



2 Gannett Drive
South Portland, Maine 04106-6911

Anthem Individual Enrollment/Change Application

PLEASE USE BLACK OR BLUE INK ONLY

Thank you for applying for Anthem Individual coverage. All questions need to be completed before this application can be processed. If you have any questions, please call your producer or call Anthem Blue Cross and Blue Shield (Anthem) at 1-800-547-4317.

1. Applicant Information Please check appropriate item: New Enrollment Change Add/Remove Dependent

Please write the complete name and address of the person applying for coverage.

First Name _____ M.I. _____ Last Name _____ Title _____

Street _____

City _____ State _____ Zip Code _____

Telephone No. (Home) _____ (Work) _____ Email Address _____

2. Applicant and Family Member Information (Complete Information for all Members You Wish to Cover)

Applicant Status Single Married Maiden Name _____

You may apply to cover your legal spouse/domestic partner and unmarried children and stepchildren under 19 years of age. You may also apply to cover children and stepchildren ages 19-23 if they are unmarried, more than 50% dependent on you, and a full-time student in an accredited college or university.
* Other Insurance — Please indicate (Y) Yes or (N) No under the OI column if the member will be covered by more than one health care plan.

NAME(S) OF ALL PERSONS TO BE COVERED (Please include yourself if you are to be covered)	Add	Delete	If disabled date of disability	SEX		BIRTHDATE Mo/Day/Year	SOCIAL SECURITY NUMBER	*OI	
				M	F				
First Name Self						/ /	- -	Y	N
Legal Spouse/Domestic Partner						/ /	- -	Y	N
Dependent 1 (Oldest)						/ /	- -	Y	N
Dependent 2						/ /	- -	Y	N
Dependent 3						/ /	- -	Y	N
Dependent 4						/ /	- -	Y	N

3. Coverage Choices (Please Check One of the Options Below)

<p>HealthChoice 100% \$3 Million Lifetime Maximum No Coinsurance after Deductible</p> <p><input type="checkbox"/> \$2,250 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000</p> <p>I want the additional preventive care and supplemental accident benefit <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Anthem Lumenos Consumer Directed Health Plans No Coinsurance after Deductible (In Network)</p> <p>Lumenos Health Savings Account Plan*</p> <p><input type="checkbox"/> \$2,500 Individual Deductible (not applicable for family coverage)/\$5,000 Family Deductible (for Family Policies) <input type="checkbox"/> \$5,000 Individual Deductible (not applicable for family coverage)/\$10,000 Family Deductible (for Family Policies)</p> <p>*For Health Savings Accounts, complete the following: <input type="checkbox"/> Yes, I would like to establish an H.S.A. with Anthem's banking partner. (SSN required see section 1) <input type="checkbox"/> No, I do not want to establish an H.S.A. with Anthem's banking partner.</p> <p>Lumenos Health Incentive Account Plus Plan</p> <p><input type="checkbox"/> \$5,000 Individual Deductible (not applicable for family coverage)/\$10,000 Family Deductible (for Family Policies) <input type="checkbox"/> \$10,000 Individual Deductible (not applicable for family coverage)/\$20,000 Family Deductible (for Family Policies) Add \$200/\$400 Funding (Individual/Family)</p> <p>Lumenos Health Incentive Account Plan</p> <p><input type="checkbox"/> \$5,000 Individual Deductible (not applicable for family coverage)/\$10,000 Family Deductible (for Family Policies)</p>	<p>HealthChoice Standard 80%/20% \$2 Million Lifetime Maximum \$1,000 Coinsurance after Deductible</p> <p><input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500</p>	<p>HealthChoice Basic 60%/40% \$1 Million Lifetime Maximum \$1,000 Coinsurance after Deductible</p> <p><input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500</p>
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4. Desired Effective Date (Please Check One)

The first of the month immediately following the day Anthem receives my application

Delayed until ____/__/____. (Please fill in date desired. Coverage must begin within 60 days after Anthem receives this application.)

5. Billing Choice (Please Check One)

Quarterly Monthly Electronic Fund Transfer - Complete Section 9 and attach voided check or savings deposit slip

6. State of Maine Residency (This section pertains to the applicant and his or her legal spouse/domestic partner, if enrolling)

You must be legally domiciled in Maine and satisfy at least 2 of the following 6 criteria:

- 1) hold a valid Maine motor vehicle operator's license or nondriver identification card issued in Maine;
- 2) have a valid passport or visa and be lawfully admitted to the United States;
- 3) be registered to vote in Maine;
- 4) have a permanent dwelling place in Maine;
- 5) submit a written sworn affidavit declaring intent to reside in Maine; or
- 6) file a Maine income tax return that declares you are a Maine resident.

Please indicate by number (i.e., 1, 3, 4, 6) which of the 6 criteria above you meet:

Self _____ Legal Spouse / Domestic Partner (if enrolling) _____

You may establish that you are legally domiciled in Maine by providing evidence of other relevant criteria associated with residency. A child is legally domiciled in Maine if at least one of the child's parents or the child's legal guardian is legally domiciled in Maine. A person with a developmental or other disability that prevents the person from obtaining a motor vehicle operator's license, registering to vote, or filing an income tax return is legally domiciled in Maine by living in Maine. Please call 1-800-547-4317 if you need additional information.

Do you currently live in Maine? Yes No Are you a Maine resident but attending school out of state? Yes No

Have you lived in Maine for at least the past 60 days? Yes No If no, please give the date you moved to Maine _____

How many months per calendar year do you live in Maine? _____

Note: In limited circumstances, enrollment may be possible prior to residing in Maine for 60 days.

7. Employment Information

Please check all answers that apply to you and any family member applying for Individual coverage:

I am a Sole Proprietor using an employer sponsored health plan

I am eligible for my employer's group health plan, and my employer is contributing (either directly or indirectly) to the cost of my coverage. If yes, please provide name of employer _____

Does your employer employ a total of more than 50 employees? Yes No

8. Prior Health Insurance Coverage and Other Health Insurance Coverage

Is this replacement coverage for existing health insurance coverage? Yes No If yes, please read and sign the Notice to Applicant Regarding Replacement of Health Insurance.

Please place a check in the appropriate box if any of the following apply to any family member who is applying for Individual coverage:

Are you or any family member...

SELF SPOUSE/DOMESTIC PARTNER DEPENDENT(S)

	SELF	SPOUSE/DOMESTIC PARTNER	1	2	3	4
Eligible for Medicare?						

Within the last 90 days, have you or any family member been...

Covered by Medicare?						
Covered by Medicaid?						
Covered by Federal Employee Program? _____						
Covered by an employer-sponsored health plan?						
Covered by any other health plan? Please specify:						

Please write the information requested below for all family members who had prior coverage as checked above.

Name of insurance company			
Certificate (policy) number			
Name of Health Plan and Telephone Number			
Date coverage began			
Date coverage ended			

9. Electronic Fund Transfer Authorization (EFT) (Complete if you want your payments deducted directly from your checking or savings account.)

I hereby authorize Anthem Blue Cross and Blue Shield to initiate a withdrawal (on or about the 5th business day of each month) from my bank account for payment of my premium. The bank account is with the bank named below, which is hereby authorized to withdraw this amount from my account each month.

Bank Name	Phone Number
Bank Address	City/State/Zip Code
Bank Information: Routing #	Account #

Type of Account: (Check Only One):
 Checking Account (must attach voided check)
 Savings Account (must attach saving account deposit slip)

This authorization is to remain in effect until Anthem Blue Cross and Blue Shield has received at least 30 days prior written notification from me of a termination date.

Legal Acknowledgments and Signature

I understand that:

- A pre-existing condition exclusion may relate only to conditions manifesting in symptoms that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment, or for which medical advice, diagnosis, care or treatment was recommended or received, during the twelve months immediately preceding the date of application or to a pregnancy existing on the effective date of coverage.
- Anthem will not provide benefits for twelve months from the date of application for a pre-existing condition or for complications or treatment arising from a pre-existing condition for any member without qualifying health insurance coverage within the ninety days preceding the date of application.
- I will receive notice by mail that Anthem has accepted my application. I will receive the applicable Certificate of Coverage, an identification card, and any other necessary documents. I will also receive by mail a statement for my first premium payment, which will be due and payable immediately upon receipt. I understand that no claims will be processed under this coverage unless and until Anthem has received the total premium due.
- If I decide not to accept coverage, I will send a written request to cancel coverage to Anthem's home office at 2 Gannett Drive, South Portland, Maine 04106-6911 and return all materials to Anthem within ten days after their delivery date. Anthem will refund any charges I have paid for the contract. My coverage will be null and void.
- If I or any covered family member is insured by more than one health contract, coordination of benefits will apply. Coordination of benefits ensures that the total benefits received from all contracts do not exceed the actual cost of covered services.
- I am requesting coverage for myself and all dependents listed on the reverse side of this application. All statements and answers I have given are true and complete. I understand it is a crime to knowingly provide false, incomplete and misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. I understand all benefits are subject to conditions stated in the Certificate of Coverage.
- I acknowledge that I have reviewed the Application for Additional Benefits (048320) and;
 I do not wish to purchase any of the additional benefits
 I have elected optional benefit(s) as indicated on the above referenced application

Applicant's Signature (If child, parent or guardian must sign) _____ Print Name _____ Date _____

10. Producer of Record Information (Please Complete if applicable)

The producer named below has presented Anthem Blue Cross and Blue Shield Individual plans to me. He or she has assisted me in the purchase of this policy.

Producer's Name _____ Agency _____ Producer # _____

Address _____

Applicant's Signature _____ Date _____