Insurance ISMA Agency

322 Canal Walk • Indianapolis, IN 46202-3268

(317) 261-2060 • Toll free: (800) 257-4762 • www.ismanet.org

The ISMA Insurance Agency is pleased to provide this packet of information on the Indiana State Medical Association sponsored Anthem health insurance plan for ISMA members and their families.

This packet includes:

- Medical, Life and Dental Insurance brochure
- Anthem Enrollment Application

To request firm rates for each plan, please complete the Anthem Enrollment Application, then scan and email the application to ismaia@ismanet.org, or fax it to our private fax line, (317) 261-2238.

Upon receipt, we will forward the application to Anthem Underwriting for review and rating. Within a few business days, we will email firm rates for each plan option for your consideration.

If you have any questions, please email the ISMA Insurance Team at ismaia@ismanet.org or call (317) 261-2060 and say you're calling with questions about an ISMA-sponsored Anthem individual health insurance policy.

Medical, Life and Dental Insurance

for members of the ISMA and their practices

July, 2017 - June, 2018

(317) 261-2060 • (800) 257-4762 • www.ISMAIA.com

Check out our **Health Savings Account Plans**
and our **High Deductible Plans**

Health Insurance - PPO and HSA Plans Available

UNIQUE ADVANTAGES

- ✓ This health policy can provide physicians with seamless coverage from practice to retirement – and beyond.
- ✓ Unlike other group health plans, ISMA members may keep this policy if they terminate employment, retire or become disabled prior to age 65.
- ✓ Surviving spouses and children of deceased ISMA members may continue coverage, provided the member was covered immediately prior to death. Spouses are eligible for the rest of their lives or until remarriage; children are eligible through the end of the year in which they attain age 26.
- ✓ Covered employees who retire at age 55 or over with at least 15 years of service with an ISMA member are eligible to remain in the plan. Covered employees who become disabled with less than one year employment can extend coverage for two months; with one to two years of employment, can extend coverage for one year; with more than two years of employment, can extend coverage for two years.
- ✓ Once subscribers attain age 65, they are eligible for Medicare Carve-out plan when Medicare is primary. (Subscribers are automatically changed to Medicare Carve-out, and separate policies are automatically created for any covered dependents.)
- ✓ Children can be covered under parents' policies through the end of the year in which they attain age 26, regardless of tax, student or marital status.
- ✓ Children are eligible for separate policies from the date they are removed from parents' policies through the end of the year in which they attain age 29, at the low Member Only rate, provided the parent is insured in the ISMA program.
- ✓ Knowledgeable ISMA employees and agents provide customer service for all aspects of the plan aside from claims processing, which is handled by Anthem.
- ✓ Premiums are discounted based on favorable claims experience.
- ✓ All ISMA plans use the broad Anthem Blue Access Network, providing network benefits for a very wide selection of physicians, other medical professionals, hospitals and medical facilities. Many competitive plans use more restrictive networks that limit the selection of network providers.
- ✓ More consistent annual renewal rate adjustments than many competitive plans.
- ✓ Most plans have two deductibles per family instead of three, which is common among competitive plans.
- ✓ Each physician may choose a medical plan that best fits their needs, while the employees participate in a separate medical plan.
- ✓ Practices with 10 or more employee subscribers can offer employees a choice of any of the following paired medical plan options, provided at least 20% participate in each plan:

	PPO 1000/2000	PPO 1500/3000	PPO 2500/5000	PPO 4000/8000	PPO 5000/10000	HSA 2600/5200	HSA 3000/6000	HSA 3500/7000	HSA 4000/8000	HSA 5000/10000
PPO 1000/2000										
PPO 1500/3000	X									
PPO 2500/5000	X									
PPO 4000/12000	X									
PPO 5000/10000	X	X								
HSA 2600/5200	X				X					
HSA 3000/6000	X				X					
HSA 3500/7000		X	X	X		X	X			
HSA 4000/8000		X	X	X	X	X	X			
HSA 5000/10000			X	X	X				X	

A Valuable Benefit For…

- Physicians who are members of the Indiana State Medical Association, their spouses (or domestic partners subject to certain requirements), and their children through the end of the year in which they attain age 26.
- Employees of insured ISMA members who work at least 20 hours per week in a medical office or medically related facility, their spouses (or domestic partners subject to certain requirements), and their children through the end of the year in which they attain age 26.

Information You Should Know

- Deductibles and coinsurance start over on January 1 of each year.
- Individual health insurance policy premiums are reviewed on July 1 of each year.
- You may request changes from one medical plan to another on your plan's annual renewal date. (Requests to upgrade plans may be subject to underwriting approval and may not be guaranteed.) Additionally, you may request an off cycle change to a plan with a lower premium one time per year, 4 or more months before your plan's annual renewal date.
- Newborn children must be added by contacting ISMA within 31 days of birth to be covered under the plan.

Vision

The Preventive Care benefit under all plans covers one routine vision screening test (such as an eye chart exam or visual exam of the eye) per person per calendar year by a network provider. Other services included in a comprehensive eye exam (such as visual acuity and ophthalmological exam including refraction) are not covered.

Discounts on eyeglasses and contacts are available through certain retailers. For details, go to **www11.anthem.com/specialoffers/vision.html**.

Dental Insurance - PPO Plan

Designed to provide the entire group with dental insurance, this plan also can be set up as a physician-only benefit. See Dental page of this brochure for more information. (Medical coverage is required.)

The ISMA Insurance Agency offers the following insurance plans

All plans use the Anthem Blue Access Network; search for providers at ***www.anthem.com***

Under the following plans, each covered person must meet the individual deductible. However, when a policy covers three or more people, no further deductible is applied after the family maximum deductible is met.

Plan Name	Preventive Care (PC)[2]; Office Visit (OV)		Urgent Care (UC); Emergency Room (ER)		Rx Copay[3]		Deductibles[4]			Coinsurance[4]			Out of Pocket Maximum[4]		
	In Network	Out of Network	In Network	Out of Network	Pharmacy 30-day supply	Mail Order 90-day supply	In Network		Out of Network	In Network		Out of Network	In Network		Out of Network
PPO 1,000 /2,000	PC[2]- 100% OV[7]- $20 copay	DC[1]	UC- $75 copay ER- $300 copay	DC[1]	$10/$20/$40 /25% to $200	$20/$40/$80 /25% to $200	$1,000 $2,000	Per person Family max	$2,000 $4,000	90%/10%	plan/insured	70%/30%	$3,000 $6,000	Per person Family max	$6,000 $12,000
PPO 1,500 /3,000	PC[2]- 100% OV[5,7]- $25 PCP co-pay; $50 SCP copay	DC[1]	UC- $75 copay ER- $300 copay	DC[1]	$10/$30/$60 /25% to $200	$20/$60/$120 /25% to $200	$1,500 $3,000	Per person Family max	$3,000 $6,000	80%/20%	plan/insured	60%/40%	$5,000 $10,000	Per person Family max	$10,000 $20,000
PPO 2,500 /5,000	PC[2]- 100% OV[5,7]- $25 PCP co-pay; $50 SCP copay	DC[1]	UC- $75 copay ER- $300 copay	DC[1]	$10/$30/$60 /25% to $200	$20/$60/$120 /25% to $200	$2,500 $5,000	Per person Family max	$5,000 $10,000	80%/20%	plan/insured	60%/40%	$6,450 $12,900	Per person Family max	$15,000 $30,000
PPO 4,000 /12,000	PC[2]- 100% OV[7]- $30 copay	DC[1]	UC- $75 copay ER- $300 copay	DC[1]	After $250/person Rx deductible:[6] $10/$30/$60 /25% to $200	$10/$75/$180 /25% to $200	$4,000 $12,000	Per person Family max	$8,000 $24,000	80%/20%	plan/insured	60%/40%	$6,850 $13,700	Per person Family max	$16,000 $32,000
PPO 5,000 /10,000	PC[2]- 100% OV[5,7]- $25 PCP co-pay; $50 SCP copay	DC[1]	UC- $75 copay ER- $300 copay	DC[1]	$10/$30/$60 /25% to $200	$20/$60/$120 /25% to $200	$5,000 $10,000	Per person Family max	$10,000 $20,000	80%/20%	plan/insured	50%/50%	$7,150 $14,300	Per person Family max	$20,000 $40,000
HSA 2,600 /5,200	PC[2]- 100% OV- DC[1]	DC[1]	DC[1]	DC[1]	Discount, DC[1]	Discount, DC[1]	$2,600 $5,200	Per person Family max	$5,000 $10,000	100%/0%	plan/insured	50%/50%	$2,600 $5,200	Per person Family max	$10,000 $20,000
HSA 3,000 /6,000	PC[2]- 100% OV- DC[1]	DC[1]	DC[1]	DC[1]	After medical deductible: $15/$40/$80 /25% to $200	$38/$120/$240 /25% to $200	$3,000 $6,000	Per person Family max	$3,000 $6,000	100%/0%	plan/insured	50%/50%	$4,500 $9,000	Per person Family max	$6,000 $12,000
HSA 3,500 /7,000	PC[2]- 100% OV- DC[1]	DC[1]	DC[1]	DC[1]	Discount, DC[1]	Discount, DC[1]	$3,500 $7,000	Per person Family max	$7,000 $14,000	80%/20%	plan/insured	50%/50%	$6,550 $13,100	Per person Family max	$12,000 $24,000
HSA 4,000 /8,000	PC[2]- 100% OV- DC[1]	DC[1]	DC[1]	DC[1]	Discount, DC[1]	Discount, DC[1]	$4,000 $8,000	Per person Family max	$8,000 $16,000	80%/20%	plan/insured	50%/50%	$6,550 $13,100	Per person Family max	$16,000 $32,000
HSA 5,000 /10,000	PC[2]- 100% OV- DC[1]	DC[1]	DC[1]	DC[1]	Discount, DC[1]	Discount, DC[1]	$5,000 $10,000	Per person Family max	$10,000 $20,000	80%/20%	plan/insured	50%/50%	$6,550 $13,100	Per person Family max	$20,000 $40,000

1 DC = Covered, subject to Deductible and Coinsurance (if applicable).
2 PC = Preventive Care -- See Preventive Care item under **What's Covered** below for more detailed description of benefits for each plan.
3 Copays for Tier 1/2/3/4 prescription drugs. The copay listed for tier 4 drugs (for example, 25% to $200) includes the maximum dollar amount
4 All plans have separate In Network and Out of Network Deductibles, Coinsurance and Out of Pocket maximums.
5 PCP = Primary Care Physician; SCP = Specialty Care Physician.
6 The subscriber is responsible for paying the first $250 of prescription drug costs each calendar year before the plan begins to pay its share.
7 Allergy testing, MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products subject to deductible and coinsurance. Allergy injections - $5 copay.

All plans feature an unlimited lifetime maximum benefit

Definitions

- **Deductibles:** Charges for certain services are subject to deductibles that accumulate from January 1 through December 31 of each year. All plans have separate In Network (IN) and Out of Network (OON) deductibles.
- **Copays:** Copays are specific amounts that you are required to pay at the time of certain services, i.e., office visits, urgent care center visits, emergency room visits.
- **Coinsurances:** Coinsurances are percentages of expenses that you are required to pay after meeting your deductible.
- **Out of Pocket Maximum: The Out of Pocket Maximum is satisfied by all deductibles, copays and coinsurances** (except human organ and tissue transplants, excluding kidney and cornea).

What's Covered

- **Preventive Care:** PPO plans: Cover physical exams, one routine vision screening test per calendar year, well baby care, immunizations, diagnostic services performed during the office visit session and billed by the physician, including routine Pap smears and routine mammograms – In network covered at 100%; Out of network subject to OON deductible and coinsurance. HSA plans: Cover all In-network care coded as preventive at 100%.
- **Physician Home and Office Services:** PPO plans: Primary Care Physician and Specialty Care Physician home and office visits covered, subject to Office Visit copays listed in Plan Options chart. $5 copay for allergy injections. Allergy testing, MRAs, MRIs, PETS, C-Scans, Nuclear Cardiology Imaging Studies, non-maternity related Ultrasounds, and pharmaceutical products are subject to deductible and coinsurance. HSA plans: Subject to deductible and coinsurance.
- **NEW! LiveHealth Online®:** With LiveHealth Online, you get immediate doctor visits through live video, your choice of U.S. board-certified doctors, private, secure and convenient online visits. For more information or to sign up, go to **www.LiveHealthOnline.com**. PPO plans: Subject to PCP copay. HSA plans: A cost of only $49 per visit, subject to deductible and coinsurance.
- **Urgent Care:** (Includes all services billed with urgent care encounter claim.) PPO plans: In network $75 copay. Out of network subject to OON deductible and coinsurance. HSA plans: Subject to deductible and coinsurance.
- **Emergency Room:** (Includes all services performed, facility and professional; waived if admitted.) PPO plans: In network $300 copay. Out of network subject to OON deductible and coinsurance. HSA plans: Subject to deductible and coinsurance.
- **Prescription Drugs:** Oral contraceptives covered under all plans. PPO plans (except PPO 4000): Rx copay benefits for Tier 1, 2, 3 and 4 drugs. See Plan Options chart for copay amounts. PPO 4,000: Annual $250/person Rx deductible; then Rx copay benefits for Tier 1, 2, 3 and 4 drugs. HSA plans (except HSA 3,000/6000): Prescription Drug discount, charges subject to deductible and coinsurance; then covered in full. HSA 3,000/6,000: Prescriptions Drug discount, charges subject to deductible; then Rx copay benefits for Tier 1, 2, 3 and 4 drugs until out-of-pocket maximums are met; then covered in full.
- **Inpatient Hospital Care:** Unlimited number of days of semi-private room or ward accommodations and other necessary services not included in the room charges.
- **Inpatient and Outpatient Professional Services:** All plans: Include, but are not limited to Medical Care visits (1 per day), Intensive Medical Care, Concurrent Care, Consultations, Surgery and administration of general anesthesia and Newborn exams.
- **Diagnostic X-rays and Lab Tests:** Subject to deductible and coinsurance.

What's Not Covered

LIMITATIONS

Unless otherwise noted, covered charges are based on Anthem's allowable amounts.

EXCLUSIONS FOR MEDICAL PLANS

(complete list of exclusions printed in Certificate)

Services not covered under the Medical Plans include services or supplies not medically necessary, cosmetic surgery, dental care not caused by an accident unless you are covered under the Dental Plan, eyeglasses or hearing aids, services covered by worker's compensation.

Groups - 2 or More Subscribers

- To establish a group plan, at least one staff physician or owner must be an ISMA member. In groups with multiple physicians, 75% of insured physicians must be ISMA members.
- The group plan requires at least two participants. 75 percent of all eligible employees must participate. An eligible employee is one who does not have coverage elsewhere. For groups with 50 or more full-time employees, the greater of 75 percent of all eligible employees or 50 percent of all full-time employees must participate.
- Group plans renew on January 1, April 1, July 1 or October 1. Initial rates are guaranteed for 10, 11 or 12 months, dependent upon enrollment date. Subsequent plan years have 12-month rate guarantees.

Compliance

- The ISMA issues COBRA offers for employers with 20 or more employees.
- All medical plans are Affordable Care Act compliant.
- The ISMA pays the ACA transitional reinsurance fees for all plan participants.
- The ISMA provides each insured employer group with an annual report containing the information they will need to file IRS Form 720 with PCORI fees.
- The ISMA issues 1095-B forms to individual subscribers. The ISMA provides each insured employer group with 1-50 subscribers with one set of 1095-B forms to distribute to insured employees, and one set to file with the IRS with a 1094-B transmittal. The ISMA provides each insured employer with more than 50 subscribers with the data needed to prepare 1095-C forms for insured employees.

- **Surgery:** Subject to deductible and coinsurance.
- **Anesthesia:** Subject to deductible and coinsurance.
- **Mental Health/Substance Abuse:** PPO plans: In network physician office visits, subject to primary care office visit copay. Outpatient professional and facility services subject to deductible and coinsurance. Out of network subject to OON deductible and coinsurance. In network inpatient professional and facility services subject to deductible and coinsurance; Out of network subject to OON deductible and coinsurance. HSA plans: Subject to deductible and coinsurance.
- **Maternity:** Subject to deductible and coinsurance.
- **Infertility:** All plans include $5,000 lifetime maximum benefit per person for treatment of infertility.
- **Ambulance:** Subject to deductible and coinsurance.
- **Medical Supplies, Equipment and Appliances:** Subject to deductible and coinsurance.
- **Outpatient Therapy:** All plans include 60 physical/occupational therapy visits, 20 speech therapy visits, 12 spinal manipulation visits, 36 cardiac rehabilitation visits and 20 pulmonary rehabilitation visits per calendar year. PPO plans: In network copay based on setting; Out of network subject to OON deductible and coinsurance. HSA plans: Subject to deductible and coinsurance.
- **Skilled Nursing Facility:** 90 days per calendar year combined Network and Non Network.
- **Approved Home Health Care Services:** All plans plans include 100 visits per calendar year.
- **Private Duty Nursing:** 82 visits per calendar year combined Network and Non Network; 164 visits per lifetime combined Network and Non Network.
- **Foreign Travel:** Same benefits paid in or outside the U.S. Outside the U.S., subscriber may be required to pay provider at time of service, and file a claim form and an itemized bill with Anthem upon return.
- **Hospice Services:** PPO plans: Covered in full. HSA plans: Subject to deductible and coinsurance.
- **Human Organ or Tissue Transplant:** Covers these human to human organ and tissue transplants: bone marrow, heart, heart/lung, lung, liver, pancreas and kidney/pancreas. In network covered at 100%; out of network 50% coinsurance. Kidney and cornea transplants covered under health benefit.
- **Mandatory Precertification on Inpatient and Selected Outpatient Services with Noncompliance Penalty:** Contact Anthem Customer Service Department to determine whether precertification is required on a particular Outpatient Service. In network penalties are provider’s responsibility. Out of network, subscriber is responsible for non-medically necessary services.
- **Benefit Management Program:** In catastrophic/chronic cases, alternative means of care may be offered, subject to approval of the insured and the attending physician, i.e., skilled nursing facility, home health care, hospice care or special medical equipment such as ventilators and respirators.
- **BlueCard Program:** In many cases, when you travel or live outside your Blue Cross and Blue Shield Plan’s service area, you can take advantage of savings the local Blue Plan has negotiated with local doctors and hospitals. You should not have to pay any amount above negotiated rates. Also, you should not have to complete a claim form or pay up front for your health care services, except for out-of-pocket expenses like non-covered services, deductible, copay, and coinsurance that you’d pay anyway. More than 85 percent of all doctors and hospitals throughout the U.S. contract with Blue Cross and Blue Shield Plans. Outside of the U.S., you have access to doctors and hospitals in more than 200 countries. If you’re a PPO member, always use a BlueCard PPO doctor or hospital to make sure you receive the highest level of benefits. **Visit the BlueCard Doctor and Hospital Finder Web site (www.BCBS.com) or call 1-800-810-BLUE to locate doctors and hospitals outside of your Blue Plan’s service area.**
- **Save Money with Discounts:** If you need a little help getting fit, staying healthy or finding balance in your life, chances are you can find the incentive you need with discounts on gym memberships, weight-loss programs, smoking cessation programs, eyeglasses, contacts, hearing aids, and more. It’s just one more reason to choose Anthem Blue Cross and Blue Shield. Log in at **www.anthem.com** and click on **Discounts**.

Wellness

Wellness education and resources are offered by Anthem at **timewellspent.anthem.com**, offering tools for prevention, living well and eating healthy.

How to Apply

Review this brochure. Then, follow these easy steps: 1) All full-time employees must complete an Anthem enrollment application per instructions on the first page of the form. 2) Complete and sign a Participating Unit Page (groups only).

Scan and email, or fax the above to **ISMA Insurance Agency** at **ismaia@ismanet.org** or at our private fax line, (317) 261-2238.

Upon receipt of your completed application, an appropriate risk class will be assigned based on medical history, and you will be provided with firm rates for each medical plan option. If you accept, the ISMA will send a New Policy Confirmation and an initial invoice, and Anthem will send an identification card (within 10-14 business days of entry into Anthem’s system).

Creating a User Account

Anthem makes it easy for subscribers to create an online user account to view benefits, check year-to-date deductibles, review claims, order new ID cards, refill mail order prescriptions - and more. To begin using Anthem online access, go to **www.Anthem.com**. From the menu, click Registration (under Support) and follow the prompts to set up a User account. You will need some information from your Anthem ID card.

For More Information

For more information, questions or group rates, please call the ISMA Insurance Agency at (317) 261-2060 or (800) 257-4762 or go to **www.ISMAIA.com**.

This is not meant as a replacement to the Certificate of Coverage (Certificate) and whenever a discrepancy exists between the Certificate and this brochure, the Certificate will govern the administration of the plan.

The ISMA Dental Plan

Dental Plan Highlights

OPTIONAL DENTAL PLAN

Designed to provide the entire group with dental insurance, this plan also can be set up as a physician-only benefit. You may include dental coverage for the additional monthly rate shown in the first row of the rate chart. The Dental Plan is available only in addition to the medical coverage. Dental coverage can be elected upon enrollment or added at any annual renewal date.

DEDUCTIBLE

$50 per person per calendar year, **or $150 per family** per calendar year (whichever occurs first). Applies to all benefits except diagnostic, preventive, and orthodontia.

MAXIMUM BENEFIT

Maximum **$1,500 per person benefit** per calendar year. Maximum **$1,000 per person orthodontia benefit** per lifetime, which does not count toward the annual maximum benefit.

INDIANA ANTHEM DENTAL NETWORK

If you purchase the Dental Plan and your dentist is in the Indiana Anthem Dental network, you will not be responsible for amounts billed over Anthem's allowable amounts. And your preventive and diagnostic services will be paid at 100 percent. To determine if your dentist is in the Indiana Anthem Dental network, visit anthem.com and search for Indiana Anthem Dental network providers.

Deductible Applies	Your Responsibility		Category	Covered Services
	Network	Non-Network		
	CIF*	20%	**Diagnostic and Preventive**	Oral evaluations, X-rays, cleanings, space maintainers and other selected diagnostic and preventive services.
X	20%	20%	**General (Adjunctive), Restorative, Endodontic, Oral Surgery, Periodontal**	Emergency palliative treatment, consultations, general anesthesia and I.V. sedation for surgical procedures, office visits for observation, and other selected general services. Amalgam and composite restorations and pin retention procedures. Root canal therapy, apexification, therapeutic pulpotomy and other selected endodontic services. Simple and surgical tooth extractions and other selected oral surgery services. Gingivectomy, crown lengthening, osseous surgery, soft tissue grafts and other selected periodontal services.
X	50%	50%	**Prosthodontic** *(1 yr waiting period)*	Crowns/onlays, partial and full dentures and other selected prosthodontic services.
	50%	50%	**Orthodontic** *(1 yr waiting period; $1,000 per person lifetime benefit)*	Non-surgical dental services related to the supervision, guidance and correction of growing or mature teeth; covered services include examination, records, tooth guidance and repositioning (straightening) of the teeth. Orthodontia benefits cease at end of Benefit Period in which Member reaches age 19.

* CIF = Covered in full

Exclusions for the Dental Plan: Charges for implants; facings on crowns or pontics posterior to the second bicuspid; lost or stolen appliances, dentures or fixed bridgework. Certificate contains complete list of charges not covered.

The ISMA Group Term Life Insurance Plan

Check us out online at www.ISMAIA.com

In our effort to provide comprehensive benefits, the ISMA health plan offers the following life and accidental death term insurance plan schedule of benefits. Groups of two or more insureds on the health plan are eligible for this benefit.

DEPENDENT LIFE

Term life benefit of $5,000 for each dependent included at *no additional cost*.

Class	Life insurance benefit	Total accident death benefit
Physicians	$50,000	$100,000
Employees	$20,000	$40,000

REDUCTION SCHEDULE

At age 65 benefits will reduce by 35 percent
At age 70 benefits will reduce by 60 percent
At age 75 benefits will reduce by 72 percent
At age 80 benefits will reduce by 80 percent

Anthem Blue Cross and Blue Shield provides the true group medical, dental and life insurance plans. This brochure is provided to help you decide which plan to choose. It is not a contract, and it is not a complete description of the benefits, exclusions and limitations of any plan.

Effective 7/1/2017 for July renewals, 10/1/2017 for October renewals, 1/1/2018 for January renewals and 4/1/2018 for April renewals.

Enrollment Application

Individual

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. *All information given should apply to this employer.*
To search Blue Access℠ PPO Providers, visit www.anthem.com

1. Billing Address					
Group #		**Request. Effective Date**			**Applicant # / Dept. name**
		/ /			
Anthem use: Plan	**Health Effective Date**		**Dental Effective Date**	**COB**	**Pre-ex (date)**
	/ /		/ /	☐ Yes ☐ No	/ /
ISMA use: Agent	**Risk Class**	**Bill Cycle**		**Record #**	
		M Q S Y		**ME #**	

2. Reason for Application

☐ New enrollment
☐ Waiver
☐ Annual open enrollment
☐ New hire
☐ Rehire (date) ____/____/____
☐ Add dependent (see section 3)

Qualifying event ____________ Event date ____/____/____

3. Status Change/Event

Event date ____/____/____
☐ Marriage
☐ Birth
☐ Adoption*
☐ Legal Guardianship*
☐ Other ____________

**Include legal documentation.*

4. Type of Coverage/Plan

Health Coverage		***Dental Coverage***
☐ Employee only ☐ Employee + spouse ☐ Employee + child(ren) ☐ Family coverage ☐ No coverage	Medical Plan Name ____________	☐ Yes ☐ No

5. Employee Information

Last name	First name, M.I.	Date of birth	Age	Sex	Social security #		Height	Weight
		/ /		☐ M ☐ F	– –	☐ Single ☐ Divorced ☐ Married		

Home address	City	State	ZIP code	County (KY residents include Municipality)

Home telephone	Business telephone	eMail Address
( ) –	( ) –	

Are you:	Retired?	Disabled?	Hospitalized?	Occupation	Full time hire date	Hours working per week	Income reported by:
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No		/ /		☐ W2 ☐ 1099 ☐ Other: ________

6. Family Information ***Spouse and dependents to be covered. (Attach a separate sheet if necessary.)***

1 Last name			First name, M.I.		Relationship to applicant ☐ Spouse ☐ Daughter ☐ Son ☐ Other ________	Fulltime student? ☐ Yes ☐ No
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)						
Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)	
2 Last name			First name, M.I.		Relationship to applicant ☐ Spouse ☐ Daughter ☐ Son ☐ Other ________	Fulltime student? ☐ Yes ☐ No
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)						
Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)	
3 Last name			First name, M.I.		Relationship to applicant ☐ Spouse ☐ Daughter ☐ Son ☐ Other ________	Fulltime student? ☐ Yes ☐ No
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)						
Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)	
4 Last name			First name, M.I.		Relationship to applicant ☐ Spouse ☐ Daughter ☐ Son ☐ Other ________	Fulltime student? ☐ Yes ☐ No
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)						
Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)	
5 Last name			First name, M.I.		Relationship to applicant ☐ Spouse ☐ Daughter ☐ Son ☐ Other ________	Fulltime student? ☐ Yes ☐ No
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)						
Date of birth / /	Sex ☐ M ☐ F	Social Security # – –	Height	Weight	Eligible for federal income tax exemption? ☐ Yes ☐ No Court ordered health care coverage? ☐ Yes ☐ No (If yes, include legal documentation) Currently hospitalized or disabled? ☐ Yes ☐ No (If yes, give reason)	

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7. Other Health Coverage ***Please check one:*** ☐ *YES (complete below.)* ☐ *NO*

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Provide name, phone number and address of the HMO or insurance company		Policy/certificate number		Effective date / /
Policy/certificate holder's name	Social Security number – –	Date of birth / /	Relationship to applicant	

If you and/or your dependents are enrolled in Medicare Part A or Medicaid, complete the following.

Enrollee's name(s)	Medicare/Medicaid ID #	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
		/ /	/ /	/ /
		/ /	/ /	/ /

Reason for Medicare enrollment:
☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

8. Prior Health Coverage ***Please check one:*** ☐ *YES (complete below.)* ☐ *NO*

Have you been covered by Anthem within the past two (2) years? ☐ Yes ☐ No Policy/Certificate #:	Group name/ID #	Dates policy in effect: / / — / /
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? ☐ Yes ☐ No	List prior carrier(s)	Dates policy in effect: / / — / /

Please check the type of prior coverage
☐ Employee ☐ Employee / Spouse ☐ Employee / Child(ren) ☐ Employee / Spouse / Child(ren)

Termination reason: ☐ Divorce/legal separation ☐ Death of spouse ☐ COBRA coverage exhausted ☐ Employment terminated ☐ Group plan terminated ☐ Employer/group contribution ceased ☐ Other:

9. Medical Information

Please note that no person will be denied health coverage on an individual basis due to the answers provided below, except for Medicare Carve-Out.

(If yes, circle condition)

1. Do you or your dependents regularly take medication?............................☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future?......................☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant?..........................☐ Yes ☐ No

   If yes, name ____________ due date ___/___/___
4. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor; disorder of the blood or immune system; stroke, aneurysm, diabetes **(list age of onset below);** mental/nervous disorder, depression, alcohol or drug abuse/dependency; kidney, liver or pancreas disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; or muscular dystrophy?..☐ Yes ☐ No
5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV?..☐ Yes ☐ No
6. Have you or any of your dependents visited the emergency room on 2 or more occurrences for the same condition in the last 12 months?..........☐ Yes ☐ No
7. Have you or your dependents used tobacco products in the last 12 months?...☐ Yes ☐ No

(If yes, circle condition)

8. To the best of your knowledge, have you or any of your dependents, within the last 5 years, had a diagnosis of or treatment for the following:
   a. Ulcer, hernia, diverticulitis, irritable bowel or other intestinal disorder?.......☐ Yes ☐ No
   b. Thyroid, goiter or gallbladder disorder? ....☐ Yes ☐ No
   c. High blood pressure, cholesterol or triglycerides? ....☐ Yes ☐ No
   d. Anemia, chest pain, heart murmur or disorder of the veins/circulatory system?......☐ Yes ☐ No
   e. Rheumatic fever, carpal tunnel syndrome or disorder of the muscles or joints? ......☐ Yes ☐ No
   f. Epilepsy, convulsions, paralysis or disorder of the brain or nervous system?.... ☐ Yes ☐ No
   g. Asthma, allergies, sinus, or disorder of the respiratory system? ....☐ Yes ☐ No
   h. Any STD or disorder of the prostate, genital, reproductive or urinary system?.....☐ Yes ☐ No
   i. Any disorder of the skin, ears, or eyes?...☐ Yes ☐ No
9. Have you or any of your dependents, within the last 2 years, engaged in skydiving, hang gliding, underwater diving, racing (any type), rodeo, mountaineering, professional sports, piloting a plane or are any such activities contemplated? ....☐ Yes ☐ No
10. Are you or any of your dependents presently disabled or had a condition not identified above during the past 5 years? ....☐ Yes ☐ No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest. #	Name of individual	Diagnosis	Treatment	Medication	Date(s) of treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)	Physician's name
					/ /				
					/ /				
					/ /				
					/ /				
					/ /				
					/ /				

Please read the TERMS on the reverse side of this page. Your Signature is required on the reverse side of this to submit this application.

Significant terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
3. I am applying for the coverage selected on this application. If I select a coverage, or combination of coverages, not available to me and / or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions. (Ohio only - unless I applied for HMO/HIC coverage, in which case there is no such exclusion.)
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
6. By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or recission or cancellation of my coverage(s).

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health coverage will be provided by

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.

Thank you for choosing Anthem Blue Cross and Blue Shield

10. Read the TERMS section above carefully before signing. Please review your application for errors or omissions. By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.	
Applicant Signature	Date / /

11. PLEASE READ: If you are declining coverage for yourself, spouse, or dependents, you must complete and list all below, and sign and date application. Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All		
Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #) ☐ Other carrier (give name, ID #)	
Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All		
Name of person waiving	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other	Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #) ☐ Other carrier (give name, ID #)	
Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All		
Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #) ☐ Other carrier (give name, ID #)	
Check all that apply. Waiving: ☐ Health ☐ Dental ☐ All		
Name of person waiving		Already protected by coverage of: ☐ Spouse ☐ Parent ☐ None ☐ Other
Employer name	Carrier: ☐ Anthem (giver certificate/policy #) ☐ Other carrier (give name, ID #)	

Check all that apply

☐ I certify that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures.

If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

☐ I certify that I have been given the opportunity to apply for the available group life benefits offered by my employer/group, the benefits have been explained to me, and I and / or my dependent(s) decline to participate. Neither my dependent(s) nor I were induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Applicant signature	Date / /