Anthem

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Anthem Individual Enrollment/Change Application

For Office Use Only
Effective Date ___/___/___
Firm Division No.

P.O. Box 1014, North Haven, CT 06473
www.anthem.com

New Enrollment: 1-800-441-6634
Current Members: 1-800-843-6096

Remember to Complete All Sections of this Application

Please check appropriate item: ☐ New Enrollment ☐ Terminate Enrollment ☐ Add Dependent ☐ Remove Dependent
☐ Change Physician ☐ Other (Name change, address change, etc. Indicate reason for change.)

1. Applicant Information

NAME (LAST/FIRST/MIDDLE INITIAL)			HOME ADDRESS (NUMBER AND STREET)
[ ] Male [ ] Female	DATE OF BIRTH MO. DAY YR.	SOCIAL SECURITY NUMBER — —	CITY/STATE/ZIP CODE
MARITAL STATUS	[ ] Single [ ] Widowed [ ] Legally Separated [ ] Married [ ] Divorced [ ] Separated [ ] Domestic Partnership (Include "Statement of Domestic Partnership")		BILLING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)
TELEPHONE NUMBERS HOME:	WORK:		CITY/STATE/ZIP CODE

2. Membership Choice

CHOOSE ONE MEMBERSHIP TYPE:

☐ INDIVIDUAL

☐ TWO PERSON

☐ FAMILY

3. Plan Choice (Select BlueCare Plus Direct (HMO) OR Century Preferred Direct (PPO))

☐ BlueCare Plus Direct (HMO)
(Select ONE Deductible AND ONE Drug Maximum)

Select One: ☐ $1500 Deductible ☐ $3000 Deductible

Select One: ☐ $500 Drug Maximum ☐ $2000 Drug Maximum

OR

☐ Century Preferred Direct (PPO)
(Select ONE Deductible: Prescription Drug Coverage is optional)

Select One: ☐ $250 Deductible ☐ $500 Deductible ☐ $1500 Deductible ☐ $5000 Deductible

Optional Prescription Drug Coverage: ($2,000 Drug Maximum) YES ☐ NO ☐

Required for HMO Plan Only. Name of Primary Care Physician (PCP) (Refer to www.anthem.com)
First Last City
Name

PCP Provider No. | | | | | | | | | | |

Existing Patient ☐ Yes ☐ No

4. Dependent Information

NAME (LAST/FIRST/MIDDLE INITIAL)	Add	Delete	Social Security Number	Sex	Date of Birth (mm/dd/yy)	(HMO Only) Primary Care Physician	(HMO Only) PCP ID Number (10 digits)	Existing Patient	BELOW PLEASE INDICATE NAME OF RECOGNIZED INSTITUTION FOR FULL TIME STUDENTS
Spouse			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /		_ _ _ _ _ _ _ _ _ _	☐ Yes ☐ No	
Dependent 1			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /		_ _ _ _ _ _ _ _ _ _	☐ Yes ☐ No	
Dependent 2			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /		_ _ _ _ _ _ _ _ _ _	☐ Yes ☐ No	
Dependent 3			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /		_ _ _ _ _ _ _ _ _ _	☐ Yes ☐ No	
Dependent 4			_ _ _ _ _ _ _ _ _	☐ M ☐ F	/ /		_ _ _ _ _ _ _ _ _ _	☐ Yes ☐ No	

5. Tell Us About Your Other Insurance

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

Name of Other Insurance Company	Type of Coverage ☐ Group ☐ Individual	Last Date of Coverage

(2) If the answer to question (1) is yes, do you intend to replace your current medical or health policy with this policy? ☐ YES ☐ NO

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

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

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

6. Applicant's Signature

Date ___/___/___

INTERNET