

Anthem Blue Cross and Blue Shield Monthly Health Insurance Plan Rates*

Please select an area from the table below based on the applicant's residence ZIP code, and look up the corresponding area rate table on the following pages.

Area 1	All ZIP codes beginning with 890 and 891
Area 2	All ZIP codes EXCEPT those beginning with 890 and 891

Certain medical conditions

For certain medical conditions, an applicant may qualify for a plan at a premium that is 20 percent or 40 percent higher than the Level I rates.

Tobacco users

Tobacco users pay an additional 40 percent premium. If any family member who is to be insured uses tobacco, see the Level I + 40 percent rates on page 3.

Additional information

- First premium payment: See application instructions for specifics.
- Rates are based on the age of the applicant or spouse, whomever is older, and the residence address. Rates are recalculated at each billing period based on age and the residence address.

Payment methods

- Monthly by checking account deduction on the first of each month, or
- Monthly billing, or
- 3-month (quarterly) billing

*These rates are for the products described in the Agent Guide to Individual and Family Health, Dental and Life Insurance Plans, and the Short-term Plans brochure. Please refer to the Summary of Coverage and Policy for each plan for complete coverage information.

Rick Hokanson
Hokanson Insurance
800 N. Rainbow Blvd Ste 208
Las Vegas NV 89107
702-269-9902
smarthealth@cox.net
www.aFairquote.com

Nevada Individual and Family Rates Level 1 Area 1

	Anthem Blue Saver 2000	Anthem Blue 5000	HSA 2600
Single Male			
Under 30	52	61	68
30-34	56	66	73
35-39	60	69	77
40-44	89	100	112
45-49	108	120	136
50-54	177	196	224
55-59	226	247	283
60-64	267	290	334
Single Female			
Under 30	81	93	104
30-34	87	98	110
35-39	94	105	118
40-44	138	155	176
45-49	144	160	183
50-54	205	225	257
55-59	214	237	272
60-64	226	247	283
Applicant & Spouse			
Under 30	133	154	131
30-34	137	159	135
35-39	147	167	144
40-44	183	205	176
45-49	246	275	239
50-54	321	356	312
55-59	431	472	415
60-64	481	527	465
Applicant & 1 Child			
Under 30	117	135	93
30-34	123	140	96
35-39	130	147	101
40-44	174	197	137
45-49	180	202	142
50-54	241	267	188
55-59	262	289	203
60-64	303	332	235
Applicant & 2 Children			
Under 30	150	170	125
30-34	156	175	129
35-39	163	182	134
40-44	207	232	173
45-49	213	237	177
50-54	274	302	226
55-59	295	324	243
60-64	336	367	276
Applicant & 3+ Children			
Under 30	179	200	160
30-34	185	205	164
35-39	192	212	170
40-44	236	262	211
45-49	242	267	216
50-54	303	332	269
55-59	324	354	288
60-64	365	397	324
Family w/ 1 Child			
Under 30	169	196	171
30-34	173	201	175
35-39	183	209	183
40-44	219	247	217
45-49	282	317	282
50-54	357	398	357
55-59	467	514	462
60-64	517	569	514
Family w/ 2 Children			
Under 30	202	231	214
30-34	206	236	218
35-39	216	244	227
40-44	252	282	263
45-49	315	352	331
50-54	390	433	410
55-59	500	549	522
60-64	550	604	576
Family w/ 3+ Children			
Under 30	231	261	258
30-34	235	266	263
35-39	245	274	272
40-44	281	312	310
45-49	344	382	383
50-54	419	463	468
55-59	529	579	586
60-64	579	634	644
Child Under 1	90	102	116
Child 1-17	36	42	46
2 Children	69	77	53
3+ Children	98	107	79

Nevada Individual and Family Rates Level 1 Area 2

	Anthem Blue Saver 2000	Anthem Blue 5000	HSA 2600
Single Male			
Under 30	47	55	62
30-34	51	60	66
35-39	54	62	70
40-44	81	91	101
45-49	98	109	123
50-54	160	177	203
55-59	205	224	256
60-64	242	262	302
Single Female			
Under 30	73	84	94
30-34	79	89	100
35-39	85	95	107
40-44	125	140	159
45-49	130	145	166
50-54	186	204	233
55-59	194	214	246
60-64	205	224	256
Applicant & Spouse			
Under 30	120	139	119
30-34	124	144	122
35-39	133	151	130
40-44	166	186	159
45-49	223	249	216
50-54	290	322	282
55-59	391	428	376
60-64	436	476	421
Applicant & 1 Child			
Under 30	106	122	84
30-34	112	127	87
35-39	118	133	91
40-44	158	178	124
45-49	163	183	129
50-54	219	242	170
55-59	238	262	184
60-64	275	300	213
Applicant & 2 Children			
Under 30	135	154	113
30-34	141	159	117
35-39	147	165	121
40-44	187	210	157
45-49	192	215	160
50-54	248	274	205
55-59	267	294	220
60-64	304	332	250
Applicant & 3+ Children			
Under 30	162	181	145
30-34	168	186	148
35-39	174	192	154
40-44	214	237	191
45-49	219	242	195
50-54	275	301	243
55-59	294	321	261
60-64	331	359	293
Family w/ 1 Child			
Under 30	153	177	155
30-34	157	182	158
35-39	166	189	166
40-44	199	224	196
45-49	256	287	255
50-54	323	360	323
55-59	424	466	418
60-64	469	514	465
Family w/ 2 Children			
Under 30	182	209	194
30-34	186	214	197
35-39	195	221	205
40-44	228	256	238
45-49	285	319	300
50-54	352	392	371
55-59	453	498	472
60-64	498	546	521
Family w/ 3+ Children			
Under 30	209	236	233
30-34	213	241	238
35-39	222	248	246
40-44	255	283	281
45-49	312	346	347
50-54	379	419	424
55-59	480	525	530
60-64	525	573	583
Child Under 1	81	92	105
Child 1-17	33	38	42
2 Children	62	70	48
3+ Children	89	97	71

Dental PPO Plan Monthly Rates

One adult	\$27.00
Two adults	\$54.50
Adult with 1 child	\$42.00
Adult with 2 children	\$56.50
Adult with 3+ children	\$79.00
Family (1 child)	\$69.00
Family (2 children)	\$84.00
Family (3+ children)	\$106.00
One child	\$15.00
Two children	\$29.50
Three+ children	\$51.50

Term Life Insurance Monthly Rates

Age	\$15,000	\$25,000	\$50,000
1-18	\$ 1.50	\$ 2.50	N/A
19-29	2.80	4.65	9.30
30-39	3.25	5.40	10.80
40-49	7.50	12.50	25.00
50-59	20.90	34.80	69.60
60-64	29.40	49.00	98.00

INDIVIDUAL & FAMILY PPO HEALTH INSURANCE PLANS

[Anthem Blue 5000]
 [Anthem Blue Saver 2000]
 [Anthem Blue High-Deductible
 (HSA-Compatible) Plan—Policy 2600]
 & [Anthem LIFE] [AND DENTAL PLANS]

Application

Thank you for applying with Anthem Blue Cross and Blue Shield.

PLEASE NOTE:

- **Coverage is not available if:**
 - Any family member is currently pregnant (whether or not listed on the application) or in the process of adoption; or
 - The applicant has not resided in the U.S. for the last six consecutive months.
- **Coverage is not guaranteed until approved in writing by Anthem. Do not cancel your current insurance coverage until you have been notified in writing of approval by Anthem and your Anthem coverage is effective.**

Instructions

Do not complete this application until you have read the current product brochure.

Please follow these instructions to allow us to better process your application.

- For your own protection, **you, the applicant**, must complete this application. You are solely responsible for its accuracy and completeness.
- All information must be stated accurately.
- All questions must be answered in full or the application may be returned to you resulting in a delay in processing.
- For additional information or explanations attach extra sheets, if necessary. **All attachments must be signed and dated.**
- Print clearly using blue or black ink. No correction fluid, please. **Sorry, but typed applications will not be accepted.**
- This application must be received by Anthem Medical Underwriting within sixty days from the signature date.
- [Anthem Health] and [Dental Plans] are available only in areas where the Anthem Network exists. Please see Provider Directories or check the Provider Finder on the Anthem website at www.anthem.com for more details.
- Even if this application is approved, any misstatements or omissions may result in future claims being denied and the plan being rescinded.
- Your insurance will become effective only if this application is approved as applied for, the appropriate premium is enclosed, and other specific conditions are met. **(See details under Section 7 – Conditions of Application).**
- Please return this application and your check to your agent OR mail to the address listed at right.

Billing Information

Carefully read the instructions accompanying each billing type and make sure that your check is attached to the application.

- **Monthly paper billing:** Submit the one-month premium]
- **Monthly billing under electronic funds transfer (EFT) (with monthly bank draft authorization):** Submit the one-month premium, complete the Monthly Bank Draft Authorization.]
- **Quarterly paper billing:** Submit the three-month (quarterly) premium.]

Most common causes for delay in underwriting determination

- Missing, inaccurate or incomplete information such as:
 - Weight AND Height
 - Spouse's social security number
 - Dependent's social security number
 - Date of birth
 - Date of last pelvic examination
 - Results of last pelvic examination
 - Physician address, phone number and fax number
- Incomplete or illegible information such as the mailing address does not include city, state, and ZIP code.
- ALL questions are not answered in Sections 4 and 6. If it does not apply to you, the answer should be "No." Do not leave any answers blank.
- The application is not signed and dated by the applicant and/or all dependents over age 18.
- Agent portion of application is not completed, signed, or dated with a date on or after applicant's signature date.
- Additional documentation or information is required.

Mailing Address

- **Applicant:** Please return this application to the agent address below
Rick Hokanson
800 N Rainbow Blvd Ste 208
Las Vegas NV 89107

Also available for on-line submission at
www.aFairquote.com



Applicant's Social Security No.									

INDIVIDUAL ENROLLMENT APPLICATION - NEVADA

- Application must be completed by the applicant in blue or black ink.
- Any family member currently pregnant (whether or not listed on the application) or in the process of adoption is not eligible.

1. Applicant Information *(Please Print)*

Primary Applicant's Last Name	First Name	M.I.
Home Address <i>(Residence address required; P.O. Box not acceptable)</i>		
City	State	ZIP Code

Reason for Application *(Check one)*

- New Enrollment(s)
- Child only *(Please use youngest child for primary applicant)*
- Change coverage
- Add dependent(s) to I.D. No: _____

To change existing Anthem plan, please enter I.D. No: _____

For Summary Bill (existing), I.D. No: _____

Mailing Address <i>(If different than above)</i>	(P.O. Box or Personal Mail Box No.)	Home Phone No. ()	E-mail Address <i>(Optional)</i>
City	State	ZIP Code	Daytime Phone No. ()
In care of:		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Spouse's Social Security No. <i>(Required)</i>
Billing Type: <input type="checkbox"/> Monthly Paper Bill <input type="checkbox"/> Quarterly Paper Billing <input type="checkbox"/> Monthly EFT		Maiden Name of Applicant/Spouse <i>(If applicable)</i>	
Has any person listed on this application resided outside the U.S. for the past six (6) consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please provide name and explain:			

2. Choice of Anthem Individual Coverage

Plan Choice:

- Anthem Blue Life (R424)
- Anthem Blue Dental(R437)
- Anthem Blue 5000 (T097)
- Anthem Blue Saver 2000 (PD59)
- Anthem Blue High Deductible (HSA-compatible) Plan - Policy 2-2600 deductible (X445)

3. Applicants for Coverage

Check one: Insure all eligible applicants Insure no one unless all are accepted for coverage

Please list *all* applicants applying for coverage. *(List children youngest to oldest)*

If a family member's last name is different than yours, please attach explanation to application.

Relation	Last Name	First Name	M.I.	MUST BE ACCURATE		Date of Birth	Social Security No.	✓ Full Time Student	FamilyFlex List Medical Plan code number(s) from Section 2	✓ Dental
				Height	Weight					
<input type="checkbox"/> Male <input type="checkbox"/> Female	Yourself									
<input type="checkbox"/> Husband <input type="checkbox"/> Wife	Spouse									
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										

FOR ANTHEM USE ONLY - DO NOT WRITE BELOW

Group No.	Certificate No.	Agent I.D. No.	Effective Date	X Ref. Cert. No.
By		Date		

Applicant's Social Security No. _____

4. Other Coverage - please answer all the following questions.

- A.** Do you currently have, or has anyone to be insured had a minimum of 18 months of continuous health coverage? Yes No
 Was the coverage an employer-sponsored group health plan? Yes No
 Did this coverage end within the last 63 days for a reason other than fraud or non-payment of premium? Yes No

If Yes, please provide the following information and attach the Certificate of Creditable Coverage from your prior health insurance carrier.

Name of insured(s)	Insurance carrier(s)	Effective date	End date
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Do you agree to discontinue your current coverage if this application is accepted? Yes No

If No, please explain:

- B.** Has anyone on this application been insured by Anthem in the last 5 years? Yes No

If Yes, please provide the following information.

Name of insured(s)	Plan/I.D. No.	Group No.
Name of Plan	City	State
		Date cancelled

- C.** If any applicant has/had Anthem group coverage, please complete the following:

I certify that my Anthem group coverage will end/ended on (date):

I do not wish to enroll in any available Conversion Agreement. I understand that with the coverage for which I am applying with this application there may be a lapse in coverage. If accepted with or without lapse in coverage, each person will be subject to new waiting periods and deductibles.

- D.** Has anyone identified on this application ever been declined, postponed, had a waiver applied, or charged an extra premium for life, disability, or health insurance, or had such insurance rescinded? Yes No

If Yes, please provide the following information.

1. Name of applicant	Name of Insurance Company	Explain
2. Name of applicant	Name of Insurance Company	Explain
3. Name of applicant	Name of Insurance Company	Explain

- E.** Are any persons applying for coverage on this application eligible for Medicare benefits? Yes No

If Yes, please list all eligible person(s). Note: Any applicant eligible for Medicare Part A or B is **not** eligible for this coverage.

Eligible person(s)

- F.** Has anyone applying for coverage on this application filed a claim for disability or Workers' Compensation within the past 18 months? Yes No

If Yes, please provide the following information.

Name of applicant	Effective date	End date
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5. Term Life Insurance

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. **Submit Premium with application.**

Name of Family Member	✓ Amount of Coverage			Name of Beneficiary**	Relationship	Beneficiary Street Address City/State/ZIP Code
	\$15,000	\$25,000	\$50,000*			
Primary Applicant						
Spouse						
Dependent						

*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.

I have discussed Life Insurance with my agent and decline to apply – Initial: _____

6. Health History

6A. Health History Questionnaire – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.

Give COMPLETE details of any "Yes" answers in Section 6B on the following page.

<p>1. Have you had a physical exam, any diagnostic test or screening test such as blood tests, X-rays, CAT scans, MRIs, mammograms, etc. within the past 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you discussed or been advised to have testing, treatment, therapy or surgery that has not yet been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control pills or short term (10 days or less) antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Has it been more than 40 days since your last menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Have you been diagnosed, treated, evaluated for or experienced any genital/gynecological or reproductive problem(s) including infertility within the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you been evaluated, treated or experienced breast cysts or lumps within the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you an expectant parent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Have you had or been treated for any sexually transmitted disease (STD) within the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you been treated for any mental, emotional or behavioral disorder including anorexia, attention deficit disorder or depression within the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Have you been hospitalized within the past 5 years for any mental, emotional, or behavioral disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you been diagnosed with, treated or evaluated for symptoms related to alcoholism and/or use or abuse of alcohol within the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you used illegal drugs or been treated for drug abuse within the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have you been diagnosed, treated, evaluated for or experienced any of the following within the past 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>A. Allergy injections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Increased heart rate <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Irregular heart beat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. Heartburn (recurrent) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>F. High cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>G. Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>H. Abnormal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>I. Recurrent diarrhea and/or excessive vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>J. Unexplained weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>K. Loss of consciousness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>L. Blood and/or sugar in urine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>M. Persistent and/or intense pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>14. Do you have any implants or prostheses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you incurred charges, received treatment, had treatment recommended, diagnosed, consulted a health care professional, or taken prescription drugs for any of the following within the past 5 years:</p> <p>A. AIDS/ARC; evaluated for or recommended ANTIVIRAL treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Heart/Circulatory/Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Diabetes or other Endocrine (Glandular) Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. Kidney/Gall Bladder/Stomach/Intestinal Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. Hepatitis and other Liver Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>F. Hernia/ Hemorrhoid/Rectal Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>G. Muscle/Bone/Tendon/Joint/Back/Injuries or Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>H. Multiple Sclerosis, Migraine Headaches, Parkinson's Disease or other Brain/Nervous Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>I. Congenital Heart or other Birth Defects/ Congenital Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>J. Respiratory Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Have you had or been treated for cancer or a malignant tumor within the past five years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Have you incurred charges, received treatment, had treatment recommended, been diagnosed, consulted a health care professional or taken prescription drugs within the past 5 years for any condition(s) not listed elsewhere on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you been hospitalized or treated in the emergency room within the past 12 months (except for pregnancy?) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. In the past 12 months, have you considered or are you considering any hospitalization, medical or surgical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Have you or anyone in the household smoked cigarettes, cigars, or pipes, or used chewing tobacco within the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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I HAVE PERSONALLY REVIEWED AND ANSWERED ALL HEALTH QUESTIONS CORRECTLY.

I understand that if I intentionally provided incomplete or false material information Anthem Blue Cross and Blue Shield may revoke my coverage. This means Anthem Blue Cross and Blue Shield may cancel membership as if it never existed.

Applicant's Signature _____ Date _____

6B. Professional Services

Applicant's Social Security No.									
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Give COMPLETE details of any "Yes" answers to the questions in 6A. (Use additional sheets if necessary.)

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
	Name of Condition/Illness	Date Ended	Address			Phone No.
	Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	City	State	ZIP	Fax No.
	Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Still under treatment	Medications			Frequency	
	If abnormal, please explain:	Dosage		Date Prescribed	Date Discontinued	

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
	Name of Condition/Illness	Date Ended	Address			Phone No.
	Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	City	State	ZIP	Fax No.
	Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Still under treatment	Medications			Frequency	
	If abnormal, please explain:	Dosage		Date Prescribed	Date Discontinued	

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
	Name of Condition/Illness	Date Ended	Address			Phone No.
	Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	City	State	ZIP	Fax No.
	Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Still under treatment	Medications			Frequency	
	If abnormal, please explain:	Dosage		Date Prescribed	Date Discontinued	

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
	Name of Condition/Illness	Date Ended	Address			Phone No.
	Treatment (X-ray, lab, surgery, etc.)	Degree of Recovery	City	State	ZIP	Fax No.
	Results <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Still under treatment	Medications			Frequency	
	If abnormal, please explain:	Dosage		Date Prescribed	Date Discontinued	

6C. Prescription Medications -
List all medications not noted above taken within the last 12 months by any family member listed on this application.

Family Member	Medication and Dosage	Illness for which Medication is Prescribed	Date Prescribed	Date Discontinued

7. Conditions of Application

Applicant's Social Security No.

It is important that you carefully read and fully understand the following.

I, the undersigned, understand that under the Anthem plan for which I am applying, I may be entitled to lesser benefits if I use a non-participating hospital, physician, or other provider, than if I use a Anthem independently contracted participating hospital, physician, or other provider.

All applicants age 18 and over must personally read, agree to, and sign the following. If an applicant does not read English, the translator must sign and submit the Statement of Accountability, Section 11, for translating this entire application.

Effective Date

If you currently have health coverage, we strongly recommend that you maintain your current coverage, and allow us to assign your effective date FOLLOWING APPROVAL. If, however, you would like to request a specific effective date, we strongly recommend you allow 60 days for underwriting. This will help ensure that your application is processed before you surrender your present insurance, and will prevent you from being required to pay for two policies.

NOTE: If you are adding a dependent, the effective date will always be the first of the month after approval.

- I request that Anthem assign my effective date if my application is approved. My effective date will be assigned as the day following the approval date of my application.
- If Anthem approves my application, please assign an effective date of the:
 - 1st of the month following approval.
 - 15th of the month following approval.
 - 1st of _____.
 - 15th of _____.
 - Please assign effective date of _____.

This date must be AFTER the approval and the signature date but not greater than 60 days from the signature date on this application.

REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED. I UNDERSTAND THAT IF I SELECT AN EFFECTIVE DATE, ANTHEM CANNOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES ONCE THE POLICY IS ISSUED. Initial X

Billing Date

Anthem premiums are due on the 1st of each month. Insureds with a mid-month premium effective date will be billed on a pro-rated basis to bring future due dates to the first of a month.

Agreement (All applicants)

I, the undersigned, agree to the following:

1. I understand and agree to pay the premium required with this application. This payment is a deposit which will be returned if my application is denied, or applied to the premium charges if my application is accepted.
2. If my application for Anthem coverage is accepted as applied for, the coverage date will be as specified above, but I agree I have no coverage under this application until I am notified in writing by Anthem that my application is approved.
3. I understand that Anthem has the right to deny my application, and if it does so, I will be notified in writing and the premium I submitted will be returned.
4. **MINOR CHILDREN:** I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding minor children.
5. **CONCERNING DEPENDENTS AGE 18 AND OVER:** I represent that my dependents age 18 and over (1) have read this application, and have provided such full and accurate information necessary to

complete this application, (2) I have discussed all provisions of this application, especially Sections 6A, 6B, and 6C with them, and (3) all information contained in this application regarding them is complete and accurate.

6. I understand and agree that if Anthem rejects my application, under no circumstance will any benefits be payable for any person listed on this application. Receipt of money, cashing of my check or charging my credit card by Anthem does not constitute approval of my application or create Anthem coverage.
7. If I am accepted, this application will become part of the agreement between Anthem and myself.
8. Anthem may request additional information, and this may delay processing of this application. If the health care provider charges a fee for these services, I will be responsible for any payment.
9. The selling agent has no authority to promise me coverage or to modify Anthem underwriting policy or terms of any Anthem coverage.
10. I have personally read and completed this application. Nothing has been left off regarding the past or present health of anyone listed on this application. I understand that no one listed is eligible for benefits if any information on this application is false, incomplete or omitted. Anthem may void all coverage from the original effective date of the agreement for such material misstatements or omissions. Any fraud or misstatements on the application may lead to rescission of the policy and possible disqualification of the HSA and adverse tax implications.

If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided.

PLEASE NOTE: If the listed minor dependent does not reside with the applicant purchasing this plan, the custodial parent or guardian must complete the Health History Section and sign the Conditions of Application accepting legal responsibility for full and complete disclosure of the minor applicant, including any history of substance abuse. Also, if the responsible adult is not the natural parent, please submit court papers authorizing guardianship.

11. My Anthem agent may receive copies of any correspondence about my medical history when correspondence is required.

Authorization

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider ("My Providers") that has provided payment, treatment or services to me or any of my dependents who are also applying for coverage to disclose entire medical records, prescription history, medications prescribed and any other protected health information concerning me or any of my dependents who are also applying for coverage with Anthem, including Anthem or its designated agent. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signing below, I acknowledge that any agreements made to restrict protected health information does not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose entire medical records without restriction.

This protected health information is to be disclosed under this Authorization so that Anthem may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Anthem.

This authorization shall remain in force for 36 months following the date of signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above, I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or any of my dependents who are also applying for coverage or to the extent that Anthem has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by Anthem except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release complete medical records, Anthem may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative, Anthem designated agent or I will receive a copy of this authorization upon request.

I understand and agree to all the Conditions of Application (Section 7). I understand that coverage is subject to the provisions in the Conditional Receipt (Section 12). I have read

and understand this Application in its entirety. I have received a summary of coverage.

Signatures (Required) – All applicants over age 18 must sign and date.

1. Applicant/parent or legal guardian	Today's date
2. Applicant's Spouse <i>(required if applying for coverage)</i>	Today's date
3. Applicant age 18 or over	Today's date
4. Applicant age 18 or over	Today's date
5. Applicant age 18 or over	Today's date
6. Applicant age 18 or over	Today's date

**ATTACH INITIAL
PREMIUM CHECK HERE.
DO NOT TAPE.**

Applicant's Social Security No.									

8. Payment Method – Submit premium payment with application (required).

When you send your check to us, you authorize Anthem to convert your check into an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

8A. <input type="checkbox"/> Initial Premium Payment by Credit Card			
New members only. Not available to make a coverage change.			
Select one: <input checked="" type="checkbox"/> 1 month <input type="checkbox"/> 3 months	Initial Premium Amount \$	Credit Card: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard	
Credit Card No.	Expiration Date	Cardholder's Name	Cardholder's ZIP Code
Authorized Signature (as it appears on the credit card)		Today's Date	
X			

8B. <input type="checkbox"/> Initial Premium by Electronic Check				
Select one: <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months	Name on Account	Check No.	Initial Premium Amount \$	Checking Account No.
Bank Routing No.	Account Type	<input type="checkbox"/> Personal <input type="checkbox"/> Business		

8C. Payment Type

Monthly Paper Billing]

Monthly Electronic Funds Transfer (EFT) (Available with Monthly Checking Account Deduction).

1. Submit the one (1) month premium.
2. Complete section 8D, **Monthly Checking Account Deduction Authorization.**
3. If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account on the first of the month **ONLY.**

Quarterly Paper Billing – Submit the three (3) month premium.]

Please note: First payment will be credited to approved applicants only.

[8D. Monthly Checking Account Deduction Authorization

Attach a check for one (1) month's premium above where indicated. If the account listed below is a joint account, both account holders' signatures are required. **Anthem must be notified of any changes to your bank account no later than the 20th of the month preceding the change.**

AUTHORIZATION: As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights with respect to each debit will be the same as if it were a check drawn on you and signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premium. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Deduction and be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction option.

You will incur a \$25 service charge for any withdrawal not honored.]

Applicant Name	Applicant Social Security No.	Name on Checking Account		
Name of Bank or Financial Institution	Address	City	State	ZIP Code
Checking Account No.	Bank Routing No.	Federal Credit Union Routing No.		
Authorized Signature (as it appears in the financial institution's records)		Date	Authorized Signature (as it appears in the financial institution's records)	

(Continued on reverse)

