Section I is answered "NO", I understand that the signature(s) below will attest to non-tobacco usage for the past 12 months.

    Any person who, with intent to defraud or knowing that he 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.

Signature of Applicant *(or Custodial Parent's or Guardian's signature if applicant is under age 18)* X	Date
Signed at _____, _____ (city/state)	
Signature of Spouse or Domestic Partner (if to be covered) X	Date
Signed at _____, _____ (city/state)	
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date
Signed at _____, _____ (city/state)	

Section K – Agent Certification

To be completed by your Anthem-appointed agent:

1. Does the applicant intend to replace, discontinue or change any existing life policy or annuity contract? ..... ☐ Yes ☐ No
2. Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting? ..... ☐ Yes ☐ No
3. **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 Number/Personal Mail Box(PMB) Number		
Agent ID Number	City/State/ZIP	County Code	Area
Agent Phone Number	Agent Fax Number	Agent E-mail Address	