

Insurance Shoppers

Application Instructions For Anthem Blue Cross Blue Shield HSA Application

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Insurance Shoppers for review along with the completed application. If you do not have access to a fax machine, send the completed application to Insurance Shoppers along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also sign and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Anthem** if you are not paying by credit card.

Mail completed application and check to:

Insurance Shoppers

Attn: New Enrollment

450 Hickory Street

Broomfield, CO 80020

Insurance Shoppers will review your application for completeness and accuracy before we submit it to Anthem for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at (866)747-7913 or e-mail us at jay@insuranceshoppers.net.

Insurance Shoppers

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

Insurance Shoppers

FAX# (303)439-9550

Dear Insurance Shoppers,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____



Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.



I will contact Insurance Shoppers at (866)747-7913 to verify receipt of my application.

****I understand that Insurance Shoppers will not review this application until the following weekday morning if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to Insurance Shoppers. I will mail the original signed application to :

**Insurance Shoppers
Attn: New Enrollment
450 Hickory Street
Broomfield, CO 80020**

I will send the original application as soon as I have been contacted by Insurance Shoppers with confirmation that my application has been received by fax and reviewed for completeness.

Signature: _____

Date: _____

Colorado HSA Qualified Health Plans For Individuals Application

Each individual on the application is assessed separately. As a result, the underwriting decision may include accepted members, declined members and members accepted with a lifetime benefit exclusion. We will proceed with the processing of the application for all members who fall into either of the approved categories with the assumption that the coverage is still desired.

If the application is approved, with or without lifetime benefit exclusion(s), the effective date of enrollment will be listed on the subscriber's coverage notice. If you do not select an effective date, membership will be processed for the 1st of the month following approval by Anthem. If the entire application is not approved, Anthem will disclose, in writing, the reason(s) for non-acceptance and what needs to be done for reconsideration, if applicable.

If the applicant, or anyone on the application, is rejected and anyone on the application qualifies as a business group of one, the entire application is not approved, unless the applicant waives coverage for that family member who has other coverage in place. Anthem will disclose, in writing, the reason(s) for non-acceptance and what needs to be done for reconsideration, if applicable.

If any member is approved with a lifetime benefit exclusion, the amendment will be included in the membership certificate or sent with the letter notifying the member of the lifetime benefit exclusion.

Anthem must receive a 30-day advance notification to cancel your coverage. Anthem has 60 days to process your application.

No person other than the applicant shall alter any written application for any policy without the applicant's written consent. The exception is that the insurer may make insertions, for administrative purposes only, in such manner as to indicate clearly that such insertions are not ascribed to the applicant.

In no event shall the Company incur any liability before an application is approved or with respect to an application that has been declined. No coverage shall exist under the agreement for which the application is made until approved by the Underwriting Department.

Colorado HSA Qualified Health Plans For Individuals Application

BROKER SIGNATURE

X 

DATE

Broker Name **Jav Norris**

Broker Phone Number: **(866)747-7913**

Broker Fax Number: **(303)439-9550**

Broker Number **76866**

Broker Address: **450 Hickory Street, Broomfield, CO 80020**

Broker e-mail: **jay@insuranceshoppers.net**

SECTION I FORM MUST BE FILLED OUT IN BLACK BALLPOINT INK – PLEASE PRINT CLEARLY

APPLICATION TYPE NEW ENROLLMENT ADD FAMILY MEMBER Indicate Existing Subscriber No. _____

(Check Appropriate box)

APPLICATION FOR REINSTATEMENT COVERAGE CHANGE Deductible _____ Coinsurance _____ Other _____

HAVE YOU PREVIOUSLY BEEN COVERED BY ANTHEM BLUE CROSS AND BLUE SHIELD (HEREINAFTER REFERRED TO AS ANTHEM)? YES NO

IF "YES," WAS THIS COVERAGE UNDER A GROUP OR INDIVIDUAL POLICY? (PLEASE CHECK ONE) PROVIDE CONTRACT NUMBER _____

MONTHLY PAYMENT METHOD ELECTRONIC FUNDS TRANSFER (EFT) [PREFERRED METHOD] OR PAPER BILL

If choosing Electronic Funds Transfer, please complete the Monthly Bank Draft / EFT Authorization (Form No. 98644) and attach a voided check.

No Application will be processed without the initial month's premium being received.

Initial month payment method: Check Money Order Credit Card Debit Card

Credit / debit card accepted for initial payment only - if paying with a credit / debit card, you must fill out the bottom section of Form No. 98644

HSA Qualified Health Plan Program Selection - Please select one of the following:

Plans with Prescription Drug Benefits

- | | |
|---|---|
| <input type="checkbox"/> \$1250 Single Deductible, \$2500 Family Deductible, 100/0% Coinsurance | <input type="checkbox"/> \$1250 Single Deductible, \$2500 Family Deductible, 80/20% Coinsurance |
| <input type="checkbox"/> \$2000 Single Deductible, \$4000 Family Deductible, 100/0% Coinsurance | <input type="checkbox"/> \$2000 Single Deductible, \$4000 Family Deductible, 80/20% Coinsurance |
| <input type="checkbox"/> \$2500 Single Deductible, \$5000 Family Deductible, 100/0% Coinsurance | <input type="checkbox"/> \$2500 Single Deductible, \$5000 Family Deductible, 80/20% Coinsurance |
| <input type="checkbox"/> \$3000 Single Deductible, \$6000 Family Deductible, 100/0% Coinsurance | <input type="checkbox"/> \$3000 Single Deductible, \$6000 Family Deductible, 80/20% Coinsurance |

Plans with no Prescription Drug Benefits - These plans do include a discount prescription drug card at no additional cost.

- | | |
|---|--|
| <input type="checkbox"/> \$4000 Single Deductible, \$8000 Family Deductible, 100/0% Coinsurance | <input type="checkbox"/> \$5000 Single Deductible, \$10000 Family Deductible, 100/0% Coinsurance |
| <input type="checkbox"/> Yes, I want to participate in the discount drug program | <input type="checkbox"/> No, I do not want to participate in the discount drug program |

SECTION II APPLICANT INFORMATION

NAME (Last, First, Middle Initial)			SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTHDATE (Mo. Day Yr) : : :	HEIGHT __ft. __in	WEIGHT
PHYSICAL STREET ADDRESS			HOME TELEPHONE ()		WORK TELEPHONE ()	
CITY	STATE CO	ZIP CODE	OCCUPATION (Optional)		GROSS ANNUAL INCOME (Optional)	

BILLING ADDRESS (If different than above)

SOCIAL SECURITY NUMBER

NON-TOBACCO DESIGNATION AND CERTIFICATION
I certify that I, and all family members living in the household, HAVE HAVE NOT used a tobacco product in the past 12 months.

COVERAGE DESIRED

INDIVIDUAL FAMILY

MARITAL STATUS

SINGLE MARRIED

IF YOU AND YOUR SPOUSE ARE USING DIFFERENT LAST NAMES CHECK APPLICABLE BOX

SEPARATED COMMON LAW* PROFESSIONAL MAIDEN

*Must supply common law affidavit

Information for Each Dependent Applying for Coverage (Use additional sheet of paper if necessary.)

Last Name	First Name	Relationship to Applicant	Social Security Number	Gender	Birthdate (mm/dd/yyyy)	Height	Weight (lbs.)
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	__ft. __in.	
Dependent				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	__ft. __in.	
Dependent				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	__ft. __in.	
Dependent				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	__ft. __in.	
Dependent				<input type="checkbox"/> M <input type="checkbox"/> F	/ /	__ft. __in.	

By signing below, I verify and attest that my dependent(s), including coverage dependents ages 19-24, is/are unmarried and financially dependent on me; or, regardless of age, is/are financially or otherwise dependent on me due to mental and/or physical disability; or is/are dependent on me due to a court order, and is/are therefore eligible for coverage under the policy for which I am applying. I understand that I am responsible for notifying Anthem within 31 days of any changes to the status of my dependent(s). I understand that coverage is dictated by the actual situation at the time services are rendered, and if my dependent does not qualify as a dependent when services are provided, the charges for those services are not reimbursable and may become my sole responsibility. I also understand that over-age dependent eligibility must be renewed each year until the maximum age limit has been reached, as specified by the certificate. I understand that Anthem reserves the right to request, at any time, proof of over-age dependency.

Primary Applicant's Signature

Date

SECTION III REQUESTED EFFECTIVE DATE

Please indicate the desired effective date* (i.e., 1st, 12th, 28th, etc.): _____ *Anthem must receive the **fully completed** application before the requested effective date.

Please circle the desired effective month:

January February March April May June July August September October November December

All premiums will be due on the first of each month. If you are approved for an effective date other than the 1st of the month, your premium will be prorated for the first month. If you are approved for an effective date other than the date you requested, we will notify you of your actual effective date in writing. If you do not select an effective date, your application will be processed with an effective date of the first of the month following underwriting approval.

SECTION IV

HEALTH STATEMENT

Have you or any family member listed on the application consulted, had diagnostic or other medical tests, or been treated by any doctor, health care professional, hospital, hospital emergency room, or clinic within the last five (5) years for any of the following conditions, diseases or disorders?

(All questions must be answered.)

CONDITION/DISEASE/DISORDER	YES	NO	CONDITION/DISEASE/DISORDER	YES	NO
Alcohol or Drug Abuse			Nervous and Mental Disorders including Anxiety, Depression, Anorexia or Attention Deficit Disorder		
Back, Spine or Bone Diseases, or Arthritis					
Brain or Nervous System Disorder or Migraine Headaches			Paralysis, Epilepsy, Stroke, Parkinson's Disease, Convulsions or Fainting		
Cancer or Malignant Conditions			Sinusitis, Tonsillitis, or Adenoid Disorders		
Cardiovascular Disorders, Chest Pain, Hypertension, Heart Disease or High Cholesterol			Stomach or Colon Disorders including Colitis, Diverticulosis, Diverticulitis, or Ulcers		
Cataract or other Eye Disorders			Have you or any family members listed on the application received medical advice, been treated or diagnosed for any other condition(s), disease(s) or disorder(s) not listed above? Must check "Yes" or "No." If "Yes," specify and complete the detailed information below.		
Cirrhosis, Hepatitis or other Liver Disorders					
Diabetes or other Endocrine (Glandular) Disorders					
Emphysema, Bronchitis, Asthma, or other Lung Disorders			Are you or any family member expecting the birth of a child or the addition of any other dependent for whom you (or that other family member) may have a duty to provide medical care?		
Gallbladder Disorders					
Hemorrhoids or other Rectal Disorders					
Hernias			Are you or any family member listed on this application currently taking any prescription drugs or medicines — including narcotics, barbiturates or amphetamines?		
Kidney Disorders: Blood, Pus, Albumin, Sugar or Casts in Urine					
Male/Female Genital Disorders including Hysterectomy, Sterilization and Infertility Procedures					

Please provide information for any "Yes" answer you checked above. Include name of family member, nature of illness or injury, dates, duration of treatment and outcome, if applicable. Show specific names of medications and quantity taken, including milligrams and times per day. **ATTACH SEPARATE SHEET IF NECESSARY. (THIS SECTION MUST BE COMPLETED).**

FAMILY MEMBER NAME	ATTENDING PHYSICIAN, HOSPITAL OR CLINIC NAME AND COMPLETE ADDRESS	NAME OF CONDITION(S) ILLNESS(ES) TREATED	TREATMENT RENDERED SUCH AS CHECK-UP, X-RAY, LAB AND SURGICAL PROCEDURES, ETC. AND OUTCOME		
NAME	NAME				
DATE STARTED (Month, Day, Year)	ADDRESS (City, State, Zip Code)	1) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
DATE ENDED (Month, Day, Year)		2) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
NAME	NAME				
DATE STARTED (Month, Day, Year)	ADDRESS (City, State, Zip Code)	1) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
DATE ENDED (Month, Day, Year)		2) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
NAME	NAME				
DATE STARTED (Month, Day, Year)	ADDRESS (City, State, Zip Code)	1) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
DATE ENDED (Month, Day, Year)		2) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
NAME	NAME				
DATE STARTED (Month, Day, Year)	ADDRESS (City, State, Zip Code)	1) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
DATE ENDED (Month, Day, Year)		2) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED

SECTION IV (Continued)

HEALTH STATEMENT

Provide information for the questions listed below, for you and each family member to be covered. **If additional space is required, attach a separate sheet.**

	YES	NO
Are you planning any hospitalization, medical or surgical treatment, or has any treatment been recommended for you or any family member listed on this application? If "Yes," give details:		
Have you or any of your listed dependents, at any time in the past been declined health, disability or life insurance or had your health, disability or life insurance cancelled or rescinded? If "Yes" give reason(s):		
Have you or any family member listed on this application tested positive for the AIDS virus or are you or any family member listed in this application currently being treated for AIDS? If "Yes," please provide the name(s) of those testing positive or currently being treated for AIDS.		

SECTION V

PRE-EXISTING WAITING PERIOD

The following waiting period for pre-existing conditions applies to all members –

A pre-existing condition is an injury, sickness or pregnancy, for which the member has, during the 12 consecutive months immediately preceding the member's original membership effective date, either (1) incurred charges, (2) received medical treatment, (3) consulted a health care professional, or (4) taken prescription drugs. We will not pay for services related to a pre-existing condition for 12 consecutive months after the member's original membership effective date. I further understand that my coverage will not pay for services unless they are medically necessary as determined by Anthem.

If you have had individual medical insurance within the last 90 days that was in effect for more than one year, or had no gaps between sequential coverages of more than 31 days, or Medicare, Medicaid, or other health benefits plan within the last 90 days, you may qualify for a waiver of the pre-existing condition waiting period. See questionnaire below.

PRE-EXISTING WAITING PERIOD QUESTIONNAIRE

Have you had Individual Medical Insurance within the last 90 days, that has been in effect for more than one year, or had no gaps between sequential coverage of more than 31 days or a Group Medical Insurance Plan within the last 90 days? Yes No

If "yes," complete the following and submit copies of all applicable creditable coverage forms. Lack of creditable coverage will subject you to the maximum pre-existing period.

NAME OF INSURER: (City and State, if insurance is Blue Cross and/or Blue Shield)

POLICY NUMBER	ISSUE DATE	DATE POLICY PAID THROUGH
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NAME OR NAMES OF INDIVIDUAL OR FAMILY MEMBERS COVERED UNDER THIS POLICY:

POLICY TYPE: (i.e., MAJOR MEDICAL, HMO, PPO, HOSPITAL ONLY, SPECIFIC DISEASE, ETC.)	CHECK ONE <input type="checkbox"/> INDIVIDUAL POLICY <input type="checkbox"/> GROUP
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If circumstances for your spouse or dependent(s) are different than your responses, please list: _____

If you, your spouse or any dependent children are covered by Medicare or Medicaid, complete the following:

<input type="checkbox"/> MEDICARE	NAME OF ENROLLEE	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE
<input type="checkbox"/> MEDICAID	NAME OF ENROLLEE	EFFECTIVE DATE	END DATE

SECTION VI Determination of Self-employed Business Group of One

SECTION A. DETERMINATION OF SELF-EMPLOYED BUSINESS GROUP OF ONE

1. Are you or your spouse a self-employed person with no employees or a sole proprietor who is not offering health care coverage to or sponsoring health care coverage for your employees?	Self <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you or your spouse carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year before applying for coverage?	Self <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you or your spouse have gross income from your self employment or sole proprietorship as indicated on federal Internal Revenue Service Forms 1040, Schedule C, F or SE, or other forms recognized by the federal Internal Revenue Service for income reporting purposes from which you derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? Note: "Substantial part of your income" means income derived from business activities of the business group of one that is sufficient to pay for the annual premiums for the business group of one's health benefit plan.	Self <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you or your spouse work a minimum of 24 hours a week on a permanent basis?	Self <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No

Applicant's Statement

I, (print name) _____, attest that the answers to the questions about self-employed business groups of one in Section VI of this application are true and correct.

Signature of Applicant	Date
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Spouse's Statement

I, (print name) _____, attest that the answers to the questions about self-employed business groups of one in Section VI of this application are true and correct.

Signature of Spouse (if applying for coverage)	Date
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IF YOU OR YOUR SPOUSE ANSWERED YES TO ALL FOUR QUESTIONS ABOVE, PLEASE COMPLETE SECTIONS B AND C. IF NOT, PLEASE SKIP TO THE NEXT PAGE (SECTION VII).

SECTION B. If you waive coverage for a family member who will not be covered under this policy, you must list the other coverage for that dependent and when it became effective.

Full Name	Name of Other Coverage	Effective Date of Other Coverage		
		Month	Date	Year
Spouse				
Dependent				
Dependent				
Dependent				

SECTION C. BUSINESS GROUP OF ONE DISCLOSURE. As required by Colorado law, please read the following disclosure, and if you qualify as a business group of one, print and sign your name in the spaces below.

I, (print name) _____, meet the definition for a self-employed business group of one as attested to in the Determination of Self-employed Business Group of One, Section A of this application. I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic or other small group health benefit plan from a small employer carrier for a period of three years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three-year period. I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, the carrier's overall cost and utilization trends, the underwriting methodology used to evaluate individual coverage, my age, my family size, and a factor that reflects the cost of care where I live. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier's overall cost and utilization trends ("index rate"), my age, my family size, and a factor that reflects the cost of care where I live. I have been given a Colorado Health Plan Description Form showing the benefits under Colorado's small group Standard Health Benefit Plans. I have also been given a Colorado Health Plan Description Form for the plan for which I am applying.

Print Applicant's Name	Applicant's Business Name
Applicant's Signature	Date
Print Spouse's Name	Spouse's Business Name
Signature of Spouse	Date

SECTION VII THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

If you or anyone on this application can answer "True" to all of the following statements you may meet the definition of a "federally eligible individual." Failure to answer one or more of the statements will indicate a "False" response.

1. I had in the past 18 months, creditable coverage, the most recent of which was under a group health plan (including a government plan or a church plan).
 True False If "Yes," group name _____ Telephone number _____.
2. I am **NOT** eligible for Coverage under a group health benefit plan, Medicare or Medicaid and do **NOT** have other health benefit plan coverage. True False
3. My most recent coverage was **NOT** terminated as a result of nonpayment of premium or fraud. True False
4. If offered, I accepted continuation coverage and exhausted such benefits (i.e., State Continuation Coverage or COBRA). True False

Date State Continuation Coverage or COBRA Ended (Month/Day/Year) _____

Names of members covered _____

Do You or Anyone on this Application Qualify for HIPAA? Yes No Names of qualified applicant(s) 1) _____

2) _____ 3) _____ 4) _____

SECTION VIII AGREEMENT

It is understood and agreed that the foregoing answers are true and shall be the basis for the issuance of the Membership Certificate applied for, and that the omission or misstatement of any material information in answer to the foregoing questions shall void the Membership Certificate.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder, or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance.

I authorize release of any information regarding this application to my broker of record.

I understand that the purpose of the statement of health is to provide Anthem with information for determining the qualifications of myself (individual) and my family members (spouse and dependents) for the health coverage applied for and I agree that this statement of health shall become part of the contract between Anthem and myself.

The following authorization must be signed by the applicant and other adult persons, including adult dependents (e.g. age 18 or older in Colorado), to be covered. If the applicant does not sign this authorization, coverage cannot be issued. If any other adult person to be covered does not sign this authorization, coverage will not be extended to that person.

I hereby authorize that:

1. at the request of Anthem, any provider of health services or supplies, insurance company, organization, institution, or person may release information to Anthem about health-related services and supplies provided to me, persons covered under my health coverage, or persons to be covered under my health coverage. This authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record;
2. the Medical Review and Underwriting departments or agents of Anthem, upon receiving this information may use it to review, investigate, or evaluate any application for an insurance policy, a policy reinstatement request, or a request or change in policy benefits.
3. unless I revoke this authorization, this authorization is valid for 24 months from the date I signed it, and
4. a copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

SIGNATURE OF APPLICANT OR LEGAL REPRESENTATIVE, IF APPLICABLE on behalf of himself/herself and all other minor Person(s) X	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable X	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable X	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable X	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable X	DATE

If a legal representative signs on behalf of the applicant or any other adult person to be covered, a copy of the legal representative's authority must be attached to the application. This authorization is subject to revocation at any time by written notice to Anthem Blue Cross and Blue Shield except to the extent that Anthem Blue Cross and Blue Shield has already taken action in reliance on this authorization, any information received by Anthem Blue Cross and Blue Shield pursuant to this authorization is subject to restrictions on disclosure to others as set forth under applicable federal and state laws.

PLEASE INDICATE IF YOU ARE SIGNING FOR A MINOR <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Trustee (If trustee or legal guardian, please supply legal documentation)	YOUR SOCIAL SECURITY NUMBER (Optional)
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Incomplete Applications Will Be Returned. Have You . . .
 Completed Health Statement? Signed and Dated Application?
****ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM** OR FILL OUT THE CREDIT CARD AUTHORIZATION (FORM NO. 98644) AND INCLUDE IT WITH THIS APPLICATION.**

Monthly Bank Draft / Electronic Funds Transfer Authorization (Optional)

You can choose to have Anthem automatically deduct your premium and any state-mandated fees if applicable ("payment") from your checking account each month. Once your application is approved, your Electronic Funds Transfer Account (EFT) will be set up within 30 days from your effective date. Until the service is effective, Anthem will mail your bill for your monthly payment. To set up EFT, simply complete this section and be sure to include your first month's payment, or fill out the Initial Payment Only Credit Card Payment section below, when you return your completed application.

Bank Name	Name(s) on Bank Account
Your Bank's Routing Number	Your Bank's Account Number

I authorize Anthem Blue Cross and Blue Shield (listed on bank statement as Rocky Mountain Hospital and Medical Service, Inc.) to deduct my monthly payment due each month. The amount deducted each month will be a consistent amount unless there is a rate increase or change in state-mandated fees, where applicable. If there is an outstanding balance forward due, plus my regular payment due, I will be asked to provide authorization to allow for the entire amount to be deducted. This agreement remains in effect until Anthem Blue Cross and Blue Shield receives a 30-day advance written notice from the Bank Account holder or subscriber. In the event the Bank does not pay my payment for any reason, I understand that I am responsible for such payment. Failure to make full payments when due may result in termination of my coverage.

Signature (Exactly as it appears on bank records)	Date:
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INTERNAL USE ONLY

AUTO ID#	SUBSCRIBER #	EFFECTIVE DATE
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Initial Payment Only Credit Card/Debit Card Premium Payment (Optional)

You may choose to make your **initial** premium payment by check, money order or credit card/debit card. Credit card/debit card payment is available for your first premium payment only. **All subsequent payments will be made through monthly bills.**

If choosing to pay by credit card/debit card, you must complete **all** of the following information: Credit Card Debit Card
 VISA MasterCard

Card# _____

Expiration Date: (mm/yyyy) _____ \$ _____
 Maximum Premium Amount Authorized

I authorize Anthem Blue Cross and Blue Shield to bill my VISA or MasterCard account for the payment amount shown above at the time my application is approved. I understand that the amount authorized may or may not be my final monthly premium and I am responsible for any difference in premium due on my account. Any credits will be applied to future billings.

Applicant's Name (Please Print)	Cardholders name (If different than applicant. Please Print)
Cardholder Signature:	Date:

INTERNAL USE ONLY: DO NOT WRITE BELOW THIS LINE

IPAD auto ID#	Subscriber #
Date Processed:	Processed by: