Anthem Enhanced Choice Individual Enrollment Application Kentucky

Anthem Health Plans of Kentucky, Inc.
13550 Triton Park Boulevard
Louisville, KY 40223

Anthem Enhanced Choice plans **(short term limited duration plans)** provide a fully digital experience, which means that all plan-related communications may be sent by email and general interactions with Anthem Blue Cross and Blue Shield (Anthem) will occur digitally through Anthem's website and mobile app(s). If you have questions while filling out this form, please call Anthem at 1 (877) 212-1793. But if you've worked with an agent or broker, contact them first.

Application Type (select one):

☐ **New Enrollment** If you are a new enrollee or want to lower your deductible at renewal (upgrade), please complete the entire application.	☐ **Change Current Plan** If you are changing to a higher deductible amount (downgrade), please complete all sections of the application, except Section F – Health History Questions.

Section A — Primary Applicant

Last name (legal name)		**First name** (legal name)		**M.I.**	**Social Security Number**[1] - -
Marital status ☐ Single ☐ Married ☐ Domestic Partner	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Height** (Ft./In.)	**Weight** (Lbs.)	**County** (for home address)

Home address (not a P.O. Box)	**City**	**State**	**ZIP**
Billing address (optional — if different than home address)	**City**	**State**	**ZIP**
Mailing address (optional — if different than home address)	**City**	**State**	**ZIP**

Primary phone	**Secondary phone**	Are all persons applying for coverage legal residents of the state in which they are applying for coverage? ☐ Yes ☐ No **If no, who?** _____

Are any applicants currently incarcerated (with more than 60 days left to serve before release) as a result of a conviction? ☐ Yes ☐ No

If yes, who? _____

Email address: _____

For myself and any dependents, I am providing my email address so I may receive communications electronically. These communications may include my Identification Cards, Contract or Certificate of Coverage, billing, Explanation of Benefits, required notices including cancellation and renewals, and helpful or personalized information to get the most out of my benefits. I understand I need to register on anthem.com or Anthem's mobile app(s) to get the most out of my plan's digital experience, and to keep my email address up to date. I will make sure Anthem always has my most up to date email address. I understand I (or my enrolled dependents) can update communication preferences or request a free copy of specific materials by going to anthem.com or calling the Member Services number on my ID card.

Section B — Coverage Desired

Deductible level desired: ☐ $1500 ☐ $2000 ☐ $2500 ☐ $3500 ☐ $5000 ☐ $7500

Plan duration: The benefit period under this plan is 364 days.

Effective date: Your coverage's effective date is determined by the date we receive your completed application, provided we approve it. If we receive it:

- Between the 1st and 15th day of the month, coverage starts the 2nd day of the following month.
- Between the 16th and last day of the month, coverage starts the 2nd day of the second following month.

If you would like to choose a different month for coverage to be effective, please enter the month: _____ **(month)**

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

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

Section C — Dependent Information

If there are additional dependents, please attach a separate page with all requested information.

Dependent information must be completed for all additional dependents (if any) for whom coverage is being requested. An eligible dependent may be your spouse/domestic partner, your children, or your spouse's/domestic partner's children (to the end of the calendar month in which they turn age 26). List all dependents beginning with the eldest.

First name	Middle initial	Last name (if different from applicant)	Social Security Number[1]	Height Ft./In.	Weight Lbs.	Birthdate mm/dd/yyyy	Sex	Relationship to applicant
							☐ M ☐ F	
							☐ M ☐ F	
							☐ M ☐ F	
							☐ M ☐ F	

Section D — Other Coverage Information

Are any applicants eligible for Medicare? If so, we will reduce benefits by the amount Medicare would have paid for services you receive even if not enrolled in Medicare. ☐ No ☐ Yes **If yes, who?** _____

Are any applicants enrolled in Medicare? ☐ No ☐ Yes **If yes,** they are not eligible to enroll.

Are any applicants currently receiving Social Security Disability, Medicaid or other government program benefits, or are unable to work due to disability or receiving Workers' Compensation benefits? ☐ No ☐ Yes **If yes,** fill out the boxes below.

Who	Reason	Start date of benefits	End date of benefits

Section E — Current Medical Coverage

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

Name of person covered (Last, First, M.I.)	Coverage type	Insurer name	Member ID no.	Coverage dates (if applicable) (mm/dd/yyyy) Termination date (if different from coverage end date)
	☐ Anthem ☐ Other			Start: End: Termination Date:
	☐ Anthem ☐ Other			Start: End: Termination Date:
	☐ Anthem ☐ Other			Start: End: Termination Date:
	☐ Anthem ☐ Other			Start: End: Termination Date:
	☐ Anthem ☐ Other			Start: End: Termination Date:

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Section F — Health History Questions

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

1. Is any applicant currently pregnant (includes positive pregnancy test within the last 30 days), an expectant parent, or in the process of adoption or surrogate pregnancy? **If yes, who?** _____ ☐ Yes ☐ No

2. Within the past 12 months, has any applicant been diagnosed or had treatment for any of the following (please select all that apply)? ☐ Yes ☐ No

- ☐ AIDS, AIDS Related Complex (ARC), or HIV
- ☐ Cancer with chemo or radiation treatment
- ☐ Cerebral palsy
- ☐ Cirrhosis
- ☐ Heart attack/surgery
- ☐ Hemophilia
- ☐ Hospital confined for a mental disorder or substance abuse
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Transplant (other than cornea)

3. Within the past 12 months, have you, your spouse, or any dependent 21 or over used tobacco? **If yes, who?** _____ ☐ Yes ☐ No

4. Within the last 30 days, has any applicant been admitted to an inpatient hospital or surgical facility? **If yes, please explain in #7.** ☐ Yes ☐ No

5. Is any applicant currently being treated, been treated for, or been advised to seek treatment or counseling for any of the following (please select all that apply)? **If yes, please explain in #7.** ☐ Yes ☐ No

- ☐ Back/spinal disorder
- ☐ Blood disorders
- ☐ Brain tumor
- ☐ Cancer
- ☐ Chemical dependency/alcoholism
- ☐ Chronic respiratory/lung disease
- ☐ Crohn's disease/ulcerative colitis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Immune system disorders
- ☐ Kidney disorder
- ☐ Liver disease
- ☐ Major depression or other mental disorder
- ☐ Multiple sclerosis
- ☐ Muscular or joint disorder
- ☐ Nervous system disorders
- ☐ Obesity
- ☐ Stomach or digestive disorder
- ☐ Stroke
- ☐ Transplants
- ☐ Other

6. Does any applicant regularly take medication (other than birth control or over-the-counter medication)? **If yes, please explain in #7.** ☐ Yes ☐ No

7. Explain "Yes" answer to any question. Give complete details to avoid delay. Attach a separate sheet if necessary.

Individual name	Diagnosis	Treatment	Medication and dosage	Onset date	Treatment date(s)	Hospitalized	Surgery	Recovered
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Section G — Terms, Conditions, and Authorizations

I, the undersigned, understand that:

- The coverage I have selected does not include all of the 10 essential health benefits and other benefits that are required to be covered under plans that are compliant with the Affordable Care Act (ACA). ACA compliant plans can be purchased during the next open enrollment period as defined on healthcare.gov.
- It is mandatory that I notify Anthem, in writing, immediately if I (the applicant) or any other person for whom coverage is sought received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date, or the date underwriting approves, whichever is later. I understand that in this situation, Anthem has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be reformed or cancelled.
- If the tobacco use question in Section F is answered "NO", I understand that the signature(s) below will attest to non-tobacco usage for the past 12 months.
- I'm applying for the coverage selected on this application. 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. 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 must make my full first month's premium payment, as determined by Anthem, once my application is underwritten and provided it is approved by Anthem. My payment of the full first month's premium is deemed my acceptance of that premium rate.
- I'm responsible to let Anthem know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- Check payments may be handled as Automated Clearinghouse (ACH) debit transactions. That means if I pay by check, the paper check will be destroyed and the debit payment will appear on my bank statement. My check won't be given to my financial institution or sent back to me. This does not mean I will be enrolled in an automatic debit process to pay my premium. Any resubmissions due to insufficient funds may also be electronic. 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 me.
- 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 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 represent that I have read the Terms, Conditions, and Authorizations section, and I agree to the coverage conditions. I represent 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. I understand that any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of my benefits or cancellation of my coverage(s). I also understand that any person who knowingly and with the intent to defraud any insurance company or health maintenance organization, submits an application for insurance or files a claim containing any materially false information or a false or deceptive statement, for the purpose of misleading, is guilty of insurance fraud, which is a crime.
- I may not assign any payment under my Anthem program.
- If my request for coverage is being handled by a producer, I understand that the producer is not authorized to waive a complete answer to any question in the application, pass on insurability, make or alter any contract or waive any of Anthems' other rights or requirements.

This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.
I sign this application for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative.

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

Please read before signing.

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 this authorization is not signed by all of the persons listed above who are seeking coverage, this 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 Anthem's acceptance of coverage, including for purposes of determining my eligibility or continued eligibility for this coverage, if not previously revoked.

I authorize Anthem or an agent, subsidiary or affiliate that has a business associate agreement with Anthem to obtain any medical records or other health history information concerning me and any family member listed on this application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans, health insurers and medical or pharmacy benefit administrators.

I also authorize any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans, health insurers and medical or pharmacy benefit administrators, to furnish any medical records or health history information concerning me and any family member listed on this application to Anthem or an agent, subsidiary or affiliate that has a business associate agreement with Anthem. This information is needed to determine eligibility for coverage and Anthem's acceptance of coverage requested for me and/or any family members listed on this 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. 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, my/our information might be re-disclosed by any of those recipients and will not be protected 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.

By signing below, I agree to the Authorization for Use of Protected Health Information.

	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

* If listed on this application, 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.

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

Did an agent or broker help you?

☐ Yes ☐ No If yes, make sure they fill out this section.

Section H — Agent (or Broker) Certification All fields required.

I certify to the best of my knowledge and belief, the responses herein are accurate.			
Agent/Broker signature			**Date**
Agent name (please print clearly)			
***(A) Writing Agent TIN/SSN** (encrypted TIN is ok)		****(B) Writing Agent/Agency/General Agency TIN** (encrypted TIN is ok)	
Agent address	**City**	**State**	**ZIP**
Agent phone no.	**Agent fax no.**	**Agent email**	

***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).

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

Here's what's next.

1) We will contact you once the underwriting process is complete or if we need additional information. If you have questions before then, please call us at 1 (855) 761-8313.
2) If needed, mail the completed application to the following address: Anthem Blue Cross and Blue Shield, P.O. Box 659960, San Antonio, TX 78265-9146 or by fax to 1 (800) 848-2512.

Thank you!