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 Medicare Carve-out plan for ISMA members and their spouses with Medicare as their primary carrier.

This packet includes:

- Medicare Carve-out Summary
- Medicare Carve-out Brochure
- Anthem Enrollment Application

To apply for a Medicare Carve-out policy, 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. We will then email you to inform you whether Anthem approved the application.

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 the ISMA-sponsored Anthem Medicare Carve-out.

ISMA
INDIANA
STATE
MEDICAL
ASSOCIATION

2018 ISMA/Anthem Medicare Carve-out

Highlights

If you are already insured with the ISMA when you turn 65, and choose the ISMA/Anthem Medicare Carve-out, your covered spouse and/or child(ren) can continue coverage through the ISMA. (If you purchase a Medicare Supplement outside the ISMA plan, your dependents will not be eligible to continue coverage through the ISMA.)

If you are already insured with the ISMA when you turn 65, no paperwork is required to change to the Medicare Carve-out; the change will be automatic.

The ISMA/Anthem Medicare Carve-out offers a solid package of benefits including:

- Medicare Part A Deductible ($1,340/year in 2018) covered in full
- Medicare Part A Coinsurance or Copayment (for extended hospitalizations) covered in full
- After Medicare Part B Deductible of $183 is paid, coverage is 100% for the remainder of the calendar year
- Blood (first 3 pints) covered in full in hospital
- Foreign Travel fully eligible for coverage (other plans cover 80% during first 60 days of each trip after $250 deductible)
- Hospice Care Coinsurance or Copayment covered in full
- Skilled Nursing Facility Coinsurance covered in full

Questions?

Please see the **Frequently Asked Questions** document or call the ISMA Insurance Team at (317) 261-2060 and say you're calling with questions about the ISMA-sponsored Anthem Medicare Carve-out.

Insurance ISMA Agency

Medicare Carve-out

January - December 2018

ISMA
INDIANA
STATE
MEDICAL
ASSOCIATION

ISMA Insurance Agency
(317) 261-2060
(800) 257-4762
www.ismanet.org

When you attain age 65

When you attain age 65, you will become eligible for Medicare Part A (Hospital), Medicare Part B (Medical) and Medicare Part D (Prescription Drugs).

If you work for an employer with 20 or more employees that pays some part of your health insurance premiums, the employer-provided health insurance will continue to be primary, and Medicare will be secondary. You can wait to start Medicare Parts A and Part B until you retire, at which point Medicare will become primary.

If you do not work for an employer with 20 or more employees that pays some part of your health insurance premiums, Medicare will be primary and your Anthem health insurance policy will be changed to a Medicare Carve-out, which is a supplement to Medicare.

If Medicare will be your primary insurer, you should call the Social Security Administration at 1-800-772-1213 to apply for Medicare Parts A and B about 3 months before you attain age 65. Or, you can apply for Medicare online at **www.medicare.gov**. Your Medicare coverage will start on the first day of the month in which you attain age 65 unless your birth date falls on the first day of a month, in which case it will start on the first day of the month prior. (For example, if you attain age 65 on July 20, your Medicare coverage will start on July 1. If you attain age 65 on July 1, your Medicare coverage will start on June 1.)

You will also need to purchase a Medicare Part D Prescription Drug Plan, or you may pay a penalty if you enroll after age 65. To determine which plans will provide you with the lowest overall cost, go to **www.medicare.gov** and follow the prompts to find a Part D Drug Plan that covers all or most of your specific medications.

If you have a spouse and/or children who are currently covered under your policy, they will be moved to a separate policy when you are moved to a Medicare Carve-out. Anthem will send them a new ID card with their own unique ID number. They will need to alert their health care providers and pharmacy to this new number to ensure proper claims administration.

ISMA Medicare Carve-out

For covered persons who are eligible for Medicare, ISMA offers a Medicare Carve-out policy. The term "carve-out" is used because under this adaptation of a complete major medical insurance policy, Anthem calculates the benefits the plan would pay based on their allowable amounts as if it were the subscriber's only insurance, subtracts (or carves out) whatever Medicare pays, and then pays the difference.

Quality coverage at a reasonable price

After reviewing the details, we think you'll agree that the ISMA Medicare Carve-out will provide you with the quality coverage you need at a reasonable price.

The plan works like this: Charges for services covered as Basic benefits are paid in full with no deductible. You pay nothing. (Note: If Medicare's allowable is greater than Anthem's allowable, you may be responsible for this difference.) For services covered as Major Medical benefits, you pay an annual deductible equal to the Medicare Part B deductible. After that, coverage is 100% for the remainder of the calendar year.

A valuable benefit for

- Physicians who are members of the Indiana State Medical Association and their spouses.
- Employees of insured ISMA members who work at least 20 hours per week (on an ongoing basis) in a medical office or medically related facility, and their spouses.
- Surviving spouses of deceased ISMA members, assuming member was covered immediately prior to death.

You should know

Although each person's situation is different, it is generally not advisable to purchase more than one supplement to Medicare. Benefits are not cumulative and are not often paid from more than one policy. You may wish to consult an insurance professional or other trusted advisor on this matter.

Underwriting requirements

If you are already insured with Anthem through the ISMA when you become eligible for Medicare as your primary carrier, you will automatically be changed to the Medicare Carve-out plan. If you are not already insured with Anthem through the ISMA, coverage is subject to underwriting approval and is not guaranteed.

Effective date

Coverage begins effective the first day of the month following approval. After approved, you will be mailed a wallet identification card.

About Medicare Part D Prescription Drug Plans

The ISMA Medicare Carve-out does not provide benefits for prescription drugs. You may purchase a separate Medicare Part D Prescription Drug Plan from a number of insurers through the state of your primary residence.

The State Health Insurance Assistance Program (SHIP) provides free, unbiased health insurance information for people with Medicare. SHIP is part of a federal network of State Health Insurance Assistance Programs located in every state. SHIP counselors can help as you consider Medicare Part D Prescription Drug Plan options. In Indiana, SHIP is sponsored by the Centers of Medicare and Medicaid Services (the federal agency that administers Medicare) and the Indiana Department of Insurance. You can call SHIP at 1-800-452-4800 and ask to speak or meet with a SHIP counselor in your area. Their TDD line for the hearing impaired is 866-846-0139.

SERVICES	MEDICARE PAYS	ISMA MEDICARE CARVE-OUT PAYS	YOU PAY
HOSPITALIZATION Semi-private room and board, general nursing services and supplies such as intensive care units, diagnostic x-rays, MRIs, lab tests, operating and recovery room, anesthesia and rehabilitation.			
First 60 days:	All but Medicare Part A deductible.	The amount of the Medicare Part A deductible.†	Nothing.†
61st through 90th day:	All but Part A coinsurance for 61st through 90th day.	The amount of the Part A coinsurance for 61st through 90th day.†	Nothing.†
91st through 150th day: (Lifetime Reserve Days)	All but Part A coinsurance for 91st through 150th day.	The amount of the Part A coinsurance for 91st through 150th day.†	Nothing.†
Once 60 Lifetime Reserve Days are Used:	Nothing.	100% of all eligible expenses.	Nothing.†
SKILLED NURSING FACILITY Starting within 30 days after at least 3 consecutive days in the hospital. * A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.			
First 20 days:	100% of Medicare's allowed amount.	No benefit needed.	Nothing.†
21st through 100th day:	All but SNF coinsurance.	The amount of the Medicare SNF coinsurance.†	Nothing.†
After 100 days:	Nothing.	Nothing.	All costs.
BLOOD, In-hospital			
After first three pints	100% of Medicare's allowed amount.	Eligible amount for first three pints.	Nothing.†
MEDICAL SERVICES Covers physicians' services in the hospital or office, hospital out-patient services, medical equipment, physical and speech therapies, etc.			
After Medicare Part B deductible.	80% of Medicare's allowed amount.	Inpatient: One physician's visit and one consultation per day paid at 100%.† Outpatient services: Unlimited amount under Major Medical Benefits*.	Nothing.† Amount of Medicare Part B deductible, then nothing.†
BLOOD, Outpatient			
After first three pints	80% of Medicare's allowed amount.	Unlimited amount under Major Medical Benefits*.†	Amount of Medicare Part B deductible, then nothing.†
BENEFITS ABROAD			
	Nothing.	Same as if in the United States.	Same as if in the United States.
OUTPATIENT PRESCRIPTION DRUGS			
	Nothing.	Nothing.	All costs. For info on a Medicare Part D Prescription Drug Plan go to **www.medicare.gov**.

*See section entitled **Major Medical benefits** on page 5 for further details.
†If Medicare's allowable is greater than Anthem's allowable, you may also be responsible for this difference.
Source for Medicare costs: **www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-glance.html**

General information

The ISMA Medicare Carve-out divides benefits into two categories:

1 Basic benefits

Basic benefits are paid in full with no deductible. (Note: If Medicare's allowable is greater than Anthem's allowable, you may be responsible for this difference.)

2 Major Medical benefits

Major Medical benefits are subject to the calendar year deductible. For all major medical benefits *combined*, you pay a deductible equal to the Medicare Part B deductible ($183 in 2017). After that, coverage is 100% for the remainder of the calendar year.

Exclusions

Services not covered under the Medical Plans include:

- Services or supplies which are not medically necessary.
- Routine physical examinations, routine tests such as those given during physicals, and vaccinations.
- Dental care not caused by an accident unless you are covered under the Dental Plan.
- Cosmetic surgery.
- Eyeglasses or hearing aids.
- Services covered by Worker's Compensation.

A complete list of exclusions are printed in the benefit booklet.

Limitations

Unless otherwise noted, covered charges are eligible up to the Usual, Customary, and Reasonable Allowance which is measured and determined by comparing actual provider charges with the charges customarily made for similar services and supplies to individuals with similar medical conditions.

Basic benefits

Basic benefits are paid in full with no deductible.

- **Inpatient Hospital Care**: Unlimited number of days of semi-private room or ward accommodations and other necessary services not included in the room charges.
- **In-hospital Medical Care**: Visits by your doctors during confinement.
- **Diagnostic X-rays and Lab Tests**: Not included are routine tests such as those given during physicals.
- **Surgery**.
- **Anesthesia**.
- **Consultation**: Bedside consultations.
- **Radiation Therapy**: Treatment of abnormal growths by radiation (inpatient or outpatient basis).
- **Mental and Nervous Illness and Substance Abuse**: Up to 42 days hospital confinement per calendar year. Up to 92 professional visits per calendar year (42 in-hospital and 50 outpatient) covered as Major Medical benefit.

Major Medical benefits

Major Medical benefits are subject to the calendar year deductible. For all major medical benefits *combined*, you pay a deductible equal to the Medicare Part B deductible ($183 in 2017). After that, coverage is 100% for the remainder of the calendar year.

- **Skilled Nursing Facility**: Provides benefits for 21st to 100th day of skilled nursing facility care, per benefit period. A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.
- **Doctor Visits**: Routine checkups excluded.
- **Wellness Benefits**: Benefits provided each calendar year for one screening mammogram for women, one PSA test for men, and one colorectal exam for both sexes.
- **Ambulance**.
- **Approved Home Health Care Services**: Medically necessary skilled care services and medical supplies. Up to 100 visits per calendar year; includes private duty nursing. $10,000 annual and $50,000 lifetime maximum benefits.

- **Physical/Occupational Therapy** - Covers 60 visits per calendar year
- **Speech Therapy** - Covers 60 visits per calendar year.
- **Spinal Manipulation** - Covers 12 visits per calendar year.
- **Use of Durable Medical Equipment** at home, such as hospital beds and wheelchairs.
- **Artificial Limbs, Eyes, etc.**
- **Crutches and Braces**: Corrective shoes not included.
- **Hospice Care**: Approved program for terminally ill.
- **Foreign Travel**: Same benefits paid in or outside the U.S. Please have all bills translated into English.
- **Human Organ or Tissue Transplant Rider**: Covers these human to human organ and tissue transplants: bone marrow; heart; heart/lung; lung; liver; pancreas; and kidney/pancreas.
- **Benefit Management Program**: To help contain healthcare costs, pre-notification is required for all hospital admissions (no penalty for non-compliance). In catastrophic and chronic high cost cases, alternative means of care may be offered, subject to approval of the insured and the attending physician. Examples include skilled nursing facility, home health care, hospice care, or special medical equipment such as ventilators and respirators.

Foreign travel

The ISMA Medicare Carve-out covers you when you travel outside of the United States, providing the same Basic and Major Medical benefits as in the United States. *There is no specific lifetime maximum benefit for foreign travel, which sets this plan apart from other Medicare Supplement policies.*

Optional Dental Plan

You may include Dental Plan coverage for the additional monthly rate shown in the rate chart. The Dental Plan is available only in addition to medical coverage.

Deductible

$50 per person per calendar year.
Applies to all benefits except diagnostic, preventive, and orthodontia.

Diagnostic and Preventive

- No deductible; covered in full if service provided by Anthem Dental PPO provider, otherwise 80% benefit.
- Covered services include Oral evaluations, X-rays, cleanings, space maintainers and other selected diagnostic and preventive services.

General (Adjunctive), Restorative, Endodontic, Oral Surgery, Periodontal

- Subject to annual $50 deductible; 80% benefit.
- Covered services include 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.

Prosthodontic

- Covered after 12-month waiting period. Subject to annual $50 deductible; 50% benefit.
- Covered services include crowns/onlays, partial and full dentures and other selected prosthodontic services.

Orthodontic

- Covered after 12-month waiting period. No deductible; 50% benefit; $1,000 per person lifetime maximum benefit.
- Covered services include non-surgical dental services related to the supervision, guidance and correction of growing or mature teeth, examination, records, tooth guidance and repositioning (straightening) of the teeth. Orthodontia benefits cease at end of Benefit Period in which Member reaches age 19.

Annual maximum benefit

There is a maximum dental benefit of $1,500 per person per calendar year.

Indiana Anthem Dental network

If you purchase the Anthem Dental Plan and your dentist is in the Indiana Anthem Dental network, you will not be responsible for amounts billed over the Usual and Customary Allowance. And your preventive and diagnostic services will not be subject to the deductible. To determine whether your dentist is in the Indiana Anthem Dental network, visit anthem.com and search for Indiana Anthem Dental network providers.

Exclusions for the Dental Plan

- Charges which the insured is not legally obligated to pay, such as services from a dental or medical department maintained by an employer, charges for U.S. Government Hospital confinement and services, and charges payable as Worker's Compensation claims.
- Charges for any portion of a dental procedure performed before the effective date or after the termination of the individual's insurance.
- Charges for facings on crowns, or pontics, posterior to the second bicuspid.
- Charges for replacement of lost or stolen appliances, dentures, or bridgework.
- Charges for appointments which are not kept.
- Be sure to check your dental plan booklet for a complete list of dental charges not covered.

Anthem Blue Cross Blue Shield† provides the medical and dental insurance plans for members of the Indiana State Medical Association and their employees. Anthem Blue Cross Blue Shield provides a special Claims Paying Unit for processing ISMA claims, with access through toll-free phone lines.

†Anthem Blue Cross Blue Shield is a member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

For information on a new or existing policy, call:

(317) 261-2060
(800) 257-4762

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 January 1, 2018 - December 31, 2018.

Anthem Enrollment Application

Anthem

Individual

Your Anthem enrollment application is inside.

It is essential that you read it carefully and

complete all the necessary sections.

Indiana State Medical Association

www.ismanet.org

If you are a new enrollee:

a) applying for health and / or dental coverage
please complete sections 1, 2, and 4 through 10.

b) waiving medical coverage for any eligible dependent(s)
not enrolling, please complete section 11.

If you are adding a dependent(s),
complete section 3 in addition to the above.

It is important that you read and understand the Significant Terms, Conditions and Authorizations on the last page.

Your signature is required on the last page.

Note: *You may be required to supply additional information.*

Thanks for choosing Anthem Blue Cross and Blue Shield.

www.anthem.com

AIN-69I\ISMA (11/08)

Enrollment Application

Individual

Anthem

Indiana State Medical Association

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

Qualifying event _____ Event date ___/___/___

3. Status Change/Event
Event date ___/___/___ ☐ Adoption* ☐ Legal Guardianship* ☐ Marriage ☐ Birth ☐ Other _____
**Include legal documentation.*

4. Type of Coverage/Plan

Health Coverage
☐ Employee only
☐ Employee + spouse
☐ Employee + child(ren)
☐ Family coverage
☐ No coverage
Medical Plan Name _____

Dental Coverage
☐ 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 ☐ Spouse ☐ Son ☐ Daughter ☐ 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	Social Security #	Height	Weight	
/ /	☐ M ☐ F	– –			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 ☐ Spouse ☐ Son ☐ Daughter ☐ 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	Social Security #	Height	Weight	
/ /	☐ M ☐ F	– –			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 ☐ Spouse ☐ Son ☐ Daughter ☐ 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	Social Security #	Height	Weight	
/ /	☐ M ☐ F	– –			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 ☐ Spouse ☐ Son ☐ Daughter ☐ 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	Social Security #	Height	Weight	
/ /	☐ M ☐ F	– –			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 ☐ Spouse ☐ Son ☐ Daughter ☐ 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	Social Security #	Height	Weight	
/ /	☐ M ☐ F	– –			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)

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 / /