Individual Change of Coverage Application – For existing enrollments only.

Please complete in blue or blank ink only

☐ Change to new product ☐ Rate review for (member name) ______________________ ☐ Both

IMPORTANT: If you are applying for a change of coverage from any HMO or Basic Plan or if you want to apply for Life Insurance, you must complete the Individual Enrollment Application (IU2138) or go online to complete an application with our assisted application wizard at www.anthem.com/ca.

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 ☐Domestic Partnership ☐Single	Applicant/Spouse Maiden Name	Spouse Social Security or ID No.

Mailing Address *(If different than above or P.O. Box)*		
City	State	ZIP Code

Home Phone No. ( )	Business Phone No. ( )

Mail Service Agreement to: ☐ Primary Subscriber ☐ Your Anthem Blue Cross agent

2. Choice of Anthem Blue Cross Plan and/or Anthem Blue Cross Life and Health Insurance Company Policy

Medical Benefit Options

- ☐ ClearProtection Plus 1000 (06B3)
- ☐ ClearProtection Plus 3300 (06B4)
- ☐ ClearProtection Plus 5000 (06B5)
- ☐ SmartSense Plus 1000 Standard Rx (01KB)
- ☐ SmartSense Plus 1000 Rx Upgrade (01KF)
- ☐ SmartSense Plus 2000 Standard Rx (01KC)
- ☐ SmartSense Plus 2000 Rx Upgrade (01KG)
- ☐ SmartSense Plus 3500 Standard Rx (01KD)
- ☐ SmartSense Plus 3500 Rx Upgrade (01KH)
- ☐ SmartSense Plus 6000 Standard Rx (01KE)
- ☐ SmartSense Plus 6000 Rx Upgrade (01KJ)
- ☐ PPO Share 1000 (06BL)
- ☐ Lumenos HSA 1500 (no maternity) (06BN)
- ☐ Lumenos HSA 5000 (maternity) (06BP)
- ☐ Lumenos Plus HSA 3000 (Individual) (01KK)
- ☐ Lumenos Plus HSA 4500 (Individual) (01KL)
- ☐ Lumenos Plus HSA 5950 (Individual) (01KM)
- ☐ Lumenos Plus HSA 3500 (Family) (01KN)
- ☐ Lumenos Plus HSA 5500 (Family) (01KP)
- ☐ Lumenos Plus HSA 7500 (Family) (01KQ)
- ☐ Lumenos Plus HSA 11900 (Family) (01KR)
- ☐ CoreGuard Plus 750 w Facility Copay (06B6)
- ☐ CoreGuard Plus 1500 w Facility Copay (06B7)
- ☐ CoreGuard Plus 2500 w Facility Copay (06B8)
- ☐ CoreGuard Plus 3500 (06B9)
- ☐ CoreGuard Plus 5000 (06BA)
- ☐ CoreGuard Plus 7500 (06BB)
- ☐ CoreGuard Plus 10000 (0ADX)
- ☐ Premier Plus 1000 (06BD)
- ☐ Premier Plus 1500 (06BE)
- ☐ Premier Plus 2500 (06BF)
- ☐ Premier Plus 3500 (06BG)
- ☐ Premier Plus 5000 (06BH)
- ☐ Premier Plus 6000 (06BJ)

Anthem Blue Cross Products*

- ☐ PPO Share 3500 (06BX)
- ☐ PPO Share 5000 (06BZ)
- ☐ PPO Share 7500 (06BY)
- ☐ HMO Saver (06C1)
- ☐ Individual HMO (06C0)
- ☐ Select HMO (06C2)

If you are enrolling in any of the Anthem Blue Cross HMO plans, please enter the number of the IPA or PMG Office you have chosen in Section 3A.

To apply for a plan/policy not listed, write in the name here:
☐ ______________________

If you have chosen a Health Savings Account (HSA) product, choose the following:

- ☐ Yes, I would like to establish an HSA. Please forward my information to Anthem Blue Cross' banking partner.
- ☐ No, I DO NOT want to establish an HSA. Please DO NOT forward my information to Anthem Blue Cross' banking partner.

Dental Benefit Options

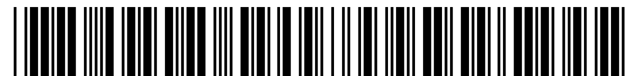
PPO Plans: ☐ Dental Blue Basic (01PU)
☐ Dental Blue Enhanced (01PW) ☐ Other ______________________

DHMO Plan: ☐ Dental SelectHMO (ZE7N)† ☐ Dental HMO Office Number ______________________
☐ Other ______________________

The Dental Select HMO plan is offered by Anthem Blue Cross. Dental Blue plans are offered by Anthem Blue Cross Life and Health Insurance Company.

† If you are enrolling in the Anthem Blue Cross Dental SelectHMO plan, please enter the number of the Dental Office you have chosen in the space above. If I purchase optional dental benefits, I understand that I may have a waiting period for the coverage.

* Products administered by Anthem Blue Cross Life and Health are regulated by the California Department of Insurance. Products administered by Anthem Blue Cross are regulated by the California Department of Managed Health Care.



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/Domestic Partner									
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										

My domestic partner, if applicable, is only eligible for coverage if he or she has established a domestic partnership with me pursuant to California law.
*PMG = Participating Medical Group, IPA = Independent Practice Association

4. Health History of Members Listed on this Application - **Your claims history with Anthem Blue Cross and /or Anthem Blue Cross Life and Health Insurance Company will also be used in addition to the history listed on this application.**

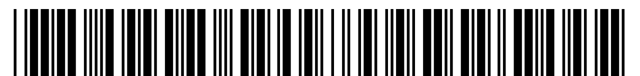
When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

NOTICE: Underwriting is the process whereby Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company determines if you are eligible for coverage. As part of this process, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company relies on the information you provide in this application to determine whether you are eligible for coverage. You must provide truthful and complete answers to the following questions to the best of your ability. Even if you have health coverage or had prior coverage with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, you must fully answer all health history questions. In addition to the information you provide in this application, we have the right to obtain and review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, you should not assume or take for granted that we will obtain and review all of your medical records before approving your application. Consistent with California law, if Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company issues coverage to you and later discovers that any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is found on this application, we may rescind your coverage even after the contract has been issued. This means that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may revoke your coverage.

PLEASE NOTE: The health history questions apply to ANY medical advice, diagnosis, care or treatment that you received or that a healthcare provider recommended that you receive for any health condition or issue.

		YES	NO
1.	Has any enrolled family member been hospitalized, seen a physician or other health care provider or taken prescription medication within the last 3 months? If yes, please provide name of applicant and details below.	☐	☐
2.	Has any enrolled member been advised to seek treatment, have surgery or testing that has not yet been completed? If yes, please provide name of applicant and details below.	☐	☐
3.	Is any enrolled family member currently pregnant (includes positive pregnancy test within the last 30 days), an expectant parent, or in the process of adoption or surrogate pregnancy? If yes, please provide name of applicant and details below.	☐	☐
4.	Has any enrolled member used tobacco products within the past 12 months? If yes, please provide name of applicant below.		
	Cigarettes, cigars or pipes?	☐	☐
	Chewing tobacco?	☐	☐

Family Member	Hospital / Provider Name & Address	Medication Prescribed	Condition / Illness Treated



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

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 in which I am enrolling, 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. Contact customer service at 1-866-297-7647 with any questions about the use of network providers and the financial impact of using out-of-network providers. 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 5).**

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.

By applying for 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. The effective date of my coverage, if this application is accepted, will be assigned by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company at its discretion.
2. Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company nor any affiliated company shall have any liability to me or anyone else listed on it. If this application is not accepted, neither I nor anyone listed on it will be entitled to benefits or coverage from Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
3. 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.
4. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
5. 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.
6. I understand Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.
7. If I purchase optional dental coverage, I understand that I may have a waiting period for the coverage of major services.
8. I understand that it is mandatory that I notify Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, in writing, immediately if I (the applicant) or any other person for whom coverage is sought received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date or the date underwriting approves, whichever is later. I understand that in this situation, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be denied, delayed, or reformed or, for applicants age nineteen (19) and older, benefits denied due to the illness, injury or condition being treated as a preexisting condition.
9. 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. If the policy is issued, I understand and agree that I am responsible for 100% of the premium and I must ensure that premiums are paid timely. I certify that no employer of any person covered under this policy will pay any premium for this health coverage policy, directly or indirectly, through wage adjustments or otherwise. If my employer has agreed to remit my premium payment to Anthem Blue Cross/Anthem Blue Cross Life and Health on my behalf, my employer will not directly or indirectly contribute to that payment and will only forward to Anthem Blue Cross/Anthem Blue Cross Life and Health my premium payment that is directly funded by the regular wages paid to me by my employer.
10. I understand that my domestic partner, if applicable, is only eligible for coverage if he or she has established a domestic partnership with me pursuant to California law.
11. When answering questions on this application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will be considered and applied only to the individual in question.

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 (the Statement of Accountability must be signed, see below) all persons applying for coverage agree that they have personally answered all health history 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.

☐ By checking this box, 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. All calls made pursuant to this provision shall be limited to information regarding benefits, services or discounts available under health benefit plans offered or administered by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and its affiliated companies. I also understand that my consent to receive such calls is voluntary and may be discontinued by calling Anthem. The benefits available under health benefit plans offered or administered by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates will not be altered in any way if I do not consent to calls made under this provision.

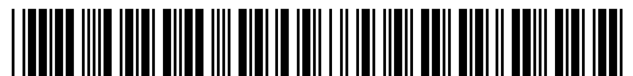
REQUIREMENT FOR BINDING ARBITRATION:

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 dispute 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.

Applicant/Parent or Legal Guardian	Today's Date *(Required)*	Applicant's Spouse/Domestic Partner	Today's Date *(Required)*
X		X	
Applicant's Dependent Age 18 or over	Today's Date *(Required)*	Applicant's Dependent Age 18 or over	Today's Date *(Required)*
X		X	

IMPORTANT: ALL APPLICANTS AGE 18 AND OVER MUST PERSONALLY READ, AGREE TO, SIGN AND DATE THIS APPLICATION.



Anthem Blue Cross

Health. **Join In.**

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

NOTE: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I________________________________, personally read and completed this Individual Application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English
☐ Applicant is Limited English Proficient ☐ Other (explain): ______________________________

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

Or by: ______________________________

I also interpreted and fully explained the 'Application Understandings, Conditions and Agreement,' the 'Authorization for Use of Protected Health Information' and the 'Payment Method'

I confirm that the application was interpreted on my behalf.

____
Signature of Interpreter *(Required)*

____
Today's Date *(Required)*

____
Signature of Applicant *(Required)*

____
Today's Date *(Required)*

Language interpreted (e.g. Spanish): ______________________________

To be completed by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company appointed agent

1. Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting? ☐ Yes ☐ No
2. Did you see the proposed subscriber (and spouse/domestic partner, if applying) at the time this application was executed? ☐ Yes ☐ No
   If no, please explain: ______________________________
3. I certify that, to the best of my knowledge and belief, the responses herein are accurate.
4. Please check one of the following and complete the information below:
   - ☐ I have not had any interactions whatsoever with this applicant either by phone, e-mail or in person and did not provide any information, advise or assist the applicant in any manner in providing answers or responses to any questions in the application.
   - ☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code Section 1389.8(c)/Insurance Code Section 10119.3.

Name of Agent (Print Name)		Agent Street Address / Suite No./Personal Mail Box (PMB) No.
Agent ID Number	Sub-Agent ID Number	City/State/ZIP Code Location No.
Phone Number	FAX Number	E-mail Address

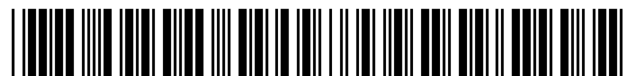
Please mail this application to the following address:

Anthem Blue Cross
P.O. Box 9041
Oxnard, CA 93031-9041

OR

Fax to: 800-327-9255

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent
® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.



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