

Application For Individual HMO Standard and Basic Coverage



2 Gannett Drive
South Portland, Maine 04106-6911

Thank you for applying for HMO 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 1-800-585-0099.

1. Your Name, Address, and Phone Number

Please write the complete name and address of the person applying for Individual HMO 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, children and stepchildren. Children and stepchildren must be under 25 years of age; unmarried; not have dependents of their own; not have other health insurance coverage; and be a resident of this State or enrolled as a full-time student at an accredited public or private institution of higher education.
*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 <i>(Please include yourself if you are to be covered)</i>			If disabled date of disability	SEX M F	BIRTHDATE Mo/Day/Year	SOCIAL SECURITY NUMBER	*OI	PRIMARY CARE PHYSICIAN <i>(Each member must choose a primary care physician.)</i>		
First Name	M.I.	Last Name						Physician Name	Current patient? Y N	Physician Number
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)

Individual HMO Standard Plan Individual HMO Basic Plan

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 10 and attach voided check

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:

- hold a valid Maine motor vehicle operator's license or nondriver identification card issued in Maine;
- have a valid passport or visa and be lawfully admitted to the United States;
- be registered to vote in Maine;
- have a permanent dwelling place in Maine;
- submit a written sworn affidavit declaring intent to reside in Maine; or
- 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 HMO coverage:

I am a Sole Proprietor using Individual HMO as my 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 Individual HMO coverage. If yes, please provide name of employer _____

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

(Continued on back)

8. Prior Health Insurance Coverage and Other Health Insurance Coverage

Please answer ALL of the following questions. Anthem gives credit for prior creditable coverage toward the preexisting waiting period for those applicants who apply and are accepted for coverage and request an effective date within 90 days after termination of qualifying prior creditable coverage as required by law. To obtain credit toward the preexisting waiting period, please complete the following questions. Please provide information about your previous coverage for the past 24 months. Attach a separate sheet if necessary.

1. Are any applicants eligible for Medicaid or Medicare? Yes No

If yes, who? _____ Please provide your Medicare or Medicaid Number _____

2. Has any applicant been previously insured by an Anthem health Insurance plan? Yes No

If yes, indicate Policy No. _____

3. Do you currently have coverage? Yes No

If No, has any applicant had coverage in the last 90 days? Yes No

If you answered "Yes", please provide the following information for each applicant:

Applicant Name(s) OR <input type="checkbox"/> All applicants		Insurer Name and Phone Number	Policyholder ID Number
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Plan Name	State	Start Date of Coverage OR <input type="checkbox"/> More than 2 years ago	Coverage End Date OR <input type="checkbox"/> Start of Anthem coverage	Type of Coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Other
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Reason for Cancellation	Will you cancel this coverage if approved by Anthem? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Applicant Name(s) OR <input type="checkbox"/> All applicants		Insurer Name and Phone Number	Policyholder ID Number
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Plan Name	State	Start Date of Coverage OR <input type="checkbox"/> More than 2 years ago	Coverage End Date OR <input type="checkbox"/> Start of Anthem coverage	Type of Coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Other
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Reason for Cancellation	Will you cancel this coverage if approved by Anthem? <input type="checkbox"/> Yes <input type="checkbox"/> No
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9. 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 also will 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. Electronic Fund Transfer Authorization (EFT) (Complete if you want your payments deducted directly from your checking account—attach voided check)

Anthem Blue Cross and Blue Shield (Anthem) is hereby authorized and requested to charge my (our) checking account at:

Bank Name _____ Bank Address _____ Checking Account Number _____

for the payment of the monthly subscription charges for my (our) Individual HMO certificate. This authority is to remain in effect until revoked in writing by me (us), and I agree that until Anthem receives such notice of revocation, it shall be fully protected in initiating such charges. I understand that if any charge is dishonored by my bank and such amount due Anthem is not paid within the contractual grace period provided by my certificate, my coverage with Anthem will be cancelled in accordance with the terms in my certificate. I have read and understand the rights outlined in the EFT brochure.

Signature (as on checking account) _____ Date _____

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

The producer named below has presented Anthem Blue Cross and Blue Shield's Individual HMO 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 _____