

4b. Yes No Are all applicants listed on this application legal residents of the United States and residents of the state in which you are applying for coverage? If NO, who? _____
 Yes No Are all applicants listed on this application United States citizens?
 If NO, who? _____
 and how many months/years have they resided in the United States? _____ years and _____ months

5. Prior and Other Insurance Information - Please answer ALL of the following questions.

(A) Do you have any other health insurance policy or certificate in force? YES NO

(B) Have you had coverage within 120 days of the application? YES NO

If you answered "Yes" to A or B, please provide the following information:

Name of Other Insurance Company _____

Policy Number _____ Type of Coverage Group Individual Last Date of Coverage _____

If the answer to question (A) is yes, do you intend to replace your current medical or health policy with the policy?

Yes No

6. Billing Choice (Please Check One) Electronic Fund Transfer - complete section 7 and Monthly Paper Bill
attach a voided check or savings account deposit slip.

7. 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.

8. Effective Date

If Anthem approves my application, please assign an effective date of _____. The effective date must be no earlier than the signature date and no greater than 60 days from the receipt by Anthem of this application. **(NOTE: REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE COVERAGE OR ENROLLMENT AS OF THE DATE REQUESTED. Effective date will ultimately be assigned by Anthem Blue Cross and Blue Shield and communicated to you.)**

A completed, signed Health Statement must be enclosed with this completed, signed application. Important: Please attach copies of any certification or other documentation of prior creditable coverage furnished by previous carriers or employers, if available. This will help us process your application.

Anthem Individual products are issued on an individual basis and are regulated as an individual health insurance plan.

I acknowledge receipt of an outline of coverage provided by the policy checked above. I certify that neither I nor any family member listed is eligible for Medicare. I understand the following: (a) that all coverage and services are subject to the Exclusions, Limitations and Conditions of the Subscriber Agreement or other Evidence of Coverage document; (b) that no benefits will apply until I receive written approval and confirmation of effective date, and my first month's paid premium has been processed by, Anthem Blue Cross and Blue Shield and; (c) that I will be responsible for notifying the Company of any change in dependent status or change of address. I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or nonpayment of claims for myself or my dependents. I certify that my statements in this form and the attached Health Statement are true and complete to the best of my knowledge and belief.

9. Applicant's Signature (If applicant is under 18, parent or guardian signature required.)

Date

/ /

Spouse's Signature

Date

/ /



**CONNECTICUT
INDIVIDUAL MARKETS HEALTH STATEMENT**

Anthem Blue Cross and Blue Shield is a trade name of Anthem Health Plans, Inc.
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APPLICANT AND FAMILY INFORMATION

PLEASE USE BLACK OR BLUE INK ONLY

**PART A
COMPLETE FOR YOU AND ANY FAMILY MEMBERS APPLYING FOR COVERAGE:**

	FIRST NAME	INITIAL	LAST NAME	HEIGHT	WEIGHT	DATE OF BIRTH	SEX M/F	SOCIAL SECURITY #
APPLICANT				/		//		
SPOUSE				/		//		
DEPENDENT				/		//		
DEPENDENT				/		//		
DEPENDENT				/		//		
DEPENDENT				/		//		

- PART B** **YES NO**
1. IS ANY PERSON TO BE INSURED CURRENTLY ON MEDICARE?
2. HAS ANYONE HAD HEALTH OR LIFE INSURANCE MODIFIED, POSTPONED OR RATED?
PLEASE SUBMIT DETAILS _____

- PART C**
1. Are you or your spouse or any dependent to be insured currently disabled or unable to perform their normal activities?
2. Have you or any dependent to be insured been hospitalized, had surgery or been advised to have surgery within the past 5 years for any reason?
3. Are you or any dependents to be insured currently pregnant, or an expectant parent?
4. Are you or any dependents currently taking any medication? If yes, please specify medication and condition for which it is used: _____
5. Do you or any dependents have any conditions or symptoms for which a physician or other medical care provider has not been consulted?
6. Have you or any dependent had medical expenses in excess of \$5,000 in the last 12 months?

- PART D**
1. Have you or any dependent to be insured ever had or been told they had, or been medically counseled, consulted or treated for any of the following? (Check **yes** or **no** and **circle the disorder**)
- A. Chest pain, heart attack, heart murmur, heart trouble, rapid, slow or irregular heart beat, other diseases of the heart, circulatory system or blood vessels, varicose veins, phlebitis, anemia or other disorder of the blood?
 - B. Cancer, tumor or lymph node enlargement? (Indicate type of cancer and location _____)
 - C. Sexually transmitted disease?
 - D. Mental, emotional, nervous disorder, depression, anxiety, psychotherapy or counseling of any kind?
 - E. Brain disorder, neurologic problems, seizure disorder, any disorder of the central nervous system, stroke or paralysis?
 - F. Alcohol or drug use, abuse and/or dependency?
 - G. Medical diagnosis of AIDS (Acquired Immuno Deficiency Syndrome) or ARC (AIDS Related Complex)?
 - H. Any disorder of the male/female reproductive organs including infertility and complications of pregnancy?
 - I. Back, neck, bone, joint problems, Lupus, arthritis or autoimmune disorder?
 - J. Diabetes? If so, specify date of diagnosis, type of treatment, amount of medications (if any): _____
- _____
- K. Any disorder of the stomach, intestines, gallbladder or esophagus?
 - L. Any disorder of the lungs or respiratory system or Tuberculosis?
 - M. Any disorder of the kidneys, bladder or urinary tract?
 - N. Any disorder of the liver or pancreas?
 - O. Any disorder of the endocrine system or glands?

