

# Application for Coverage under HIPAA

(Health Insurance Portability and Accountability Act)



## 1. Applicant Information

Please print in blue or black ink

Applicant's Last Name	First Name	M.I.
Home Address (Must be complete: P.O. Box not acceptable)		
City	State	ZIP Code

## 2. Choice of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Individual Coverage

Choose one plan per application

- HIPAA HMO Saver (025T)\*  
 HIPAA Select HMO (025R)\*

Billing Address (If different than above.) or P.O. Box	Personal Mail Box (PMB) No.	Daytime Phone No. ( ) ( )	Fax Phone No. ( ) ( )
City / State / ZIP Code	County (Required)	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership	Applicant/Spouse Maiden Name
E-mail Address	If possible, do you want e-mail notification? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has any person listed on this application resided outside the U.S. for the past three (3) consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Language Choice (Optional)	<input type="checkbox"/> English (ENG) <input type="checkbox"/> Korean (KOR) <input type="checkbox"/> Vietnamese (VIE) <input type="checkbox"/> Tagalog (TGL)	<input type="checkbox"/> Spanish (SPA) <input type="checkbox"/> Chinese (ZHO) (C/M) <input type="checkbox"/> Other (W09) _____	

Applicant DOES speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a Statement of Accountability (Section 6).

## 3. Family Members and Dependents Applying

Please list ALL eligible family members and dependents applying.

If a listed family member or dependent's last name is different from your own, please explain on a separate sheet of paper.

### 3A. For HMO Use Only

Choose a physician for each family member by calling 1-866-297-7647 or from the Provider Directory, which can be found at [anthem.com/ca](http://anthem.com/ca)

Relation	Last Name	First Name	M	Social Security or ID No.	Date of Birth	Age	PMG/ IPA**	Primary Care Physician (PCP)	Current Patient
10 <input type="checkbox"/> Male 20 <input type="checkbox"/> Female	Yourself								<input type="checkbox"/> Yes <input type="checkbox"/> No
30 <input type="checkbox"/> Male 40 <input type="checkbox"/> Female	Spouse*								<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No

**Dependent Information:** Do you claim any child listed above who is between the ages of 19 through 22 as a dependent on your Federal Income Tax?  Yes  No

If "No," any child between the ages of 19 through 22 who is not claimed on your Federal Income Tax is NOT eligible as a dependent but may apply individually.

\*Spouse includes domestic partner (when applicable).

\* These products are administered by Anthem Blue Cross and are regulated by the California Department of Managed Health Care. All other products are administered by Anthem Blue Cross Life and Health and are regulated by the California Department of Insurance.

\*\*PMG = Participating Medical Group; IPA = Independent Practice Association



4. Eligibility

- 1. Have all applicants had a minimum of 18 months of continuous health coverage most recently under an employer-sponsored group health plan that ended within the last 63 days for a reason other than fraud or non-payment of premium?
If yes, please attach the Certificate of Creditable Coverage provided by your former employer or carrier OR letter from the employer giving us the start and end date of coverage.
Name of insurance carrier: Phone No. ( )
If no for any applicant, then he or she is not eligible for this guarantee issue plan.
2. Did all applicants elect and exhaust any continuation coverage available under COBRA or Cal-Cobra?
If yes, date coverage started (Mo/Day/Yr) Date coverage ended (Mo/Day/Yr)
If no, please explain:
If all available COBRA or Cal-COBRA is not exhausted for any applicant, then he or she is not eligible for this coverage.
3. Is any applicant currently covered by or eligible for Medicaid, Medicare or any health coverage?
If yes for any applicant, then he or she is not eligible for this coverage.
4. Has any applicant lost coverage for fraud or failure to pay premiums?
If yes, then he or she is not eligible for this coverage.

5. Prior Insurance History

For any period of creditable coverage for which you are unable to provide a certificate of creditable coverage, please complete the following section for the last two years, beginning with the most recent coverage. Please include any COBRA and Cal-COBRA continuation coverage. Attach additional sheet if necessary.

Table with 4 columns: Applicant name(s) OR All applicants, Insurer Name(and Phone Number), Policyholder ID Number, Plan/Policy Name, State, Effective Date of Coverage, Coverage End Date.

Type of Coverage: Group Individual Other

6. Application Understandings, Conditions and Agreement -

IMPORTANT: You, the applicant, are solely responsible to review and attest to the completeness and validity of information provided on this application. It is important that you carefully read and fully understand the following:

All Applicants

I, the undersigned, understand that under the Anthem Blue Cross plan and/or Anthem Blue Cross Life and Health Insurance Company policy for which I am applying, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician.

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.

Agreement

By requesting coverage, I, the undersigned, agree to the following:

- 1. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may decline my application. No coverage comes into effect until Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company approves this application and informs me in writing.
2. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company underwriting policy or the terms of any Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company coverage.
3. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application.
4. In no event shall Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company or any affiliated company have any liability to the applicant if the application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by the Medical Underwriting Department of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
5. I understand and agree that I am applying for an individual health coverage policy which is not part of any employer-sponsored plan and the policy, if issued, shall not be used as an employer-sponsored health benefit plan.
6. I expressly consent to receive calls made by or on behalf of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliated companies, contractors and vendors that use an automated dialing system or deliver prerecorded messages, including telemarketing sales calls that encourage the purchase of goods or services, to any of the telephone numbers I have provided in this Application.
7. I understand that my domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.
8. When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information.

Initials



## 6. Application Understandings, Conditions and Agreement - continued

I have personally read and attest to the completeness and validity of the information provided on this application. If I am accepted, this application will become part of the plan contract/policy between Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and me.

I, and any enrolled family members, agree to abide by the terms of that plan contract/policy. With the exception of minors and persons for whom this application has been interpreted (a signed Statement of Accountability must be attached, see Section 7) all persons applying for coverage agree that they have personally answered all questions directed to them. If an Applicant does not read English, the interpreter must sign and submit a Statement of Accountability for interpreting this entire application (see Section 7).

### REQUIREMENTS FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. *It is understood that any disputes including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including 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. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.*

**Signatures (Required) – IMPORTANT: All applicants age 18 and over must personally read, agree to, sign and date this application.**

Applicant/ Parent or Legal Guardian	Today's Date	Applicant's Spouse/Domestic Partner	Today's Date
X		X	
Applicant's Dependent age 18 or over	Today's Date	Applicant's Dependent age 18 or over	Today's Date
X		X	

■ **IMPORTANT: All signatures MUST include today's date** ■



