Anthem Blue Cross

Individual Change of Coverage Application – For existing enrollments only.

The following plans are offered by Anthem Blue Cross: PPO Share 2500/1500/1000/500, Select HMO, HMO Saver, Individual HMO, EPO and DentalSelect HMO plans. The following plans are offered by Anthem Blue Cross Life and Health Insurance Company: Basic PPO 1000/2500, PPO Saver, PPO Share 5000/1000/500, RightPlan PPO 40 plans, PPO 3500 (HSA-Compatible), 3500 Deductible PPO, Dental PPO and Term Life products.

IMPORTANT: If you are applying for a change of coverage from any HMO or Basic Plan, you must complete the Individual Enrollment Application (IU2138).

1. Subscriber Information

Current subscriber must complete this section.

Last Name	First Name	M.I.
Street Address *(Must be complete: P.O. Box not acceptable)*		
City	State	ZIP Code

Social Security or ID No.	Marital Status ☐ Married ☐ Single
Mailing Address *(If different than above or P.O. Box)*	
City / State / ZIP Code	
Home Phone No. ( )	Business Phone No. ( )
Applicant/Spouse Maiden Name	Spouse Social Security or ID No.
Mail Service Agreement to: ☐ Primary Subscriber ☐ Your BCC agent	

2. Choice of Anthem Blue Cross Individual Coverage

MEDICAL COVERAGE:

PPO Coverage:
- ☐ Basic PPO 1000 (7900)
- ☐ Basic PPO 1000 without Life (PE25)
- ☐ Basic PPO 2500 (R418)
- ☐ Basic PPO 2500 without Life (R419)
- ☐ Share 5000 (H062)
- ☐ PPO Saver (NM31)
- ☐ PPO Saver without Life (PE27)
- ☐ 3500 Deductible PPO (R420)
- ☐ RightPlan PPO 40-No Rx (P958)
- ☐ RightPlan PPO 40-Generic Rx (PE48)
- ☐ RightPlan PPO 40-Comprehensive Rx (PE49)
- ☐ Share 1000 (1930)
- ☐ Share 500 (1929)
- ☐ PPO Share 2500 (7891)
- ☐ PPO Share 1500 (7889)
- ☐ PPO Share 1000 (1393)
- ☐ PPO Share 500 (7895)
- ☐ EPO (HSA Compatible) (7892)
- ☐ PPO 3500 (HSA-Compatible) (T160)
- ☐ _____

HMO Alternative Coverage*
- ☐ Select HMO* (PE43)
- ☐ HMO Saver* (7896)
- ☐ Individual HMO* (7898)

DENTAL COVERAGE:
- ☐ Dental PPO (7874)
- ☐ Dental Saver SelectHMO (ZE6N)
- ☐ Dental SelectHMO (ZE7N)
- ☐ Dental Premier SelectHMO (ZE8N)

List dental applicants below. If you are only adding dental coverage, do not complete Section 4, "Health History." You must complete all other sections.

ANTHEM BLUE CROSS DENTAL PROVIDER NO:
(Required for any Dental SelectHMO) ⌊ ⌋

3. Subscriber Family Information

List yourself and all enrolled family members requesting a change in coverage.

If spouse's last name is different from yours, please explain:_____

***3A. Select an IPA or PMG for yourself and each family member.**
If an IPA is selected, also provide the Primary Care Physician (PCP) number.
Please list your selections below.

	Last Name	First Name	M.I.	Height	Weight	Birthdate	Age	Social Security or ID Number	PMG/IPA	Primary Care Physician (PCP)
10☐ Male 20☐ Female	Subscriber									
30☐ Male 40☐ Female	Spouse									
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										

4. Health History of Members Listed on this Application

Your claims history with Anthem Blue Cross will also be used in addition to the history listed on this application.

Has any enrolled family member been hospitalized, seen a physician or other health care provider or taken prescription medication within the last 6 months? ☐ Yes ☐ No

If Yes, please provide the required medical information below.

Member Name	Hospital / Provider Name and Address	Medication Prescribed	Condition / Illness Treated

Has any enrolled family member used any tobacco products within the last 24 months? ☐ Yes ☐ No

Is either the applicant or spouse, whether or not listed on application, currently pregnant? ☐ Yes ☐ No

If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application? ☐ Yes ☐ No

FEMALES ONLY – Please provide the following information. (Applicable to ALL females listed on this application.)

Do you menstruate? ☐ Yes ☐ No Has it been more than 40 days since her/their last menstrual period? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes ☐ No

5. Conditions of Application **It is important that you carefully read and understand the following.**

ELIGIBLE/INELIGIBLE APPLICANTS

All Applicants age 18 and over must personally read, agree to, and sign the following:

☐ Applicant does read and write English. If an Applicant does not read English, the translator must sign and submit a Statement of Accountability (see Page 3).

Anthem Blue Cross will enroll all eligible family members unless otherwise instructed.

☐ I, the Applicant, request that Anthem Blue Cross not enroll eligible applicants unless all family members qualify.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

I, the undersigned, understand that:

1. If my application for Anthem Blue Cross coverage is accepted as applied for, Anthem Blue Cross will assign the effective date, but I agree that I have no coverage under this application **until notified in writing** by Anthem Blue Cross that I am accepted.
2. I understand that Anthem Blue Cross has the right to deny my application and if so, I will be notified in writing.
3. **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. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. **If the responsible adult is not the natural parent, please submit court papers authorizing guardianship.**

   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.
4. **DEPENDENTS AGE 18 AND OVER:** To the best of my knowledge and belief, I represent that (1) my dependents age 18 and over 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 with my dependents age 18 and over, and (3) all information contained in this application regarding dependents age 18 and over is complete and accurate.

   I understand and agree that if Anthem Blue Cross denies my application, under no circumstances will any benefits be payable for any person listed on this application.
5. If I am accepted, this application will become part of the agreement between Anthem Blue Cross and myself. Enrolled family members and I agree to be bound by the arbitration clause in the Anthem Blue Cross contract instead of trial by court or jury.
6. Anthem Blue Cross may request additional information and this may delay processing of this application. If the health care provider bills for these services, Anthem Blue Cross will determine payment and I will be responsible for any difference.
7. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross underwriting policy or terms of any Anthem Blue Cross coverage.

5. Conditions of Application (Continued) It is important that you carefully read and understand the following.

8. **I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if I intentionally provided incomplete or false material information Anthem Blue Cross may revoke my coverage. This means Anthem Blue Cross will cancel membership as if it never existed. Also, after approval for membership, if material information is discovered by Anthem Blue Cross that was not provided to the Plan prior to the effective date of the policy, Anthem Blue Cross may deny coverage.**

I have personally read and completed this application. I understand and agree to all the Conditions of Application. I understand that coverage will come into effect only if this application is approved by Anthem Blue Cross. I, the Applicant, acknowledge that I have read and understand this application in its entirety.

REQUIREMENT FOR BINDING ARBITRATION: If you are applying for coverage, please note that Anthem Blue Cross requires binding arbitration to settle all disputes against Anthem Blue Cross, including claims of medical malpractice. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: **"It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."** Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL

X _____ _____
Signature of Applicant/Parent or Legal Guardian — Today's Date *(Required)*

X _____ _____
Signature of Applicant's Spouse — Today's Date *(Required)*

X _____ _____
Signature of Applicant's Dependent Age 18 or over — Today's Date *(Required)*

X _____ _____
Signature of Applicant's Dependent Age 18 or over — Today's Date *(Required)*

***Statement of Accountability* – To be completed when the applicant cannot complete the application.**

I, _____ , personally read and completed this Individual Change of Coverage Application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain): _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained the "Conditions of Application."

_____ _____
Signature of Translator *(Required)* — Today's Date *(Required)*

Individual Services
P.O. Box 9041
Oxnard, CA 93031-9041

Anthem Blue Cross

Authorization for Use of Protected Health Information

By signing below:

I authorize Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, to obtain any medical records from any physicians, hospitals, pharmacies, pharmacy benefits managers, health benefits plans, and/or other health care providers or medical or pharmacy benefit administrators concerning my care and the care of any family member listed on my Application.

I also authorize any physicians, hospitals, pharmacies, pharmacy benefits managers, health benefit plans and/or other health care providers or medical or pharmacy benefit administrators to furnish any medical records concerning my care and the care of any family member listed on my Application to Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company. This information is needed to determine eligibility for coverage and Anthem Blue Cross' or Anthem Blue Cross Life and Health 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.

I understand that my application will not be considered if this form is not signed and returned with my completed Application if I am initially applying for enrollment in a medically underwritten health plan offered by Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or signed and returned with my completed Change of Coverage Form if I wish to add a family member or upgrade my coverage in the future. This Authorization will expire 24 months following Anthem Blue Cross' or Anthem Blue Cross Life and Health Insurance Company's acceptance of coverage, if not previously revoked.

I understand that I may revoke this Authorization at any time while Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company is determining eligibility for the coverage requested. To do so, I must submit a completed Authorization Revocation Form to Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company. An Authorization Revocation Form is available by calling 1-866-297-7647, going to our website, www.anthem.com/ca, or writing to: Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9041, Oxnard, CA 93031. If I revoke this Authorization after I initially apply for coverage, I understand that I/we will not be considered by Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company for enrollment in one of its medically underwritten health plans. 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 the information disclosed pursuant to this authorization may be subject to re-disclosure by recipient and, in some circumstances, may no longer be protected by federal regulations governing the privacy of health information.

_____	_____	_____
Printed name of Applicant/Member	Signature of Applicant/Member or his/her Personal Representative	Date
_____	_____	_____
Printed name of Spouse or Dependent Child age 18 or over listed on Application	Signature of Spouse/Dependent Child or his/her Personal Representative	Date
_____	_____	_____
Printed name of Dependent Child age 18 or over listed on Application	Signature of Dependent Child or his/her Personal Representative	Date

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

For Anthem Blue Cross Use Only

HCID:

For Anthem Blue Cross Use Only

WFI:

9680 6/08