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INTRODUCTION

The Individual Business Unit at Anthem Blue Cross and Blue Shield caters exclusively to the direct-pay consumer and offers a diverse package of individual health coverage products. This guide is intended to help the writing agent when soliciting and writing applications for coverage. It is important to remember that these are only guidelines, and should not be interpreted as a guarantee of underwriting action on any specific case.

Medical Underwriting is the process of assessing risk or morbidity of an applicant for health coverage. Various sources are used for assessing this risk, however, the most important source is the application. The agent and applicant should be aware that the final decision regarding insurability, rating and effective date assignment will always be determined by the underwriter.

The information contained in this manual is intended for internal use only and may not be copied or distributed in any manner. The benefit descriptions are intended to be a brief overview of some benefits available to Anthem members.

ANTHEM BLUE CROSS AND BLUE SHIELD

Anthem Overview

Anthem Inc. and WellPoint Health Networks Inc completed its merger on November 30, 2004.

WellPoint, Inc. serves approximately 28 million members through its Blue Cross and Blue Shield operations in 13 states and its non-Blue branded operations in other states. The company has over 38,000 associates nationwide.

About WellPoint, Inc.

WellPoint, Inc, is the largest publicly traded commercial health benefits company in terms of membership in the United States. WellPoint, Inc. is an independent licensee of the Blue Cross and Blue Shield Association and serves its members as the Blue Cross licensee for California; the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri (excluding 30 counties in the Kansas City area), Nevada, New Hampshire, Ohio, Virginia (excluding the Northern Virginia suburbs of Washington, D. C.) Wisconsin and through HealthLink and UniCare. Additional information about WellPoint is available at www.wellpoint.com.

Mission and Philosophy

Our mission is to improve the health of the people we serve. At Anthem, we believe the best health care coverage can actually help people stay healthy. That's why we go beyond simply providing coverage. We help encourage members' wellness by:

- Offering large networks and some of the region's best physicians, specialists and hospitals.
- Reminding members to have important preventive screenings.
- Providing coverage for preventive care.
- Providing programs to help manage chronic health conditions.

We work with physicians, hospitals and other providers to help ensure that care is accessible, coordinated, timely and provided in a manner and setting that promotes positive patient-provider relationships.¹

¹ Blue Cross and Blue Shield Association, *Brand Talk*

Under 65 Health Insurance Products

Blue Accesssm

Anthem offers Blue Accesssm, a PPO product with three health care coverage plans. All plans have a lifetime maximum of \$5,000,000 and each plan has network and non-network benefits. An Optional Maternity Rider is available in Ohio and Indiana. An Extended Mental Health Rider is available in Kentucky.

- Plan 1 deductibles of \$500, \$1000, \$2500 and \$5000 with \$15 generic only prescription coverage.
- Plan 2 deductibles of \$250, \$500, \$1000, and \$2500 with \$25 office copays and \$15/\$30/\$45 prescription copays.
- Plan 3 deductibles of \$2500, \$5000 and \$10,000 with \$15/\$30/\$45 prescription copay.

Blue Accesssm Economy

Blue Accesssm Economy is a lower priced PPO product designed for the uninsured.

- Deductibles of \$500, \$1,000 and \$1,500.
- 30% coinsurance after deductible on covered services.
- \$15 copay on generic drugs only, \$500 maximum per member per year.
- \$30 copay for the first 3 office visits, then deductible and coinsurance for 4+ office visits.

Blue Accesssm Saver

Blue Accesssm Saver is a High Deductible Health (HDHP) plan for a Health Savings Account (HSA). HSAs are tax-favored IRA type accounts that “eligible individuals” who are covered by a HDHP can establish. The money in a HSA can be withdrawn to cover qualified medical expenses tax-free. Individuals must contact a HSA trustee in order to set up their HSA account.

- Plan 1 - \$2,400 single or \$4,800 family deductible with 20% coinsurance.
- Plan 2 - \$2,400 single or \$4,800 family deductible with 30% coinsurance.
- Plan 3 - \$1,200 or \$2,500 single or \$2,400 or \$5,000 family deductible with 20% coinsurance.
- Plan 4 - \$4,000 or \$5,000 single or \$8,000 or \$10,000 family deductible with 0% coinsurance.

NOTE: Either one member or all members must satisfy the family deductible collectively before any covered services will be paid by the plan.

Blue Traditional[®] (IN and OH only)

Blue Traditional[®] is an affordable health care plan that offers unrestricted access to doctors and hospitals. There are three plans to choose from, all of which have a lifetime maximum of \$5,000,000.

- Plan 1 deductibles of \$500, \$1000, \$2500 and \$5000 with \$15 generic only prescription coverage.
- Plan 2 deductibles of \$250, \$500, \$1000, and \$2500 with \$15/\$30/\$45 prescription copays.
- Plan 3 deductibles of \$2500 and \$5000 with \$15/\$30/\$45 prescription copays.

Blue Accesssm TAA

Blue Accesssm TAA is specifically designed for individuals who are eligible for Trade Adjustment Assistance (TAA) benefits, including individuals over 55 years of age who are receiving Pension Benefit Guaranty Corporation (PBGC) payments.

The plan has deductibles of \$500, \$1000, \$2,500 and \$5,000 with a \$15 generic-only prescription coverage, coinsurance at 80/20 and a lifetime maximum of \$1,000,000.

Standard Benefit Plan (KY only)

Anthem offers the Standard Plan that includes an unlimited lifetime maximum benefit. The Standard Plan has a \$400/\$800 deductible, 80/20 co-insurance, \$1500/\$3000 out of pocket maximum and prescription drug coverage (subject to deductible and co-insurance). In-network physicians require a co-payment of \$10 per office visit. Inpatient services are not subject to the deductible and have a separate co-insurance of 85/15. There are two separate riders that can be purchased: a \$15 Prescription Drug Rider and a Mental Health Rider (this includes benefits if a member chooses to go out of network).

Short-Term Coverage

This product provides a choice of four deductibles and 80/20 co-insurance. Coverage is not renewable. However, a person can purchase a new contract a second time if he or she is able to answer "NO" to the current medical questions on the application. He or she must complete a new application and send it in for approval with the appropriate premium. (At least six (6) months must lapse after the end of the second contract term before he or she can purchase another short-term plan. Any condition that occurred during an earlier contract term will be treated as a pre-existing condition under subsequent contracts.) Policy can be cancelled with a 30-day prior written notice.

UNDER 65 GUIDELINES

Adding Benefits (Upgrades)

Benefits can be added at anytime, but this can only be done once within 12 months and once more at renewal. Adding benefits/upgrades must be done on an application to Underwriting. The effective date will be assigned by underwriting for a future date. We will not backdate benefit changes, unless at renewal.

Agent Tips - Customers may qualify for a better rate tier if they were:

1. Previously issued as a tobacco user and are now 12 months tobacco free.
2. Previously issued higher tier due to build, but have maintained a weight loss for 12 months.
3. Previously issued higher rate due to history of a medical condition that no longer warrants a rating due to timeframe.

As always, a new application must be filled out and will be subject to complete Medical Underwriting.

Adding Dependent

Newborn or Adoption

Coverage is automatically provided for the first 31 days for newborns and newly adopted children of the policyholder or spouse. In order to continue coverage past the 31st day, the policyholder must notify Anthem to add such dependent either by contacting Customer Service or submitting the request in writing. In the case of newly adopted children, a copy of the document awarding applicant or spouse court-appointed custody and an affidavit for special dependents must be completed and accompany the application. If notification is not received within 31 days, coverage will not be extended beyond the 31st day. To obtain coverage after the 31st day, a new application must be submitted and full underwriting will be required. In this case, coverage will not begin until Underwriting approves the application.

Moving a newborn to a 'sibling only' policy requires submitting an application to Underwriting and the first 31 days are not free. They will get the next available effective date from when the application is received.

Any current subscriber wanting to add a "newly acquired" dependent due to marriage, birth or adoption may do so within 31 days of the qualifying event (date of marriage, date of birth, date of adoption or date placed for adoption.) For dependents added as the result of marriage, Anthem must receive the required form or application within 31 days of the qualifying event to be effective as of the date of the qualifying event. The dependent will be subject to full underwriting. Dependent additions may require the policy to be re-underwritten.

Guardianship

If the legal guardian of a child is someone other than the natural parent of that child, proof of the guardianship will be required, and must be submitted with the application. If provided within the first 31 days of guardianship placement, it is guarantee issue, and not subject to underwriting. Full medical underwriting will be required if applied for after 31 days.

Any current member wanting to add a dependent, other than a newborn or adopted child must submit a new application. The dependent is subject to full medical underwriting and the effective date will be assigned according to the regulations set forth under the Effective Date Assignment section of this guide.

Adding Dependent Continued

Guardianship - continued

To add a newly eligible dependent due to a qualifying event, Anthem must be notified within 31 days of the event. The new dependent will be covered as of the date of the event if the application is received by Anthem within 31 days of the event. If the application is received more than 31 days after the qualifying event, the effective date will be assigned according to the regulations set forth under the Effective Date Assignment section of this guide.

Address and Billing Changes

The policyholder may make address and billing changes verbally by contacting Customer Service, by submitting a written request or by using Member Self Serve. If the Automatic Bank Draft billing method is desired, the bank authorization form must be completed and a voided check (deposit slips are **NOT** accepted for checking accounts) submitted. Automatic deductions will begin on the next billing period after the approval date.

Age Determination

The applicant's age, upon the effective date of coverage, will determine the correct age rate. If the effective date is changed, the rate could also change.

Attending Physician's Statement (APS)

Medical records and an APS may be requested by Underwriting to supplement the information on the application. An APS may be requested if the application indicates a condition that requires more detailed information or if medical conditions are not fully explained on the application and/or questionnaires. An APS may also be requested based on claims information in our files. A **mandatory APS** will be requested if an applicant is over age 55 and **is not** replacing prior coverage. Underwriting will notify the applicant/agent if medical records are needed and it is his/her responsibility to have these records sent to Anthem. **Remember, properly completed Medical Questionnaires may often eliminate the need for medical records.** Applicant is responsible for the cost of medical records.

Cancellation

All new policies may be cancelled by the applicant, back to the effective date of coverage, if written notification is received within 31 days of the date the application is processed by Anthem. If the contract is returned and no claims have been submitted, Anthem will refund all premiums to the applicant.

A policy can be automatically cancelled when the policyholder transfers to another Anthem Individual plan. The cancellation date will be midnight the day prior to the effective date on the new coverage.

All other cancellation requests must be received in writing from the policyholder 30 days in advance of the cancellation date. If proper notification is not given, the member will be asked to pay the final month's bill or have the policy lapse for nonpayment if payment is not made.

Note: Policy is not automatically cancelled when transferring to or from an Anthem Group plan. Requests must be received in writing.

Certificate or Policy Delivery

The certificate of coverage or policy will be mailed directly to the customer at the address listed on the application.

Child Only Policy

Coverage may be written for a child(ren) only. The parent and/or guardian must sign the application and is considered to have contracted with Anthem Blue Cross and Blue Shield to provide insurance to the covered child(ren). Applications may be submitted for a child(ren) only if the child(ren) are under age 18. Once a child reaches age 18 they will be removed from the policy. Newborns cannot be written on Child Only Policy until they have been released from the hospital. The effective date will be the 1st or 15th of the month based upon the application receipt date.

Completion of the Application

The underwriting process can often be completed with a simple review of the application. The most important source of information is the application and medical questionnaires. Each question on the application must be *specifically* asked of the applicant with the response accurately and completely recorded on the application. All applications must be completed in **ink** with the writing agent verifying that the applicant answered the questions and signed and dated the application. The applicant must initial any erasure or corrections. All "YES" answers to medical questions **must be fully explained** along with the name, address and telephone number of all doctors consulted by the applicant.

Conditional Coverage

Coverage does not become effective until Underwriting approves the application. Therefore, an applicant's current coverage should not be cancelled until they receive an approval from Anthem Blue Cross and Blue Shield's Underwriting Department.

Counter Offers

Anthem Blue Cross and Blue Shield may decline one family member, but offer coverage to others. Or, the applicant may be extended a counter-offer for coverage that may include a different rate or higher deductible level. Counter-offers for higher rate bands only, will offer alternatives for higher deductibles, along with the premiums for those deductibles. Any counter-offer will be forwarded to the applicant for their approval and signature. The applicant must sign and return the counter-offer to the Underwriting Department within 15 business days of the date of the counter-offer letter. If a member wants to downgrade or request a future effective date they can indicate this on the counter-offer letter.

Effective July 1, 2005, counter-offer letters will not be done for rate-ups within the same tier band (preferred, standard, modified) or rate-ups for build (height and weight) alone. Example, if applicant applies for Standard 1 and the underwriting decision is Standard 3, a counter-offer will not be done. Instead, an Issue Letter will be sent to the applicant to inform them of the new premium. The Issue Letter will not have to be signed and returned and the application will not be pended.

Death of a Certificate Holder

Written or telephone notification to Anthem Blue Cross and Blue Shield is required after the death of a policyholder. Termination of the certificate or policy will be effective the day after the policyholder's death; this is to ensure eligible benefits are paid on the day of death and any unused premiums will be refunded. If Anthem Blue Cross and Blue Shield is notified of the death of the certificate or policy holder after 91 days, a copy of the death certificate will be required for a refund of any un-used premiums.

Declination

If a health condition(s) or other underwriting criteria makes it impossible for coverage to be offered on any basis, the application is declined and a refund of the initial premium will be made. The applicant will receive a letter from Anthem Blue Cross and Blue Shield advising them of the reason for declination.

Deleting Benefits (Downgrades)

Any deletion of benefits is considered a 'downgrade in benefits.' Downgrades, increasing a deductible or deleting a rider, can only be done once within 12 months and once more at renewal. The certificate/policy holder can make changes by completing an Application Supplement Form or submit in writing. The change will be effective the next available effective date (1st or 15th) after notification is received by Anthem Blue Cross and Blue Shield or a requested future effective date. Please note, downgrades may be declined.

Dependent Coverage

Unmarried children who are related to the policyholder or the policyholder's spouse are eligible dependents. Eligible dependents are covered to the end of the calendar month in which they turn age 19 or age 25 if a full-time student and/or eligible as a federal tax exemption.

Short-Term

Unmarried children who are related to the policyholder or the policyholder's spouse are eligible dependents. Eligible dependents are covered until they turn age 19 or age 25 if a full-time student and/or eligible as a federal tax exemption but not beyond the end of the contract term.

Dependents Who Reach Age Limitation

A covered dependent child who loses eligibility upon attaining the maximum age may apply for his/her own coverage. A new application must be completed by the coverage dependent and received within 31 days of losing eligibility. If the application is received within the 31-day period, acceptance to the SAME plan, or similar plan if original plan is no longer offered, with no lapse in coverage, is guaranteed. Pre-existing credit and credit for any deductible amount met under the original plan will be applied to the new plan.

If the application is received after the 31-day period, it will be subject to medical underwriting approval. Coverage will begin according to the regulations set forth under the effective date assignment of this guide.

Divorce

When a covered person and/or dependent loses coverage due to divorce, he or she may apply for his or her own coverage. A new application must be completed and received within 31 days of losing eligibility. If the application is received within the 31-day period, acceptance to the SAME plan, or similar plan if the same plan is no longer offered, with no lapse in coverage, is guaranteed. Pre-existing credit and credit for any deductible amount met under the original plan will be applied to the new plan.

If the application is received after the 31-day period, it will be subject to medical underwriting approval. Coverage will begin according to the regulations set forth under the effective date assignment of this guide.

Effective Date Assignment

Applications will be assigned an effective date of either the 1st or the 15th of the month. Exceptions for other dates can be made for continuous coverage only. Continuous coverage is defined as no break in coverage.

If the application is received by Anthem within 10 days of the signature date and the signature date was on or prior to the requested effective date, coverage will begin on the date requested. This applies as long as the requested effective date is not more than 90 days after the application signature date.

NOTE: In cases where an application is closed due to not receiving requested information, the original requested effective date will not be held. A new effective day will be assigned. The new effective date will be the next available effective date (1st or 15th) after the information is received.

Short-Term

Coverage will begin no earlier than the received date of your submitted application, or no later than the future date you have requested.

Applicants are encouraged to choose an effective date of coverage. The requested effective date will be granted by Underwriting if:

- The application is received prior to the requested effective date.
- The requested effective date is not more than 90 days after the application signature date.

Eligibility

Applicants who meet the following criteria are eligible to apply:

- Cannot be eligible for Medicare.
- Must be between the ages of “newborn” and age 64. Persons over age 65 **who are not** eligible for Part A of Medicare may be considered under a Direct Pay policy and are subject to full medical underwriting. A reason for not being eligible for Medicare must be provided with the application.
- Must be a resident of the state for which they are applying.
- Persons who are not currently pregnant or an expectant parent.
- Must be a legal U.S. resident

If an existing subscriber moves out of state, he or she may lose eligibility and their coverage may be terminated.

Full-Time Students

Coverage for full-time students within the age limit continues as long as they are enrolled in an accredited educational facility and are classified as full-time students by the school and/or allowed as a federal tax exemption. Coverage ends when they no longer meet the eligibility guidelines as a dependent. However, they may be eligible for guaranteed acceptance for the same coverage, or similar coverage if the same coverage is no longer offered, or lesser benefits provided Anthem Blue Cross and Blue Shield is notified within 31 days of the loss of eligibility. Pre-existing credit met under the original plan will be applied to the new plan. Refer to the contract for specific eligibility information.

List Bill

Criteria for List Billing

- List billing is intended for employer/employee convenience. It is not intended for use by families. List bill groups must consist of a minimum of 2 members in order to be set up and maintained.

Applying for Coverage

- The "Request for List Billing Arrangement" form must be completed by noting all employees to be enrolled in the List Bill account.
- Each employee must then complete an individual application for coverage and sign the Permission to Provide List Bill Arrangement form. A copy of the authorization form must be attached to each application. It is the writing agent's responsibility to ensure each submitted application is completed and a copy of the "Request for List Billing Arrangement" form accompanies each application.
- All individual applicants must request the same billing due date and bill cycle (monthly, quarterly, semi-annual, annually).
- Please do not submit payment with application.

Adding to an Existing List Bill

- To add an employee to an existing List Billed account, the employee must complete an individual application for coverage and attach a copy of the "Request for List Billing Arrangement" form (which should include the new member), and the "Permission to Provide List Bill Arrangement" form (Disclaimer) and send the completed forms to their agent. This form must include the Parent Group Number that can be found on the monthly bill summary. Please note that the billing date for this new member will be the same as the other Group members. (i.e.: 1st or the 15th of the month)
- In order to add a dependent to an existing individual policy, the policyholder must submit an application to Anthem via his or her agent. (same effective date: 1st or the 15th of the month)

Cancellation of List Bill Affiliation

- Cancellation of a List Bill account must be received by Anthem in writing from the employer or the employer's authorized agent 30 days prior to the cancellation date requested. If the notification is received 90 days after the death, we will need a death certificate.
- Upon cancellation of a List Billed account, all individual policyholders billed within that group will begin receiving monthly billings at their home address. Any refund that is due will be issued to the policyholder.

Marriage

Any current member wanting to add a spouse due to marriage must submit a new application. The spouse is subject to full medical underwriting. Both the certificate holder and the spouse must sign the application. The new application must be received by Anthem Blue Cross and Blue Shield within 31 days of marriage in order for coverage to begin on the date of marriage. If applying for coverage after the 31 days and Underwriting approves the application, the effective date will be the next available effective date.

Medical Questionnaires

Medical questionnaires are used to supplement “yes” answers indicated on the application. Questionnaires should be completed, signed and dated by the applicant. However, an agent may obtain the information over the telephone and sign, date and indicate with whom they spoke. Completed Medical Questionnaires should be submitted with the application. In most instances, an Attending Physician’s Statement (APS) may not be necessary if a fully completed questionnaire is submitted. The following is a list of the Medical Questionnaires currently used by Anthem:

Abnormal Pap Smear
Alcohol & Drug
Arthritis
Asthma/Allergy
Attention Deficit Disorder
Back/Spinal
Colitis/Irritable Bowel
Diabetes



Digestive
Ear/Otitis
Endometriosis
Fibromyalgia
Gout
Heart Murmur/MVP
Hypertension



Kidney/Urinary
Mental Health
Migraine
Seizure/Epilepsy
Thyroid
Tumor/Cyst
Ulcer

Member Self Serve

Members have the ability to manage their health benefits any time, day or night, through anthem.com. Simple click on *MyAnthem* for access to:

- find a doctor or hospital
- order a new ID card
- view benefits
- check a claim status
- address change
- check the formulary

Non-Tobacco Use Rate

Preferred rates may be available to any applicant, spouse or dependent that has not used ANY form of tobacco products within the past twelve (12) months.

Plan Transfers

If a current Anthem Blue Cross and Blue Shield member moves outside the state of residence in which the policy is held, the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, requires the individual to transfer to the local plan for which they reside. It is the policy holders responsibility to apply with that state. A letter will be sent to the member requesting permission to send a letter to the other plan.

Pregnancy

Coverage is NOT available to any applicant or spouse if either is currently pregnant, whether they are to be covered on the policy or not, ***IF*** they are an expectant parent. However, children of the expectant parent(s), or sibling of an expectant minor, may be written independently.

Premium Requirements

The first month's premium may accompany the application. The initial premium check will be cashed upon receipt of the application. If the application is subsequently denied, a refund of the deposit check will be issued, within 7-10 business days.

Automatic Bank Draft: Premium payments will be automatically deducted from a checking or savings account. The Automatic Bank Draft Authorization is included on the application form. Applicants requesting Automatic Bank Draft must complete and sign the Automatic Bank Draft section of the application. Automatic Bank Draft can also be setup after the policy is established.

To assure the Automatic Bank Draft is setup without delay, a voided check from the applicants' checking account (not a deposit slip) or a blank deposit slip from the applicants' savings account needs to be submitted. The deposit slip must show the Routing Number of the financial institution. Please advise your customer that he or she may receive a direct bill at home if the customer is not paid up to the current billing when the Automatic Bank Draft is set up. All Automatic Bank Drafts are arranged with the appropriate financial institution as soon as possible.

Bill Direct: Billed at home monthly, quarterly, semi-annually or annually.

List Bill: If an applicant will be making premium payments through his or her employer (via payroll deduction) Anthem can arrange to bill the employer directly each month via a list bill. Must have 2 or more employees to set up.

Short-Term

Advance Payment: Entire term of coverage in the form of check, money order or credit card.

Automatic Bank Draft: \$10 monthly fee will be accessed.

Monthly Billing: \$10 monthly fee will be accessed. (At least one month's premium is required with the application)

Pre-Existing Conditions

KENTUCKY LANGUAGE

A pre-existing condition is defined as a condition (mental or physical) that was present and for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the Enrollment Date. Pregnancy that exists on the effective date is considered a pre-existing condition. Domestic violence is not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

Pre-existing conditions are only covered after the coverage has been in force for 12 consecutive months following the effective date of coverage. Credit for a prior carrier's coverage may be given, if that coverage was continuous to a date not more than 63 days prior to Anthem's receipt date of a completed application.

INDIANA LANGUAGE

A pre-existing condition is defined as an illness, injury or condition which within the 12-month period, depending on the policy prior to the effective date, manifested itself in such a manner as would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment for which medical advice, diagnosis, care or treatment was recommended or received. Pregnancy, in addition, which exists on the effective date, is also considered a pre-existing condition.

Pre-existing conditions are only covered after the coverage has been in force for 12 consecutive months, following the effective date of coverage. Credit for a prior carrier's pre-existing period may be given, if that coverage was continuous to a date not more than 63 days prior to Anthems' receipt date of a completed application.

OHIO LANGUAGE

A pre-existing condition is defined as an illness, injury or condition which within six months prior to the effective date manifested itself in such a manner as would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received. Pregnancy, which exists on the effective date, is also considered a pre-existing condition.

Pre-existing conditions are only covered after the coverage has been in force 12 consecutive months, following the effective date of coverage. Credit for a prior carrier's pre-existing period may be given, if that coverage was continuous to a date not more than 63 days prior to Anthem's receipt date of a completed application.

Tri-State

Prior coverage can be from a group, individual or short-term contract, (Medicaid qualifies as prior coverage) but it must be a major medical type policy. To apply for pre-existing credit, the applicant must complete the section for prior coverage information on the application. Credit is not available if the prior coverage was an indemnity plan, hospital only plan or supplemental policy.

Pre-Existing Conditions - continued

Short-Term

A pre-existing condition is an illness, injury or condition, which within 24 months prior to the effective date, manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which a medical advice, diagnosis, care or treatment was recommended or received. Pregnancy, which exists on the effective date, is also considered a pre-existing condition. Pre-existing conditions are not covered for the term of the certificate. If you become pregnant during the term of coverage, the plan only covers complications.

Reinstatements

If a current member allows his/her contract to terminate and wishes reinstatement, he/she will automatically be eligible if they meet the following guidelines:

1. Request for reinstatement is received within 90 days of the cancellation date and money is received in full by the 90th day after the members paid to date.
2. No more than one previous cancellation for non-payment on current, continuous coverage within the last 12 months.
3. No more than three bad checks in the past 12 months.

If a member does not fall within above guidelines, they must complete an application for new coverage and will be underwritten and given a new effective date.

Renewals

Customers will be notified at least 30 days in advance of any intended rate increases. Approximately 15 days prior to the customer notification, each agent will receive a client listing of his/her customers who will be affected by the rate increase.

(KY only) All policyholders' rates are guaranteed for 12 months starting from their effective date. Rate renewals will occur each month as policies exhaust their 12-month rate guarantee. (Changes made outside of renewal could potentially change members' renewal month.)

Required Forms

In addition to the application, make sure all required forms are submitted, such as:

- Health Questionnaire* - when applicable, (see section on Medical Questionnaires)
- Replacement Form* - if replacing a non-group policy with another carrier (KY only)

Signature Requirements

The primary applicant and spouse, if applying, must sign and date the application. The parent/guardian of a dependent child applying must sign and date the application. Failure to obtain any of the above signatures will result in the return of the application. The application will expire 90 days from the signature date, if health coverage has not been approved by the end of the 90-day period.

Small Group Requirements (Indiana Only)

Coverage is not available to any person in an employer setting if two or more employees of an employer who meets the criteria of IC 27-8-15-1 as a small employer will be reimbursing or paying for any part of the premium for the policy. A small employer is classified as any person, firm, corporation, limited liability company, partnership or association actively engaged in business, which employs at least two but not more than 50, eligible employees during at least 50% of the working days of the employer during the preceding calendar year. The majority of those employed during that time work in Indiana. Companies that are affiliated or that are eligible to file a combined tax return for purposes of taxation are considered to be one employer.

Surviving Spouse/Dependents

When a covered spouse and/or dependent(s) loses coverage due to the death of the contract holder, he or she may continue the contract in his/her name. Enrollment must receive written notification within 31 days of losing eligibility.

If the notification is received after the 31-day period, it will be subject to medical underwriting approval. Coverage will begin the next available effective date (1st or 15th) once the application is approved by Underwriting, or a later date if requested.

Telephone Interviews

The applicant should be aware that the Underwriting Department might conduct a telephone interview. This is used to verify information on the application or to obtain additional details for the purpose of underwriting.

Tier Rating

Anthem offers tier-rated coverage on all non-Medicare Supplement and non-short term products. Super Preferred, Preferred 1, Preferred 2, Preferred 3, Standard 1, Standard 2, Standard 3, Modified 1 and Modified 2 rates are available based upon health status and tobacco usage.

(Underwriting will permit tobacco users any plan at a risk tier of Standard 1 with no other ratable health history in Indiana and Ohio. For Kentucky, the tobacco user must be under the age of 30 to be Standard 1. Age 30 and over tobacco users are Standard 3.)

As always, the application will be subject to medical underwriting, where the final rate tier placement is decided. Any changes to the rate, quoted by the applicant's agent, will be communicated to the applicant by the Underwriting Department. This will either be a counter offer letter which must be signed by the applicant and returned to the Underwriting Department within 15 business days of the date on the letter or an Issue Letter that doesn't have to be signed and returned (see Counter Offer Section).

In order to qualify for the Super Preferred risk tier, the applicant and/or spouse must submit the Super Preferred Healthy Lifestyle questionnaire with their application. The Super Preferred Rate is not a quotable rate and will be determined by Underwriting. Children are not eligible.

Underwriting Opinion Form

The Underwriting Opinion Form is designed to be used when you have a difficult question that may not be addressed in the Medical Condition Guide or if you are questioning whether we would consider or decline.

The Underwriting decision will be based on the information that is provided on this form only. When an Underwriting Form is returned to you with a decision and you want to submit the application, please attach that completed Underwriting Form to your completed application.

Withdraw Application

To withdraw an application, Anthem Blue Cross and Blue Shield must be notified in writing by the applicant or agent. Faxes are acceptable.

MEDICAL CONDITIONS AND RATING GUIDE

Introduction

Medical Underwriting is the process of estimating risk or morbidity of an applicant for health coverage. Various sources are used for estimating this risk, however, the most important is the application. This guide is intended to help the writing agent in soliciting and writing applications for coverage, and should not be interpreted as a guarantee of underwriting action on any one specific case. The agent and applicant must be aware that the final decision regarding insurability and possible effective dates is always made by the Underwriter.

As part of this guide, we have listed some medical conditions and the probable underwriting action that would be taken on an application. This is not an all-inclusive list and final decisions will be determined by Medical Underwriting. Medical conditions preceded by a “-” designate that they require Medical Questionnaires. These questionnaires should be completed and submitted with the application. Conditions are classified and rated as follows:

SPRE	SUPER PREFERRED RATE BAND (Only available for applicant and spouse/Healthy Lifestyle Questionnaire required)
PREF1	PREFERRED ONE RATE BAND (non-tobacco use)
PREF2	PREFERRED TWO RATE BAND
PREF3	PREFERRED THREE RATE BAND
STD 1	STANDARD ONE RATE BAND * (tobacco use)
STD 2	STANDARD TWO RATE BAND
STD 3	STANDARD THREE RATE BAND ** (tobacco use)
MOD1	MODIFIED RATE BAND
MOD 2	MODIFIED RATE BAND
IC	INDIVIDUAL CONSIDERATION
APS	MEDICAL RECORDS MAY BE REQUIRED
DEC	DECLINE
COM	COST OF MEDICATION

***Indiana and Ohio:** Underwriting will permit tobacco users any plan at a risk tier of Standard 1 with no other ratable health history.

***Kentucky:** Underwriting will permit tobacco users any plan at a risk tier of Standard 1 with no other ratable health history, the tobacco user must be under the age of 30.

****Kentucky:** Tobacco user age 30 and above.

KEY POINTS TO CONSIDER

- Applicants contemplating surgery will be postponed until surgery is completed.
- Applicants with several conditions may be declined due to a combination of conditions.
- Please refer to the Build Chart for applicants and all dependents to determine the “baseline” rate band **before** factoring in any medical conditions.
- Expectant parents will be postponed until after delivery.
- All ratings will depend on the plan of benefits and deductible selected.
- If information is developed that is not on the application, it will be referenced as PHI (Protected Health Information) and cannot be released to the agent per HIPAA guidelines. Correspondence will be handled between the applicant and underwriting.
- Prescription drug usage will be rated for dosage and cost. This could result in an offer of no Rx coverage or Plan 1 only.



You (and/or your spouse) may qualify for **a better rate** if you can answer **YES** to the following:

Circle your answers accordingly. Husband / Male Wife / Female

- 1. Have you been a non-tobacco user for three years or longer? YES YES
- 2. Do you exercise regularly? YES YES
- 3. Excellent health with no on-going medical conditions? YES YES
- 4. Does your build fall within the guidelines below?
(In the chart below, circle your height and weight) YES YES

MALES

FEMALES

Height	Weight No greater than	Height	Weight No greater than
5' 0	141	5' 10	175
5' 1	143	5' 11	179
5' 2	145	6' 0	183
5' 3	148	6' 1	187
5' 4	151	6' 2	192
5' 5	155	6' 3	197
5' 6	159	6' 4	202
5' 7	163	6' 5	207
5' 8	167	6' 6	212
5' 9	171	6' 7	217
		6' 8	222

Height	Weight No greater than	Height	Weight No greater than
4' 8	124	5' 7	158
4' 9	127	5' 8	162
4' 10	130	5' 9	166
4' 11	133	5' 10	170
5' 0	136	5' 11	174
5' 1	138	6' 0	178
5' 2	140	6' 1	182
5' 3	143	6' 2	187
5' 4	146	6' 3	192
5' 5	150	6' 4	197
5' 6	154		

Husband /Male Signature and date	Wife / Female Signature and date
_____	_____
<p>All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining the premium rate charged.</p>	

In Indiana Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.
In Kentucky Anthem Blue Cross and Blue Shield is the trade name of Anthem health Plans of Kentucky, Inc.
In Ohio Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company
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SUBMIT THIS PAGE WITH YOUR APPLICATION

MEDICAL CONDITION RATINGS

<u>Condition</u>	<u>Rating</u>
Acne	
On Accutane/Amnesteem/Claravis/Sotret.....	DEC
Others, rate based on medications	STD 1/IC
Acquired Immune Deficiency Syndrome or Aids Related Complex.....	DEC
<input checked="" type="checkbox"/> Alcohol / Drug Dependency	
< 5 years since last treatment	DEC
> 5 years since last treatment	IC/APS
<input checked="" type="checkbox"/> Allergy	
Mild (seasonal), minimal prescription usage	PREF1
Mild (seasonal), multiple medications	STD 1/COM
Moderate year round and/or allergy shots.....	STD 1/STD 2/COM
Severe (Allergy Shots/Multiple Medications) ER visits.....	IC/MOD 1/2/COM
Alzheimer's	DEC
Amputation (not caused by disease)	
Fingers / toes	PREF1
Other limbs or with prosthesis	MOD1
Angina.....	DEC
<input checked="" type="checkbox"/> Anxiety (Mental Health Questionnaire)	
Current treatment with medication	STD1/COM
Medication and/or current counseling sessions w/weekly, bi-weekly visits.....	DEC
Hospitalization within 1 year.....	DEC
Others	IC
<input checked="" type="checkbox"/> Arthritis	
Osteoarthritis, no med/OTC med, in hip, knee, shoulder, spine or neck.....	MOD1
Osteoarthritis, no med/OTC, other sites.....	PREF3
Osteoarthritis, on prescription medication	MOD1/COM
Rheumatoid Arthritis.....	DEC
With joint replacement done age 60-64 and over one year ago.....	MOD1
With joint replacement done under age 60 or under one year ago	DEC
Ascites, (all cases).....	DEC
<input checked="" type="checkbox"/> Asthma	
Acute attack within 6 months	DEC
Acute attack > 6 months, meds as needed or meds taken w/in one year	PREF3
Acute attack > 6 months, meds taken daily	MOD1/COM
No medication or treatment > one year	PREF1

MEDICAL CONDITION RATINGS

<u>Condition</u>	<u>Rating</u>
✎ Attention Deficit Disorder (ADD) Rated based on medication	COM
✎ Back Strain/Sprain Single occurrence, < 1 year, full recovery	STD1
Recurrent episodes or with ongoing chiropractic care	IC/APS
✎ Bronchitis (Allergy and/or Asthma Questionnaire) Mild, Single Occurrence, Not Hospitalized, Full Recovery	PREF1
Moderate, recurrent episodes, infrequent attacks	IC/STD1
Severe, with hospitalization and/or numerous attacks/medications	DEC
Chronic bronchitis within 2 years.....	DEC
Bursitis Single occurrence <1 year	PREF3
Unresolved, current treatment.....	DEC
✎ Cancer (Tumor Questionnaire) Metastatic Cancer	DEC
Internal Cancer < 10 years last treatment	DEC
Others	STD1
Carpel Tunnel Syndrome Unoperated With Symptoms within 1 year	DEC
Unoperated no symptoms within 1 year	PREF3
Operated, resolved.....	PREF1
Cataracts Unoperated	MOD1
Operated, released from care	PREF1
Cerebral Palsy < age 20	DEC
> age 20	IC/APS
Cholesterol (fasting) Diet Controlled, < 200	PRE
> 200 or with medication	PREF3/COM
Cirrhosis of the liver	DEC
Chronic Fatigue Syndrome	IC
Chronic Obstructive Pulmonary Disease (COPD, Emphysema).....	DEC

MEDICAL CONDITION RATINGS

<u>Condition</u>	<u>Rating</u>
Colitis	
Mild, Irritable Bowel Syndrome, normal weight	STD1
Moderate, recurrent episodes	IC/MOD1
Severe, chronic, underweight.....	DEC
Ulcerative Colitis (Crohn's Disease).....	DEC
Coronary Insufficiency	
Angina	DEC
Angioplasty.....	DEC
Bypass Grafting (CABG)	DEC
Myocardial Infarction (Heart Attack).....	DEC
Coronary Occlusion	
Angina	DEC
Angioplasty.....	DEC
Bypass Grafting (CABG)	DEC
Myocardial Infarction (Heart Attack).....	DEC
Crohn's Disease	DEC
Cystic Fibrosis	DEC
Cystitis	
Single episode, recovered.....	PREF1
Recurrent episodes	STD1
Depression, not Manic or Psychotic (Mental Health Questionnaire)	
Current treatment with medication	STD1/COM
Medication and/or current counseling sessions w/weekly, bi-weekly visits.....	DEC
Hospitalization within 1 year.....	DEC
Others	IC
Deviated Septum	
Not Operated, with symptoms	MOD1
Operated, full recovery	PREF1
Diabetes	
Diet controlled, adult onset, excellent control.....	STD 1/APS
Oral medication, excellent control	MOD 1/APS
Diet/Oral/Insulin, Fair to Poor control	DEC
Juvenile Diabetes.....	DEC
Disc Disorders (see Spinal Disorders)	
Diverticulitis / Diverticulosis	STD1 to MOD1

MEDICAL CONDITION RATINGS

<u>Condition</u>	<u>Rating</u>
Drug Treatment - See Alcohol/Drug Dependency	
Emphysema	DEC
<input checked="" type="checkbox"/> Endometriosis	
No current symptoms or symptoms controlled	STD1
Current symptoms or laser treatment.....	DEC
Operated (hysterectomy).....	PREF1
<input checked="" type="checkbox"/> Epilepsy (Seizure/Epilepsy Questionnaire)	
Any Seizure < 3 Years	DEC
Grand Mal, no seizure > 5 years	MOD1
Others, no seizure > 5 years	STD2
<input checked="" type="checkbox"/> Fibrocystic Breast Disease (Tumor/Cyst Questionnaire)	
Benign, definite diagnosis, treatment/testing < 1 year	STD1
Benign, definite diagnosis, treatment/testing > 1 year	PREF1
<input checked="" type="checkbox"/> Fibromyalgia	
No medication or symptoms within the year.....	PREF1
Use of anti-depressant medication(s).....	MOD 1/COM
Chronic with pain/narcotic medication.....	DEC
Friedreich's ataxia	DEC
Gallbladder Disease	
Unoperated, with Current Symptoms	DEC
Operated, complete recovery	PREF1
Gastric Bypass	
<3 years	DEC
3-5 years, no complications.....	MOD1
> 5 years	STD1
Gastric Reflux (GERD)	
Single Episode, No Medication	PREF1
On maintenance medication.....	COM
Glaucoma	
Mild, controlled by drops	STD2
With past surgery	STD3
<input checked="" type="checkbox"/> Gout	
No attack/treatment within 2 years.....	PREF1
With attack/treatment within 2 years.....	STD2/COM

MEDICAL CONDITION RATINGS

<u>Condition</u>	<u>Rating</u>
✎ Graves Disease (see Thyroid Disorders)	
Heart Attack (Myocardial Infarction)	DEC
✎ Heart Murmur	
Insignificant/asymptomatic, no treatment	STD1
Others	IC/APS
Heart Palpitations	
Symptoms controlled, no surgery within 6 months	STD2
Symptoms uncontrolled or surgery in last 6 months	DEC
Hemophilia	DEC
Hemorrhoids	
Unoperated, with symptoms < 2 years	STD1
Operated, full recovery	PREF1
Hepatitis	
A and B, within one year	IC/APS
A and B, over one year	PREF1
C/Chronic or Alcoholic	DEC
Hernia	
Unoperated, with current symptoms	DEC
Operated within 6 months, complete recovery	PREF3
Operated more than 6 months, complete recovery	PREF1
Hiatal, unoperated, no medication in last year	PREF3
Hiatal, unoperated, with medication in last year	MOD1/COM
Herpes	
Diagnosed within one year or on daily medication	MOD1/COM
No medication or medication with outbreaks only	STD1/COM
✎ High Blood Pressure (Hypertension Questionnaire)	
Uncontrolled, Malignant	DEC
Well controlled, one medication	PREF2
Well controlled, more than one medication	STD1/COM
Hodgkin's Disease	
Within 10 years	DEC
Over 10 years	STD1
Huntington's Chorea	DEC

MEDICAL CONDITION RATINGS

Condition

Rating

Hyperthyroidism (see Thyroid Disorders)

Hypoglycemia

Mild, controlledSTD1
Severe or uncontrolled IC

Hysterectomy

Benign Cause PREF1
Due to Cancer (non metastatic) < 10 years DEC

Infertility Treatment (current) DEC

Interstitial Cystitis

Chronic MOD1/COM
No symptoms/treatment >1 year PREF1

Irritable Bowel Syndrome (See Colitis)

Joint Replacement

Done age 60-64 and over one year agoMOD1
Done under age 60 or under one year ago DEC

Kidney Failure or Dialysis DEC

Kidney Stones

Multiple within one year DEC
Multiple > one year OR one episode within yearSTD2
After one year PREF1

Leukemia

Within 10 years DEC
Over 10 yearsSTD1

Maintenance Medications for any condition

Will be underwritten based on number of medications and costs IC/COM

Melanoma (Tumor/Cyst Questionnaire)

Within 10 years DEC
Over 10 yearsSTD1

Metastatic Cancer DEC

Meningitis (viral or bacterial)

Present DEC
Recovered, no residual effects PREF1

MEDICAL CONDITION RATINGS

<u>Condition</u>	<u>Rating</u>
Menstrual Disorders	IC
<input checked="" type="checkbox"/> Migraines	
Infrequent, one per year or less often	PREF1
Moderate to severe with chronic medication	MOD 1/2/DEC
<input checked="" type="checkbox"/> Mitral Valve Prolapse (MVP) (Heart Murmur / Mitral Valve Prolapse Questionnaire)	
No Symptoms Or Treatment Required(except antibiotics with dental work)	PREF1
No symptoms within last 2 years, controlled on medication.....	PREF2
With symptoms within last 2 years	DEC
Motor or Sensory Aphasia	DEC
Multiple Sclerosis	DEC
Muscular Dystrophy	DEC
Myasthenia Gravis	DEC
Myotonia	DEC
Obesity (see Height/Weight Build Charts)	
Obsessive Compulsive Disorder	DEC
Open Heart Surgery	DEC
Organ Transplant Recipient/Candidate	DEC
Osteoporosis/Osteopenia	
No history of fractures	STD1/COM
With history of fractures.....	DEC
<input checked="" type="checkbox"/> Otitis Media (Ear/Otitis Questionnaire)	
Single Episode, Recovered	PREF1
Multiple episodes	STD1
Ovarian Cyst	
Single episode, resolved	PREF1
Single episode, unresolved or recurrent episodes	MOD1
Pacemaker Implantation	DEC
Palpitations (see Heart Palpitations)	
Pancreatitis	
Single episode, > 1 year, no residuals	IC/APS
Recurrent/multiple episodes.....	DEC

MEDICAL CONDITION RATINGS

<u>Condition</u>	<u>Rating</u>
<input checked="" type="checkbox"/> Pap Smears (Cervical Dysplasia, Cervicitis)	
Class I or II - clean pap obtained	PREF1
Clean pap NOT obtained.....	DEC
Class III or more.....	IC/DEC
Parkinson's Disease	DEC
<input checked="" type="checkbox"/> Peptic Ulcer (Ulcer Questionnaire)	
Unoperated, current symptoms	DEC
Unoperated, no current symptoms, current treatment.....	STD3/COM
Operated within one year, resolved.....	PREF3
Operated more than one year, resolved.....	PREF1
Phlebitis	
Current symptoms or treatment.....	DEC
No current symptoms/treatment but symptoms/treatment within 3 years	MOD1
No symptoms/treatment within past 3 years	STD1
Polycystic Kidney Disease	DEC
Polycystic Ovaries	
Both ovaries removed	PREF1
No current symptoms on glucophage/hypoglycemic med.....	MOD1
No current symptoms on hormone replacement or BCP.....	STD1
With current symptoms.....	DEC
Pregnancy	
Currently.....	DEC
Premature Infant	
Birth to one year of age.....	IC/APS
Prostate Disorders (Benign)	
Hypertrophy (BPH),unoperated, no symptoms on medication	STD1/COM
Hypertrophy (BPH),unoperated, current symptoms	MOD1/COM
Operated, complete recovery	PREF1
Elevated PSA, no follow-up or repeat test.....	DEC
Elevated PSA, follow-up test normal	PREF2
Prostate Disorders (Malignant) <5 years.....	DEC
Prostatitis	
Acute within one year, resolved, no current symptoms or treatment	STD1
Acute within one year, unresolved or Chronic within 1 year.....	MOD1
Chronic after 1 year.....	STD2
<input checked="" type="checkbox"/> Psychotic Disorders (Mental Health Questionnaire)	
Psychosis / Schizophrenia	DEC
Manic Depression / Bipolar	DEC
All others, severe but not Psychotic or Manic.....	DEC

MEDICAL CONDITION RATINGS

<u>Condition</u>	<u>Rating</u>
Quadriplegia (Paralysis)	DEC
<input checked="" type="checkbox"/> Rheumatoid Arthritis (see Arthritis)	DEC
Skin Cancer	
Basal cell	PREF1
Squamous cell within 1 year.....	MOD1
Squamous cell, 1 to 5 years.....	PREF3
Squamous cell, over 5 years.....	PREF1
Skin Disorders (psoriasis, rosacea)	
Infrequent attacks, no regular meds.....	PREF1
Moderate/maintenance meds, not Methotrexate or Plaquenil.....	STD2/COM
Severe/ultralight therapy or use of Methotrexate or Plaquenil	DEC
Sleep Apnea	
Normal height/weight, controlled on CPAP	MOD1
Others	STD1
<input checked="" type="checkbox"/> Spinal Disorders (Back Pain Questionnaire)	
Mild Curvature (Scoliosis), No Symptoms Or Treatment	PREF3
Moderate to severe curvature, unoperated or operated <1 year.....	DEC
Operated to repair curvature, complete recovery,1-3 years.....	STD3
Operated to repair curvature, complete recovery,>3 years.....	STD1
Disc disorder, unoperated, < 5 years	DEC
Disc disorder, operated < 1 year	DEC
Disc disorder, operated, full recovery, 1-3 years.....	MOD1
Disc disorder, operated, full recovery, >3 years.....	STD1
Stroke (Cerebral Infarction, Hemorrhage, Embolism, Thrombosis)	DEC
Syringomyelia	DEC
Temporomandibular Joint Syndrome (TMJ)	
Unoperated	IC
Operated, no residuals, recovered.....	PREF1
Tendonitis	
Current treatment	DEC
Resolved < 1 year	PREF3
<input checked="" type="checkbox"/> Thyroid Disorders	
Hyperthyroidism, Adequately Controlled	PREF2
Graves Disease, I-131 or operated, recovered	PREF2
Goiter, present	IC

MEDICAL CONDITION RATINGS

<u>Condition</u>	<u>Rating</u>
Tonsillitis	
Single episode, fully recovered	PREF1
Chronic, requiring surgery	DEC
Varicose Veins	
Operated < 2 years	STD1
Operated, > 2 years complete recovery	PREF1
Unoperated, current symptoms/treatment.....	MOD1
Wilson's Disease	DEC

CONDITIONS THAT ARE A DECLINE

Adrenal Gland Disorders	Drug treatment w/in 5 years	Obsessive Compulsive Disorder
AIDS/AIDS Related Complex	Drug use (selling or dealing)	Open Heart Surgery
Alcohol/Drug Dependency less than 5 years since treatment	Dwarfism - Giantism	Organ Transplant recipient
Alzheimers	Emphysema	Osteogenesis Imperfecta
Amyotrophic Lateral Sclerosis	Encephalitis within 3 years	Pacemaker implantation
Anemia - aplastic, sickle cell	Endocarditis	Pagets Disease of bone
Angina	Epilepsy / any seizure < 3 years	Pancreatitis, recurrent/multiple episodes
Arthritis - Rheumatoid	Friedreichs Ataxia	Pap Smears, abnormal, Class III or more
Ascites	Gallbladder Disease /unoperated	Paraplegia
Asthma / severe w/hosp or attack w/in 6 months	Gastric Bypass < 3 yrs	Parkinsons Disease
Bipolar Disorder	Heart Attack	Peripheral Vascular Disease
Bronchitis, w/hosp and/or many meds	Heart Murmur - Organic	Pernicious Anemia - present
Cancer internal < 10 years last treat	Heart Surgery, except septal defect closed by direct suture	Phlebitis, multiple episodes, 3 years
Cancer / metastatic	Hemiplegia - Hemiparesis	Polycystic Kidney Disease
Cardiomyopathy	Hemophilia	Pregnancy, current
Carpal Tunnel / unop w/symptoms	Hepatitis - Chronic	Prostate Disorder, malignant < 5 years
Cerebral Aneurysm	HIV Infection	Pulmonary Embolism
Cerebral Palsy < age 20	Hodgkins Disease < 10 years	Quadriplegia (paralysis)
Cerebral Vascular Accident	Huntingtons Chorea	Reyes Syndrome
Cirrhosis of Liver	Hydronephrosis, present or bilateral	Rheumatoid Arthritis
Chronic Obstructive Pulmonary Disease (COPD/Emphysema)	Hysterectomy due to cancer	Schizophrenia - Paronia
Colitis/severe/chronic/underwt	Infertility treatment (current)	Spinal Deformity - severe
Collagen Diseases	Kidney failure or dialysis	Stroke/Cerebral Infarction/Hemorrhage/Embolism/Thrombosi
Connective Tissue Disease, Lupus	Kidney Stones, present	Syringomyelia
Coronary Insufficiency/Occlusion Angina	Kidney transplant recipient	TIA - Transcient Ischemic Attack
Bypass Grafting (CABG)	Leukemia < 10 years	Toxic Shock Syndrome - present
Heart Attack/MI	Liver Abcess - present	Von Willebrands Disease
Craniotomy 2 years due to trauma	Liver Cyst - present	Wilson's Disease
Crohns Disease	Liver transplant recipient	
Cystic Fibrosis	Lupus Erythematosis (SLE)	<i>Any condition for which testing or surgery is scheduled.</i>
Depression / hosp w/in 1 year	Marfan syndrome	<i>ALSO SEE RX DECLINE LIST</i>
Diabetes – insulin/juvenile	Melanoma, malignant, unop	
Diabetes - diet or oral, poor control	Melanoma, w/in 10 years	<i>REV. 10/08/04</i>
Disc Disorder, unop < 5 yrs	Meningitis, present	
Disc Disorder, operated < 1 yr	Mental Retardation < 9 years old	
Downs Syndrome < age 19	Metastatic Cancer	
	Motor or Sensory Aphasia	
	Multiple Sclerosis	
	Muscular Dystrophy	
	Myasthenia Gravis	
	Myotonia	

Medication Denials

Deny if any applicant is taking/has taken any of the following medications within the last twelve months*:

Abacavir	d4T	Haloperidol	Navane	Symbyax
Abilify	Dalteparin	Heparin	Neupogen	Synagis
Accutane**	Dapsone	HIVID	Norvir	Synvisc
Aggrenox	Daunoxome	Hydroxychloroquine	Orap	Tacrolimus
Amnesteem**	Delavirdine	Sulfate	Orgaran	Tasmar
Amprenavir	Didanosine	Insulin	Orthoclone OKT3	Thioridazine
Antabuse	Dipyridamole	Interferon	Oxycontin	Thiothixene
Anzemet	Dopar	Invirase	Pentamidine	Thorazine
Apokyn	Doxil	Kaletra	Pergolide	Ticlid
Arava	Duralith	Lamivudine	Permax	Ticlopidine
Aricept	Efavirenz	Lantus	Persantine	Trental
Arimidex	Eldepryl	Larodopa	Plaquenil	Trifluoperazine
Aromasin	Emtriva	Leponex	Platinol	Trilafon
Artane	Enbrel	Levodopa	Plavix	Trizivir
Avonex	Entocort	Lexiva	Pletal	Valcyte
Azathioprine	Epivir	Lithane	PMPA	Videx
AZT	Epogen	Lithium	Pneumopent	Viracept
Betaseron	Eskalith	Lithizine	Procrit	Viramune
Bleomycin	Exelon	Lithobid	Prolixin	Viread
Capoxone	Fabrazyme	Lithonate	Rebif	Vistide
Carbolith	Faxlodex	Lithotab	Remicade	Vitravene
Chlorpromazine	Felbamate	Lovenox	Rescriptor	Warfarin
Cibalith-S	Felbatol	Lymphocyte Immune	Retrovir	Xolair***
Claravis**	Femara	Globulin	Reyataz	Zalcitabine
Clozapine	Flolan	Mamantine	Rheumatrex	Zerit
Clozaril	Fluphenazine	MBACOD	Risperdal	Ziagen
Cognex	Folex	Mellaril	Sandimmune	Zidovudine
Combivir	Fortovase	Meproton	Serentil	Zyprexa
Comtan	Foscavir	Methatrexate	Seroquel	
Crixivan	Fuzeon	Methadone	Somavert	
Coumadin	Ganciclovir	Moban	Stavudine	
Cyclosporine	Geodon	Muromonab	Stelazine	
Cytovene	Haldol	Mycophenolate	Sustiva	
		Namenda		

** Will consider after off medication for 3 months.

*** Will consider after off medication for 6 months.

- Any medication not on this list should be investigated in order to determine the underlying medical condition for which the medication was prescribed.

REV. 10/04

BUILD CHART - MALES

AGES 13 AND OVER

Height	Preferred 1	Preferred 2	Standard 1	Standard 2	Modified 1	Decline
5' 0	<160	161-183	184-191	192-200	201-215	216
1	<163	164-187	188-198	199-206	207-220	221
2	<167	168-191	192-202	203-210	211-225	226
3	<172	173-196	197-207	208-215	215-231	232
4	<177	178-202	203-212	213-220	221-237	238
5	<182	183-207	208-217	218-225	226-242	243
6	<187	188-211	212-222	223-230	231-248	249
7	<192	193-216	217-227	228-235	236-255	256
8	<197	198-222	223-233	234-241	242-261	262
9	<202	203-228	229-239	240-247	248-268	269
10	<207	208-234	235-245	246-253	254-274	275
11	<212	213-240	241-251	252-259	260-283	284
6' 0	<217	218-249	250-257	258-265	266-293	294
1	<222	223-252	253-263	264-271	272-300	301
2	<227	228-259	260-271	272-279	280-306	307
3	<232	233-266	267-277	278-285	286-312	313
4	<237	238-273	274-284	285-292	293-319	320
5	<242	243-280	281-291	292-299	300-324	325
6	<247	248-287	288-298	299-306	307-329	330
7	<252	253-294	295-305	306-313	314-334	335
8	<257	258-302	303-313	314-321	322-339	340

BUILD CHART - FEMALES

AGES 13 AND OVER

Height	Preferred 1	Preferred 2	Standard 1	Standard 2	Modified 1	Decline
4' 8	<126	127-148	149-164	165-175	176-184	185
9	<130	131-152	153-166	167-180	181-189	190
10	<133	134-156	157-170	171-184	185-196	197
11	<137	138-158	159-173	174-187	188-202	203
5' 0	<141	142-162	163-179	180-192	193-210	211
1	<145	146-166	167-183	184-197	198-215	216
2	<149	150-170	171-187	188-202	203-221	222
3	<153	154-176	177-192	193-206	207-228	229
4	<157	158-179	180-198	199-212	213-233	234
5	<161	162-183	184-203	204-217	218-238	239
6	<165	166-187	188-208	209-222	223-243	244
7	<169	170-192	193-214	215-228	229-250	251
8	<173	174-198	199-220	221-234	235-257	258
9	<177	178-204	205-225	226-239	240-266	267
10	<181	182-208	209-230	231-244	245-271	272
11	<185	186-216	217-237	238-251	252-281	282
6' 0	<189	190-222	223-242	243-256	257-290	291
1	<193	194-227	228-247	248-261	262-297	298
2	<197	198-236	237-253	254-267	268-304	305
3	<201	202-238	239-259	260-273	274-310	311
4	<205	206-244	245-267	268-281	282-319	320

ABNORMAL PAP SMEAR QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Date(s) of abnormal pap smear(s)? _____

2. Diagnosis (please try to use classifications below when possible):

- ___ Class 1: Normal cells but viral infections, bacteria or yeast
- ___ Class 2: Mild dysplasia, atypical cells, inflammation,
- ___ Class 3: Moderate dysplasia, abnormal cells, (CIN I or CIN II)
- ___ Class 4: Severe dysplasia, carcinoma in-situ, (CIN III)
- ___ Class 5: Malignant cells (Cancer)

3. Was a cervical biopsy performed? Yes ___ No ___ Results _____

4. Please indicate type of treatment(s), if any, and date:

___ **Colposcopy** Date: _____

___ **Laser vaporization of cervix (laser surgery)** Date: _____

___ **Cryotherapy of cervix (freeze cervix)** Date: _____

___ **Conization (cone, LEEP)** Date: _____

___ **Hysterectomy** Date: _____

___ **No treatment but repeat pap smear**

Date of repeat pap smear: _____

Results (use class): _____

Medication prescribed? Yes _____ No _____

Name of Medication: _____ Dosage: _____ (Date last used) _____

5. Have you had a follow up pap smear since the original diagnosis or treatment? Yes _____ No _____

If yes, when: _____

Results (use class): _____

6. Name and address of treating physician: _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

ALCOHOL & DRUG QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Are you currently using or have you ever used the following substances:
- | | Yes | No |
|--------------------------------------------------------------|-------|-------|
| Alcohol (beer, wine or liquor) | _____ | _____ |
| Narcotics (heroin, opium, Demerol or their derivatives) | _____ | _____ |
| Hallucinogens (LSD, PCP, DMT, STP or derivatives) | _____ | _____ |
| Stimulants (cocaine, crack, amphetamines, antidepressants) | _____ | _____ |
| Depressants (bromides, barbiturates or their derivatives) | _____ | _____ |
| Tranquilizers (Valium, Librium, Haldol or their derivatives) | _____ | _____ |
| Marijuana (hash, pot, grass, tea or their derivatives) | _____ | _____ |
| Intravenous drug use | _____ | _____ |
| Any other substance not listed above | _____ | _____ |

(Please provide details to any "YES" answers below:

Type	Quantity	Frequency	From	To

2. Have you had a DUI, OUI or OWI within the last 5 years? Yes _____ No _____ If yes, please provide the date, state of your driver's license and your driver's license number:
- _____

3. Have you undergone treatment for substance abuse? Yes _____ No _____ If yes, provide details for:

a. Type of treatment (hospitalization, medication, psychotherapy): _____

b. Date of treatment, length of treatment and date treatment ended:

c. Name, address and phone number of treating physician, counselor, and facility:

4. Have you, in the past 10 years, been a member of Alcoholics Anonymous, Narcotics Anonymous, or similar aftercare programs? Yes _____ No _____. If yes, are you an active member? Yes _____ No _____. If an inactive member, what was the date last attended? _____

Have you used any substances since your initial treatment? Yes _____ No _____. If yes, please give details:

ALCOHOL & DRUG QUESTIONNAIRE
(continued)

5. Have you had a liver function or liver enzyme test? Yes _____ No _____. If yes, please provide date and results of most recent test:

6. Any history of:

Heart problems	Yes _____	No _____
Gastritis/ulcer	Yes _____	No _____
Depression	Yes _____	No _____
Kidney/liver disease	Yes _____	No _____

Please explain any "yes" answers: _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

ARTHRITIS QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Type of arthritis: Rheumatoid _____ Osteoarthritis _____ Other _____ (please explain):

2. Age at time of diagnosis or first symptoms? ____ Symptoms at time of diagnosis: _____

What are your symptoms now? _____

3. Which joints have arthritis? _____ Any deformity of joints? Yes ___ No ___
If yes, please explain:

4. Any work loss or restriction of activities? Yes _____ No _____ If yes, provide details:

5. Do you require the use of cane, crutches or a wheelchair to move about? Yes _____ No _____

6. Have you used any type of steroids, methotrexate or gold injections? Yes _____ No _____

If yes, give dates and type of treatment: _____

List your medication(s):

Name of Medication:	Dosage:	Frequency (i.e., daily, weekly)
----------------------------	----------------	----------------------------------------

7. Have you ever been hospitalized for arthritis or any related conditions? ___ Yes ___ No. If yes, provide complete details regarding dates of hospitalization(s), duration of stay and treatment received?

8. Have you had or been advised to have surgery for arthritis? Yes _____ No _____ If yes, indicate type of surgery and joints involved: _____

9. Name and address of treating physician: _____

Date last seen: _____

10. What is your current height? _____ Weight? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

ATTENTION DEFICIT DISORDER QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Date first treated: _____

2. Please state the name(s), dosage(s) and frequency for taking any medications prescribed:

3. Is medication still being taken? Yes _____ No _____ If no, when was medication discontinued? _____

4. Is medication taken throughout the year, or are there "breaks" when medication is not taken?
Please provide details: _____

5. Have there been any behavioral problems at school, truancy, etc.? Yes _____ No _____
If yes, please provide details: _____

6. Any growth problems or other mental/physical problems noted? Yes _____ No _____
If yes, please provide details: _____

7. Has the individual received psychological counseling, or has counseling been recommended? Yes ___ No ___
If yes, please provide details (including dates of treatment and name, address and phone number of counselor, physician or therapist): _____

8. Have there been any hospitalizations for this or other related conditions? Yes _____ No _____
If yes, please provide details: _____

Date of confinement: _____ Length of stay: _____

Name, address and phone number of hospital where confined:

9. Are you still being treated? Yes _____ No _____
If no, indicate date released from doctor: _____
If yes, indicate date you are to be released: _____

10. Name, address and phone number of treating physician or health care practitioner:

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

SPINAL QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Have you ever had pain in your back, neck or shoulder? Yes ___ No ___ If yes, complete the following:
- a. How many times: _____
 - b. Date of first episode: _____
 - c. Date of last episode: _____

2. What area(s) involved? (circle appropriate areas)
Neck (cervical) Middle (thoracic) Low (lumbosacral)
- a. Does the pain radiate? Yes ___ No ___ If yes, where? _____
 - b. Give definitive diagnosis, if known _____

3. Is this a disc disorder? Yes _____ No _____ If yes, indicate type:
_____ Herniation _____ Rupture _____ Protrusion

4. Was this the result of an injury? Yes _____ No _____ If yes, provide details _____

5. Have you ever been diagnosed with Scoliosis? Yes ___ No ___ If yes, degree of curvature _____

6. Due to back pain, do you take prescription medication? Yes _____ No ___ If yes, provide the following:
- | | | |
|---------------------------|----------------|-----------------------------------|
| Name of Medication | Dosage: | Frequency/Date last taken: |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

- a. Have you ever had or been advised to have surgery/or spinal fusion? Yes _____ No _____
If yes, provide details: _____
- b. Have you ever had or now have chiropractic treatment or physical therapy for your back?
Yes ___ No ___ If yes, how often? _____ Date last seen? _____
- c. Have you ever had loss of time at work or restriction of activities? Yes _____ No _____
If yes, how long were you off work? _____
When did you return to work? _____

7. What is the current status of your back, neck or shoulder pain? _____

8. Name and address of treating physician: _____

9. What is your current height _____ Weight? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

COLITIS/IRRITABLE BOWEL SYNDROME QUESTIONNAIRE (complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Was diagnosis of condition Ulcerative Colitis, Spastic Colon, Diverticulosis or Diverticulitis? Yes ___ No ___
If yes, which condition? _____
If no, provide exact diagnosis: _____
What was the cause? _____

2. Date of first episode? _____ Date last treated? _____ # episodes in last year? _____

3. How many attacks/episodes/flare ups have you had since the initial diagnosis? _____
Date of last attack/episode/flare up? _____

(Circle the most accurate description for each column below:)

Attack Duration	Attack Frequency	Weight Loss	Abdominal Pain and attack
Up to 4 weeks	1 per year	None	Mild
4-6 weeks	2 per year	10 lbs. or less	Moderate
Over 6 weeks	3 per year	Over 10 lbs.	Extreme

4. Have you had any of the following tests:
 ___ Blood Test Date _____ ___ Barium Enema Date _____
 ___ Colonoscopy Date _____ ___ Sigmoidoscopy Date _____
 ___ Pathology/biopsy Date _____

5. Have you been hospitalized or had surgery for this or any other related condition(s)? ___ Yes ___ No
 If yes, what type of surgery? _____ Date(s): _____
 Please provide details: _____

6. Are you on a special diet or do you use regular medication for this condition? Yes _____ No _____
Name of Medication: _____ **Dosage:** _____ **Frequency (i.e., daily, weekly)** _____

7. Have you ever taken, or been advised to take, any type of steroids (oral/suppositories) or azulfidine/sulfasalazine? ___ Yes ___ No
 If yes, give name(s) of medication(s) and date(s) taken: _____

8. What is your current height? _____ Weight? _____

9. Name and address of treating physician: _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

DIABETES QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Date diagnosed or date of first symptoms: _____ Blood sugar reading at that time? _____

2. Please indicate type of treatment: _____ Diet _____ Oral medication _____ Insulin

Are you compliant with dietary restrictions and recommended medications? Yes _____ No _____

If no, explain: _____

Name of Medication	Dosage:	Frequency (i.e., daily, weekly)

3. Have you ever been hospitalized for diabetes or any related conditions? Yes ___ No ___ If yes, provide complete details regarding dates of stay and treatment received: _____

4. How often does your doctor check blood sugar levels _____

How frequently do *you* test your blood sugar? _____ Usual reading? _____

5. Please provide **last 4 fasting blood sugar readings or Hgb A1C readings from your doctor and date of tests:**

_____	_____
_____	_____

6. Any history of:	(Circle one)	
Kidney disease	yes	no
Recurrent infections	yes	no
Circulatory disorders	yes	no
Leg or foot ulcers	yes	no
Insulin reactions	yes	no
Vision problems (Retinopathy)	yes	no
Decreased feeling, numbness or tingling in extremities	yes	no

Please explain any "yes" answers: _____

7. What is your current height? _____ Weight? _____

8. Name and address of treating physician: _____

9. Any other comments? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

DIGESTIVE QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Exact diagnosis of condition: _____

2. Have you ever been diagnosed or treated for:

- | | |
|---------------------------------------|-------------------------|
| ____ Gastroesophageal Reflux (GERD) | ____ Esophageal Spasm |
| ____ Esophageal Stricture | ____ Reflux Esophagitis |
| ____ Esophagitis | ____ Hiatal Hernia |
| ____ Difficult swallowing (Dysphagia) | ____ Heartburn |

3. Date of first episode? _____ # Episodes in last year? _____ Date of last episode? _____

4. Are you on a special diet or do you use regular medicine for the condition? Yes _____ No _____

Name of Medication:	Dosage:	Frequency (i.e., daily, weekly)
----------------------------	----------------	----------------------------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Have you had any special tests or X-rays? Yes _____ No _____

When? _____

Type of test? _____

Results and diagnosis? _____

6. Have you been hospitalized or had surgery for this or any other related condition? Yes _____ No _____

If yes, name of hospital: _____

Surgery date(s): _____ Hospitalization date(s): _____

Details of surgery or hospitalization: _____

7. What is your current height? _____ Weight? _____

8. Name and address of treating physician: _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

EAR/OTITIS QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Give diagnosis of ear disorder: _____

2. Date diagnosed or date of first symptoms: _____

3. How many episodes in the past 2 years? _____

Frequency of episodes? _____

4. Give details including dates of past and current treatment: _____

5. Is any prescription medication taken for this condition? Yes _____ No _____

Name of Medication:

Dosage:

Frequency (i.e., daily, weekly)

6. Give name and address of treating physician: _____

7. Date last seen for this condition? _____

8. Ever had or been advised to have surgery? Yes _____ No _____

If yes, please provide details: _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

ENDOMETRIOSIS QUESTIONNAIRE
(Complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated/relationship to applicant: _____

1. Date of first episode: _____

2. # of episodes in last year: _____

3. Date of last episode: _____

4. Have you had any special test or x-rays? Yes _____ No _____

If yes, type of test? _____

Results and diagnosis: _____

5. Have you had any surgery? Yes _____ No _____

If yes, give details: _____

6. Do you use regular medication for this condition? Yes _____ No _____

Name of medication	Dosage	Frequency

7. Name and address of treating physician:

All of the above statements are true, complete and correctly recorded to the best of my knowledge.
I understand that the insurer will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

FIBROMYALGIA QUESTIONNAIRE
(Complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Age at time of diagnosis or first symptoms? _____ Symptoms at time of diagnosis: _____

What are your symptoms now? _____

Date of last symptoms? _____

2. Affected muscles/areas? _____

3. Any work loss or restriction of activities? Yes ___ No ___ If yes, provide details:

Have you applied for disability? Yes ___ No ___ If yes, provide details:

4. Do you require the use of cane, crutches or a wheelchair to move about? Yes ___ No ___

5. List your medication(s):

Name of Medication:	Dosage:	Frequency (ie., daily, weekly)
_____	_____	_____
_____	_____	_____

6. Have you ever been treated for depression? Yes ___ No ___ If yes, provide details including dates and medications: _____

7. Details of physical therapy and/or pain management including dates of past and current treatment: _____

8. Have you ever been hospitalized for fibromyalgia or any related conditions? Yes ___ No ___ If yes, provide complete details regarding dates of hospitalization(s), duration of stay and treatment received? _____

9. Have you had or been advised to have surgery for fibromyalgia? Yes ___ No ___ If yes, advise type of surgery: _____

10. Name and address of treating physician: _____

Date last seen: _____

11. What is your current height? _____ Weight? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand that Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent / guardian if under 18)

Date

GOUT QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Date diagnosed or date of first symptoms: _____

2. Number of attacks in the last year? _____

3. Date of last attack? _____

4. Give details of past and current treatment: _____

5. Name of Medication:	Dosage:	Frequency (i.e., daily, weekly)
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Do you have any history of:
Hypertension (high blood pressure) Yes _____ No _____
Kidney disease/Kidney Stones Yes _____ No _____

Explain any "yes" answers and provide date(s) of treatment: _____

7. Name and address of treating physician: _____

8. Date last seen? _____

9. What is your current height? _____ Weight? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

HEART MURMUR/MITRAL VALVE PROLAPSE QUESTIONNAIRE (complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Give exact diagnosis: _____ Date of diagnosis: _____

2. Description of murmur (check one):
 functional organic diastolic systolic other (specify)

3. Have you had any of the following?

Test:			If yes, when?	Results were (circle):		
EKG	Yes ___	No ___	_____	Normal	Abnormal	Unknown
Echocardiogram (Echo)	Yes ___	No ___	_____	Normal	Abnormal	Unknown
Doppler Test	Yes ___	No ___	_____	Normal	Abnormal	Unknown
Heart Catheterization	Yes ___	No ___	_____	Normal	Abnormal	Unknown
Holter Monitor	Yes ___	No ___	_____	Normal	Abnormal	Unknown
Thallium	Yes ___	No ___	_____	Normal	Abnormal	Unknown
Stress/Treadmill	Yes ___	No ___	_____	Normal	Abnormal	Unknown

4. Have you ever experienced symptoms (chest pain, shortness of breath, dizziness, palpitations, irregular heartbeat)? Yes ___ No ___ If yes, please give details (**date of onset, frequency, severity, date of last symptoms**): _____

5. Have you ever taken medication for this condition? Yes ___ No ___

Medication:	Dosage:	Frequency (i.e., daily, weekly)	Date stopped (if no longer taking)
_____	_____	_____	_____
_____	_____	_____	_____

6. Have you ever had surgery, or has surgery or other treatment been recommended for this or any related condition? Yes ___ No ___ If yes, give details: _____

7. Has there been any hospitalization for this or any other related condition? Yes _____ No _____

If yes, dates of confinement(s): _____ Length of stay(s): _____

Name and address of hospital(s) where confined: _____

8. Do you have any other cardiovascular conditions? Yes ___ No ___ If yes, please provide complete details: _____

9. Name and address of treating physician: _____

10. What is your current height? _____ Weight? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

HYPERTENSION QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Date high blood pressure first diagnosed? _____ Blood pressure reading at that time? _____

2. Are you taking medication(s) for your blood pressure? Yes _____ No _____

Name of Medication: _____ **Dosage:** _____ **Frequency (i.e., daily, as needed)** _____

If no, did your doctor recommend discontinuation? Yes ___ No ___ Date Discontinued _____

3. How often do you see your doctor for blood pressure checkups? _____

4. Please provide your last **5 blood pressure readings from your doctor and date of readings:**

If you monitor your blood pressure at home, what does it normally run? _____

5. What is your current height? _____ Weight? _____

6. Any history of:

(Circle one)

Circulatory Disorder	Yes	No
Kidney disease	Yes	No
Diabetes	Yes	No
Heart disorder/murmurs	Yes	No
Cerebrovascular disease (Stroke, TIA)	Yes	No
Valve problems or enlarged heart	Yes	No

Please explain any "yes" answers: _____

7. Please provide your latest cholesterol reading (if know): _____

8. Medication required? Yes _____ No _____

Name of Medication: _____ **Dosage:** _____ **Frequency (i.e., daily, weekly)** _____

9. Have you ever been hospitalized for your high blood pressure? Yes _____ No _____

If yes, name and address of hospital? _____

Date of hospitalization and treatment: _____

10. Name and address of treating physician: _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

KIDNEY/URINARY DISORDER QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. What kind of kidney/urinary disorder did you have? Bladder infection, reflux, cystitis, kidney stones, nephritis, prostate trouble or other? _____

2. When did you first have symptoms? _____

3. When did you last have symptoms? _____

4. How many occurrences have you had? _____

5. Name and address of hospital and treating physician? _____

6. Any surgery? Yes _____ No _____ If yes, what type? _____ Date? _____

Details: _____

7. Name and address of hospital? _____

8. Do you now have, or have you ever had any heart trouble or high blood pressure?
Yes _____ No _____ (If yes, provide dates and details): _____

9. What special studies have you had? (Provide dates and results of studies)

10. When was urine last checked? Date: _____ Why was it checked? _____

11. Name and address of treating physician: _____

12. What is your current height? _____ Weight? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

MENTAL HEALTH QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Clinical name (definitive diagnosis) of condition: _____
Have you been diagnosed with: _____ Depression _____ Anxiety _____ Panic Disorder
_____ Schizophrenia _____ Obsessive Compulsive Disorder _____ Bipolar Disorder
_____ Manic Depression

2. Did you seek treatment from a psychologist, psychiatrist, physician, LSW or other type of counselor?
Yes ___ No ___. **If yes, circle which one was seen** and give date(s) of treatment: _____

Frequency of treatment: _____

If treatment has ended, provide date of last visit: _____

3. Was medication prescribed? Yes _____ No _____

Name of Medication:	Dosage:	Frequency (i.e., daily, weekly)
----------------------------	----------------	----------------------------------------

4. Are you still on medication? Yes _____ No _____. If no, when was medication discontinued? _____

If yes,

Name of Medication:	Dosage:	Frequency (i.e., daily, weekly)
----------------------------	----------------	----------------------------------------

5. Have you been hospitalized for this, or a similar condition? Yes _____ No _____. If yes, provide complete details regarding date(s) of hospitalization, duration of stay and name of facility: _____

6. If this was a "situational" depression, please explain cause: _____

7. Have you ever attempted suicide? Yes _____ No _____. If yes, please provide details: _____

8. Any other comments? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

MIGRAINE QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Date of diagnosis or first symptoms: _____

2. Frequency of headaches: _____ # per week _____ # per month

3. Are headaches mild, moderate or severe? _____

Date of last headache? _____

Name and address of treating physician: _____

4. Any work loss or restricted activities? Yes _____ No _____

If yes, give details: _____

5. Are you taking medication for this condition? Yes _____ No _____

Name of Medication:	Dosage:	Frequency (i.e., daily, weekly)
----------------------------	----------------	----------------------------------------

6. How often do you see the doctor for this condition? _____

7. Results and dates of any special test/studies:

Dates	Name of test/study & results
_____	_____
_____	_____
_____	_____

8. Are the headaches caused by eyestrain, sinus infection, hypertension, brain tumor, aneurysm, trauma, acute febrile illness or temporal arteritis: Yes _____ No _____

If yes, provide details: _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

THYROID QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Date of first symptoms or diagnosis? _____

2. What was the original diagnosis (hypothyroid, hyperthyroid, goiter, other)? Please specify:

3. Give details of past and current treatment: _____

4. Ever had or been advised to have surgery? Yes _____ No _____
If yes, give details: _____

5. Any prescription medications taken for this condition? Yes _____ No _____

Name of Medication:	Dosage:	Frequency (i.e., daily, weekly)
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Name and address of treating physician: _____

7. Date of last office visit and laboratory studies? _____

Was the last thyroid level within range? Yes _____ No ____ If no, please indicate results of last thyroid level and date: _____

8. What is your current height? _____ Weight? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

TUMOR/CYST/SKIN CANCER QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Date of diagnosis or date of first indication of tumor/cyst/skin cancer: _____

What diagnosis or description was given to you by your doctor about the tumor/cyst/skin cancer?

2. Was it diagnosed as: Malignant _____ or Benign _____ (If malignant, provide details) _____

If malignant, what was the stage, grade, Clark level (Melanoma) or Gleason (Prostate) score? _____

Size of tumor/cyst/skin cancer? _____ Location? _____

Has there been any metastasis or spread to any other location(s)? Yes _____ No _____
(If yes, provide details):

Has there been any recurrence or relapse? Yes _____ No _____. If yes, provide details:

3. Did you receive medication for the tumor/cyst/skin cancer? Yes ___ No _____. If yes, provide name and dosage of medication and date medication was taken: _____

Did you receive radiation or chemotherapy for the tumor/cyst/skin cancer? Yes ___ No _____. If yes, provide details and date(s) taken: _____

4. Have you had surgery or been advised to have surgery to remove the tumor/cyst/skin cancer? Yes ___ No ___
If surgery done, when? _____

Have you been released from treatment? Yes ___ No _____. If yes, when? _____

5. Are further studies or future operations for the tumor/cyst/skin cancer anticipated? Yes ___ No ____

If yes, when? _____

6. Name and address of treating physician: _____

7. Any other comments? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date

ULCER QUESTIONNAIRE
(complete all questions)

Name of primary applicant: _____ ID/SSN: _____

Name of person treated: _____ Relationship to applicant: _____

1. Please indicate type of ulcer: Gastric _____ Duodenal _____ Peptic _____ Other (specify) _____

2. Details of ulcer history:

First episode

Last episode

Date: _____

Duration: _____

Location: _____

Treatment: _____

Number of episodes/flare-ups in the last 4 years? _____ Is ulcer now present? Yes ___ No ___

3. Have you ever had any complications (such as anemia, vomiting blood, blood in stool, perforation, other)?
Yes ___ No ___ If yes, provide date(s) of incident and details: _____

4. Have you had surgery for the ulcer or is surgery anticipated in the future? Yes _____ No _____

If yes, provide complete details regarding date(s) of surgery, type of surgery and advise if any symptoms since surgery? _____

5. Was medication prescribed? Yes _____ No _____

Name of Medication:

Dosage:

Frequency (i.e., daily, weekly)

6. Are you still on medication? Yes _____ No _____. If no, when was medication discontinued? _____

7. Recent lab test or special studies (x-ray, Upper GI, other?) _____

Results of test: _____ Normal _____ Abnormal _____ Unknown

8. Do you now use tobacco products? Yes ___ No ___

9. Name and address of treating physician: _____

10. What is your current height? _____ Weight? _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

OVER 65 HEALTH INSURANCE PRODUCTS

As a result of the Omnibus Budget Reconciliation Act of 1990 (OBRA-90,) Congress authorized the National Association of Insurance Commissions (NAIC) to develop ten model policies to replace the many varied policies on the market. By state and federal law, there are only ten plans and since 1992, all companies must sell identical policies with identical policy names. Every company must label the plans with the letters A through J. Every company must sell Plan A and then the company can choose other plans to sell if they wish.

Medicare Supplement Plans purchased prior to 1992 are not affected by standardization. These plans are also known as “pre-standardized” plans.

Medicare Supplement Plans

For applicants age 65 and over, Anthem Individual offers Medicare Supplement plans that conform to the NAIC guidelines adopted by each state. Individuals may apply up to six months in advance of their open enrollment period. Anthem offers the following plans:

Indiana

- Attained Age Banded Plans A, B, G and H
- Attained Age Plans C, D, E and F

Kentucky

- Community Rated Plans A, B, C, F and H
- Attained Age Rated Plans A and E

Ohio

- Attained Age Plans A, B, C, D, E, F, G, H and I
- Issue Age Plans A, C, F and I

Medicare Select Plans

For applicants age 65 and over, Anthem Individual offers Medicare Select plans. Medicare Select plans require the use of a “provider network,” a specific group of hospitals; when services are provided in one of these hospitals, the Medicare Part A deductible is waived. Individuals may apply up to six months in advance of their open enrollment period. Anthem offers:

Indiana

- Attained Age Banded Plan A
- Attained Age Plans C and F

Kentucky

- Community Rated Plan A, B, C, F and H
- Attained Age Rated Plans A and E

Ohio

- Attained Age Plans C and F

Note: *In Ohio, the Medicare Select plans are rated based on age and zip code. There are two different brochures and premium rate charts, one for Cuyohoga county in the Cleveland area and one for the rest of the state.*

OVER 65 GUIDELINES

Age Rated Plans (KY only)

Rates are based on age. The premium will automatically increase each year as the customer gets older. Anthem may also increase the premium as a result of an increase in overall health care costs and changes in the Medicare program.

To determine the correct rate at the time of enrollment, use the customer's age as of the effective date of coverage. Each year thereafter, the rate will increase to the customer's attained age up to age 73.

Kentucky

- Attained Age Rated Plans A and E

Attained Age Banded Rating (IN only)

The premium will automatically increase as the customer enters a new "age band." There are three "age bands" for these products which are 65-69, 70-74, and 75+. Anthem may also increase the premium because of a rise in overall health care costs and changes in the Medicare program.

Indiana

- Attained Age Banded Plans A, B, G and H

Attained Age Rating (IN and OH only)

The premium will automatically increase each year as the customer gets older. Anthem may also increase the premium as a result of an increase in overall health care costs and changes in the Medicare program.

Indiana

- Medicare Supplements C, D, E and F
- Select C and F

To determine the correct rate at the time of enrollment, use the customer's age at the time of application. Each year thereafter, the rate will increase on the anniversary date to the customer's attained age. There are seventeen "age bands" for these products, ranging from age 65 through age 81+.

Ohio

- Medicare Supplements A, B, C, D, E, F, G, H and I
- Medicare Select Plans C and F

To determine the correct rate at the time of enrollment, use the customer's age as of the current renewal date (most recent July 1st.) Each year thereafter, the rate will increase on July 1st to the customer's attained age. There are 22 "age bands" for these products, ranging from age 65 through age 86+.

Balance Billing

Federal law prohibits doctors who accept Medicare assignment from billing patients for the balance of the bill above the amount Medicare approves. If the patient does not have Medicare Supplement coverage then he/she are responsible for the 20% of the approved charge not paid by Medicare Part B.

Limiting Charge

A limiting charge is the maximum amount a doctor can charge a Medicare beneficiary for a covered service if the doctor doesn't accept assignment. The limit is 15% over Medicare's approved payment amount.

Balanced Budget Act of 1997 (BBA)

Effective July 1, 1998, carriers offering traditional Medicare Supplement Policies must offer some disenrolled members of a Medicare+Choice or Medicare Select Plans guaranteed issue policies **OR** allow the member to enroll in their previous standardized Medicare Supplement Plan if it is still available from the carrier.

To qualify for guaranteed issue plans, the insured must meet one of the following qualifying events:

1. First time Medicare+Choice or Medicare Select member that disenrolls within the first 12 months of enrollment.
2. A person involuntarily loses coverage under an employer sponsored health plan. (This includes retirement from an employer sponsored plan.)
3. Medicare+Choice or Medicare Select member moves out of the plan's service area. (Does not apply to seasonal residents/snowbirds).
4. Medicare+Choice Plan is terminated for cause (e.g. insolvency).

Individuals that meet any of these four qualifying events are candidates for guaranteed issue Medicare Supplement Plans A, B, C or F from any carrier. (The carrier must only guarantee issue a plan it already sells; for example if it does not offer Plan C, it does not have to offer it to one of these candidates.)

Notes:

- The rights of the member must be communicated by the insurer providing prior coverage.
- Application must be received by Anthem within 63 days of disenrollment.
- Proof of disenrollment from the applicant's prior carrier must be submitted.

The following chart indicates qualifying events and which plans are guaranteed issue.

CHART FOLLOWING THE FEDERAL REGULATIONS, IN, KY and OH REGULATIONS

Qualifying Event	Plans Offered As Guaranteed Issue
Any age – enrollment under an employee welfare benefit plan (group health plan) ends, or plan stops providing benefits. Must be involuntary termination by member. This includes retirement from a group health plan.	Regulations require at <u>minimum</u> , A,B,C,F (if under age 65, only plans which are already sold to under age 65 people on Medicare have to be offered) from ANY insurer.
Any age – enrollment in Medicare+Choice ends because plan ends; entity discontinues plan in service area; individual moves out of service area; plan misrepresented program to enrollee; “other exceptional conditions” occur.	Regulations require at <u>minimum</u> , A, B, C, F (if under age 65, only plans which are already sold to under age 65 people on Medicare have to be offered) from ANY insurer
Any age – enrollment in Medicare+Choice, cost contract, demo project, prepayment plan, or Medicare Select ends because plan ends; entity discontinues plan in service area; individual moves out of service area; plan misrepresented program; “other exceptional conditions” occur.	Regulations require at <u>minimum</u> , A, B, C, F (if under age 65, only plans which are already sold to under age 65 people on Medicare have to be offered) from ANY insurer
Any age – enrollment in Medicare Supplement ends because carrier becomes insolvent, bankrupt, or otherwise involuntarily terminates Med Supp. coverage; carrier or agent misrepresented policy provisions; carrier violated material policy provisions.	Regulations require at <u>minimum</u> , A, B, C, F (if under age 65, only plans which are already sold to under age 65 people on Medicare have to be offered) from ANY insurer.
Any age – person was enrolled in a medicare supplement plan, then left it to enroll for the 1 st time ever in a Medicare+Choice or other such plan, OR a Medicare Select plan, and within 12 months the enrollee dis-enrolls.	The same Medicare supplement plan in which the person was most recently enrolled prior to the Medicare+Choice/Medicare Select disenrollment, if that plan is still available from the carrier they originally had; and if it is not still available, then Plan A, B, C or F.
Age 65 – Person enrolls in a Medicare+Choice plan upon first becoming eligible for Medicare Part A benefits at age 65; then disenrolls from the Medicare+Choice plan within 12 months after the effective date of enrollment.	ANY Medicare Supplement plan offered by ANY carrier.

Notes:

- ◆ The rights of the member must be communicated by the carrier providing prior coverage.
- ◆ Application must be received by Anthem within 63 days of disenrollment.
- ◆ Proof of disenrollment from the applicant’s prior carrier must be submitted.

TRI-STATE MEDICARE SUPPLEMENT TABLE

KENTUCKY	INDIANA	OHIO
<p>PE Wavier</p> <p>Waive PE</p>	<p>PE Wavier</p> <p>Waive PE</p>	<p>PE Wavier</p> <p>Waive PE</p>
<p>Effective Dates</p> <p>1st of the month and odd dates ONLY when matching to prior coverage.</p>	<p>Effective Dates</p> <p>1st of the month and odd dates ONLY when matching to prior coverage.</p>	<p>Effective Dates</p> <p>1st of the month and odd dates ONLY when matching to prior coverage.</p>
<p>Renewal</p> <p>Open enrollment is January.</p>	<p>Renewal</p> <p>Anniversary date = effective date</p>	<p>Renewal</p> <p>July</p>
<p>Plan Transfers</p> <p>GI the same identical product they have at the plan they are coming from, if we do not have the same exact plan, GI the one that most resembles the other plan. If we cannot determine what plan they are coming from and they are a declinable sub we can offer - GI = Indemnity A or B.</p>	<p>Plan Transfers</p> <p>GI the same identical product they have at the plan they are coming from, if we do not have the same exact plan, GI the one that most resembles the other plan. If we cannot determine what plan they are coming from and they are a declinable sub we can offer - GI = Indemnity A or B.</p>	<p>Plan Transfers</p> <p>GI the same identical product they have at the plan they are coming from, if we do not have the same exact plan, GI the one that most resembles the other plan. If we cannot determine what plan they are coming from and they are a declinable sub we can offer - GI = Medicomp A or D to over 65. Under 65 Medicomp A only.</p>
<p>GI/BBA eligible</p> <p>Plans A,B,C, F only.</p>	<p>GI/BBA eligible</p> <p>Plans A,B,C,F only.</p>	<p>GI/BBA eligible</p> <p>Plans A,B,C,F only.</p>
<p>Under 65 Disability</p> <p>GI Indemnity Plan A or B. Open to public sale. This is ONLY if not a BBA situation.</p> <p>If BBA eligible they can have plans A,B,C, or F Select or Indemnity according to BBA law.</p>	<p>Under 65 Disability</p> <p>“Disability Plan A” to those coming directly (no lapse) from Anthem group OR if BBA eligible from other carriers, no lapse allowed. However, Indiana has pretty much allowed any under 65 person from anywhere, to come on board without underwriting.</p>	<p>Under 65 Disability</p> <p>GI = Medicomp Plan A only if off one of Anthem groups. No outside sales.</p>

Updated 11/15/04

Claim Forms

Hospitals and other Medicare Part A providers submit claims directly to Anthem. Physicians file Medicare Part B claims with the appropriate state Medicare Part B carrier and Anthem automatically receives the same information to pay the Medicare Supplement benefits. Unless services are rendered out of state then it's the members' responsibility for sending it.

Community Rated Plans (KY only)

These plans are rated by product rather than by the applicant's age. Two rates are available: 1) for 65 and older; and 2) for disabled under 65 eligible Medicare Supplement members. The premium never increases just because the customer gets older. Premiums may increase only because of the rise in overall health care costs and changes in the Medicare program. The following plans are available community rated:

Kentucky

- Medicare Supplements A, B, C, F and H
- Medicare Select A, B, C, F and H

Death of a Policyholder

Written or telephone notification to Anthem Blue Cross and Blue Shield is required after the death of a policyholder. Termination of the certificate will be the day after the policyholder's death; this is to assure benefits are paid on the day of death and any unused premiums will be refunded. If Anthem Blue Cross and Blue Shield is notified of the death of the policyholder after 91 days, a copy of the death certificate will be required for a refund of any unused premiums.

Effective Dates

All Medicare Supplement policies are effective the first of the month. Medicare Supplement and Medicare Select applications that are received prior to the applicant's six month open enrollment window period will be given the same effective date as their Medicare Part B enrollment date. This is the case as long as the application is received prior to the date.

All other applications must be received by the 1st in order to receive 1st effective date.

Eligibility

Applicant's who meet the following criteria are eligible to apply:

- ☑ Must live in the state for which they are applying.
- ☑ Must be enrolled for both Medicare Part A and Part B.
- ☑ Must be age 65 or older.
- ◆ **Note:** Under 65 disability products are available in Indiana and Kentucky. In Ohio, disability product only available if coming off Anthem Group.

Guaranteed Acceptance

Acceptance to any Medicare Supplement or Medicare Select plan is guaranteed, if the applicant applies within their 6 month open window period (the 6 month period following their Medicare Part B effective date.)

Guaranteed Renewable

Coverage cannot be cancelled due to age or benefit use. Coverage can only be cancelled for misrepresentation or non-payment of premium.

Guide to Health Insurance for People with Medicare

All Medicare Supplement and Medicare Select applicants must be provided with the *Guide to Health Insurance for People with Medicare*. This guide is furnished by Anthem Blue Cross and Blue Shield. Requests for additional copies of this guide should be sent to Anthem Blue Cross and Blue Shield.

Issue Age Rating (OH only)

The premium never increases just because the customer gets older. Premiums may increase only because of the rise in overall health care costs and changes in the Medicare program.

To determine the correct rate at the time of enrollment, use the customer's age as of the effective date. There are 5 "age bands" for these products, ranging from age 65 through age 80+.

Ohio

- Medicare Supplements A, C, F and I

Medicare Supplement Replacement Notice

This form must be completed if an applicant is terminating existing Medicare Supplement or Medicare Select and replacing it with a policy to be issued by Anthem Blue Cross and Blue Shield.

Open Enrollment Period

If applying for a Medicare Supplement or Medicare Select Plan, coverage is guaranteed if the applicant is at least 65 years old and applying for coverage within six months after enrolling in Medicare Part B benefits. During this six month "window," the applicant does not have to answer medical questions or pass medical underwriting requirements.

To determine if an applicant is within their 6 month window, add 6 months to the effective date of their Medicare Part B coverage. If the date is in the future and the applicant is at least 65, he/she is eligible for open enrollment. Example: If applicant's Medicare Part B effective date is June 1st, add 6 months (June, July, August, September, October, and November) making his/her 6 month window period end November 30th.

Policy Replacement

If an applicant is replacing another health insurance policy, do NOT cancel it until he/she has actually received the new policy and are sure they want to keep it.

Pre-Existing Waiting Period

There is no waiting period before pre-existing conditions are covered.

Premium Requirements

The first month's premium may accompany the application. The initial premium check will be cashed upon receipt of the application. If the application is subsequently denied, a refund of the deposit check will be issued.

Automatic Bank Draft: Premium payments will be automatically deducted from a checking or savings account. The Automatic Bank Draft Authorization is included on the application form. Applicants requesting Automatic Bank Draft must complete and sign the Automatic Bank Draft section of the application. Automatic Bank Draft can also be set up after the policy is established.

To ensure the Automatic Bank Draft is set up without delay, a voided check from the applicants' checking account (not a deposit slip) or a blank deposit slip from the applicants' savings account needs to be submitted. The deposit slip must show the Routing Number of the financial institution. Please advise your customer that he or she may receive a direct bill at home if the customer is not paid up to the current billing when Automatic Bank Draft is set up. All Automatic Bank Drafts are arranged with the appropriate financial institution as soon as possible.

Bill Direct: Billed at home monthly, quarterly, semi-annually or annually.

Renewal Date

The Medicare Supplements and Medicare Select products renew annually each year at which time any rate adjustment will become effective. Anthem may raise rates at any time, but will always give a 30-day advance notice to customers and general agents.

Indiana	Upon their anniversary date
Kentucky	January 1 st
Ohio	July 1 st

Note: New Business rates change for Indiana on January 1st, for Kentucky on January 1st and for Ohio on July 1st.

Right to Return the Policy

All new policies may be cancelled by the applicant back to the effective date of coverage if written notification is received within 31 days of the date the application is processed by Anthem. If the contract is returned and no claims have been submitted, Anthem will refund all premiums to the applicant.

Signature Requirements

The applicant must sign and date the application. The application will expire 90 days from the signature date, if health coverage has not been approved by the end of the 90-day period.

The 90-day signature requirement will be waived for Medicare Supplement applications if the requested effective date is within the applicant's six month open enrollment window period.

Single Coverage Only

The Medicare Supplement and Medicare Select plans are offered only to individuals. Family coverage is not available.

Agent Checklist for New Business Applications

1. All sections of the application must be completed in full.
2. Each response on the application should be printed legibly using ink. Any cross out, alteration, change or correction must be clearly marked and initialed by the applicant.
3. List applicant's home and business phone numbers if applicable.
4. Be sure that all medical care received during the period of time specified in the application is fully recorded for each person listed in the application.
5. Complete all necessary Medical Questionnaires for under 65 applications.
6. Make sure the applicant (and spouse when appropriate) reviews, signs and dates the completed application.
7. Your name, tax identification number, and broker code (on your sticker assigned by your general agent) must be clearly identified on the application.
8. Obtain the premium based upon premium payment method requested. **Please advise the applicant that the initial premium check will not be deposited until the individual's application has been approved.** Cash and post-dated checks are not acceptable. Checks should be made payable to "Anthem Blue Cross and Blue Shield." Anthem will return the original check with a letter of explanation to any individual whose application is closed or denied.
9. Before submission, check the application for completeness. Incomplete applications will delay the processing of your customer's application and may be returned.
10. The street address must be listed on the application. Do not use a PO Box only.

Application Chart

	APP NEEDED	APP NOT NEEDED	COMMENTS
Add newborn within first 31 days of life to parent(s) policy.		XX	Policyholder can call customer service and give information on child and request baby be added permanently.
Add newborn to sibling policy at anytime.	XX		Not guaranteed issue and will get the next available effective date after app is received
Add newborn after 31 st day.	XX		Is underwritable and will be given next available effective date after app is received.
Add adopted child.	XX		Besides application, need Affidavit for Special Dependent and a copy of the document awarding court-appointed custody.
Add any other dependent/spouse.	XX		
Changing product, BAC to HSA, BAC to TAA, etc.	XX		Even if result is a downgrade, still need application.
Delete dependent.		XX	Letter to enrollment signed by subscriber. Will be deleted effective with receipt of letter.
Delete policyholder and keep coverage on spouse/dependents.		XX	Letter to enrollment signed by subscriber. Enrollment will set up coverage in spouse's or dependent's name, if requested.
Downgrades.		XX	Application supplement can be completed or letter from member.
Individual member moving to another state within Midwest Region (IN, KY or OH).	XX		Must complete appropriate application for the state they are moving to. If applying for the same plan and deductible, will be guaranteed the same rate tier.
Policyholders want to combine separate policies into one.	XX		If don't want rate review or isn't an upgrade, medical questions don't have to be answered.
Rate review-trying for better rate due to change in medical history, lost weight, stopped using tobacco.	XX		Claims and medical history are reviewed.
Upgrades, including Blue Traditional to Blue Access.	XX		

AFFIDAVIT

Member's Name Certificate No. Group No. Area Code) Phone No.

Member's Address: Street City Zip Code

Spouse's Name and Address: Street City Zip Code

I hereby certify that as the court-appointed custodian or guardian of the dependent child(ren) listed below, such child(ren) is/are my legal and financial responsibility and will, to the best of my knowledge, reside in my home until age 19 or until the child(ren)'s marriage, whichever comes first. (Dependent children are defined as unmarried children under 19 years of age, including legally adopted or legally placed children, who are dependent upon the subscriber for support and live with the subscriber in a regular parent-child relationship.)

NAME	DATE OF BIRTH	RELATIONSHIP

Are you legally and financially responsible for the child? YES ___ NO ___
 Please advise the date on which you assumed financial responsibility for the child. _____
 Is the child claimed as an eligible dependent on your State or Federal Income Tax Return? YES ___ NO ___
 If no, please explain: _____
 Do you live in a regular parent-child relationship with the child? YES ___ NO ___
 Please advise the date the Petition for Adoption or Application for Appointment of Guardianship was filed.

Was custody or guardianship awarded by a court or an authorized governmental agency? YES ___ NO ___
 Do you intend to adopt the child? YES ___ NO ___
 Has a court already approved the adoption? YES ___ NO ___
 Is the child covered by Medicaid? YES ___ NO ___ If yes, give Medicaid Number: _____
 Is the child covered by Medicare? YES ___ NO ___ If yes, give Medicare Number: _____
 Effective dates for Medicare (if applicable): Part A _____ Part B _____
 Are the natural parents of the above listed child(ren) living? YES ___ NO ___
 Does either of the child's natural parents live in your household? YES ___ NO ___
 Mother's Name: _____ Date of Birth: _____
 Mother's Current Address: _____
 Father's Name: _____ Date of Birth: _____
 Father's Current Address: _____
 Does either natural parent have Blue Cross and Blue Shield or Option 2000 coverage YES ___ NO ___
 If yes, which parent? _____ Certificate No. _____ Group No. _____

NOTE: Please submit a copy of the Petition for Adoption or Application for Appointment of Guardianship or the legal document awarding you custody or guardianship of the listed child(ren). If the child was placed for adoption, please submit a letter from the attorney handling the adoption, including the name and date of birth of the child, the name of the adoptive parent(s), and the date the child was placed. Custody or guardianship awarded other than by a court of law or an authorized governmental agency will not be recognized in the determination of eligibility for Blue Cross and Blue Shield coverage for the listed dependent child(ren). All information requested must be furnished before coverage for the listed child(ren) will be considered.

(PLEASE SEE REVERSE SIDE)

I AGREE TO NOTIFY ANTHEM BLUE CROSS AND BLUE SHIELD IMMEDIATELY OF ANY CHANGES, PRESENTLY UNFORSEEN BY ME, IN THE CHILD(REN)'S LIVING ARRANGEMENTS WITH ME. I UNDERSTAND THAT AN ELIGIBLE CHILD(REN) WILL BE REMOVED FROM MY MEMBERSHIP WHEN HE/SHE NO LONGER QUALIFIES AS A DEPENDENT AS DEFINED IN MY CONTRACT.

Signature of Member

DATE

THIS FORM MUST BE NOTARIZED BY A NOTARY PUBLIC

STATE OF _____

COUNTY OF _____

The foregoing document was subscribed and sworn to before me on the _____ day of _____, 20 _____.

Notary Public

My commission expires: _____

The following is to be completed if the member has coverage through an employer's group plan.

Signature of Authorized Official

DATE

Name of Company

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.
An independent licensee of the Blue Cross and Blue Shield Association
®Registered marks Blue Cross and Blue Shield Association

Producer Site

The Producer Site was developed with you, our valued producers in mind. Anthem Individual wants to make it easier for you to do business with us. The site places the most up-to-date information on our products and services at your fingertips.

- Rate Calculators
- Applications and Related Forms
- Medical Questionnaires
- Uninsurable Drugs & Conditions
- Producer Manual
- Individual Products
- Producer Bulletins & News
- Miscellaneous Forms
- List Bill
- Renewals
- Web-Based Training
- Health Certificates of Coverage
- Medicare Select Hospital Directory

Our site is accessible to you 24 hours a day/7 days a week at www.anthem.com

Click on ***Brokers & Producers***

Select a state

Click on ***Enter Site***

Click on ***Individual Producer Web Site***

Click on ***Log into the Individual Producer Site***

OR

Click on ***New User Registration***

Online registration and acceptance of the user agreement will be required the first time you use the site. User name and temporary passwords will be sent to you via U. S. Mail.

All individuals will immediately be prompted to change their password after the initial log in.

Passwords will expire every 90 days. Applications will be “timed out” after 30 minutes of inactivity.

Remember to add this to your “favorites” list.

It is important to note that each agent in your agency is not expected to complete the registration form. Please designate one individual, who will serve as Site Administrator, to register all necessary parties within your agency. The site administrator will be expected to accept the User Agreement, on behalf of the agency. Each individual who is registered will receive his/her own letter, providing his/her unique security information.

In addition to the Producer Site, we also have a rating CD. This CD allows you to always have the most current rates, including the capability to update your own personal computer by using the auto-update feature via the Internet.

Send to:
Underwriting Department
P.O. Box 37810
Louisville KY 40233-7810
FAX: 502-261-2118/2330

REQUEST FOR UNDERWRITING OPINION

OHIO Request

Complete a separate form for each applicant/dependent

Date: _____ GA/Agent Name: _____ GA/Agent Phone #: _____

Send Response to GA/Agent Fax #: _____ Client Name: _____

Client Id#: _____

AGE: _____ SEX: _____ HEIGHT: _____ WEIGHT: _____ SMOKER (Y/N): _____

Blue Access Blue Traditional

<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	Other
<input type="checkbox"/> 500 <input type="checkbox"/> 1,000	<input type="checkbox"/> 250 <input type="checkbox"/> 500	<input type="checkbox"/> 2,500 <input type="checkbox"/> 10,000	
<input type="checkbox"/> 2,500 <input type="checkbox"/> 5,000	<input type="checkbox"/> 1,000 <input type="checkbox"/> 2,500	<input type="checkbox"/> 5,000	

MEDICAL HISTORY – PLEASE LIST ALL MEDICAL HISTORY

Condition/ Diagnosis	Onset Date	Date last Treated	Details of symptoms, Treatment, tests performed, results	Medications (Name,dose,freq)	Current Status

Additional Comments:

**THIS UNDERWRITING OPINION IS NOT BINDING IN ANY WAY AND ANY DECISION IS BASED SOLELY ON THE INFORMATION FURNISHED ON THIS FORM AND IS SUBJECT TO REVIEW IF ADDITIONAL INFORMATION IS PROVIDED.
UNDERWRITER OPINION (BEST CASE OR CONSIDER FOR):**

PEF 1 PEF 2 PEF 3 STD 1 STD 2 STD 3 MOD 1 MOD 2

DECLINE

MEDICAL RECORDS ARE NEEDED MEDICAL QUESTIONNAIRES ARE NEEDED



INDIVIDUAL

Send to:
Underwriting Department
PO Box 37810
Louisville KY 40233-7810
FAX: 502-261-2373

Request for Underwriting Opinion

KENTUCKY Request

Date: _____ GA/Agent Name: _____ GA/Agent Ph#: _____

Send Response to GA/Agent Fax #: _____ **Client Name:** _____

This section must be completed for each applicant:

Age: _____ **Sex:** _____ **Height:** _____ **Weight:** _____ **Smoker (Y/N):** _____

Blue Access Plan A (KY only)

<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	Other
<input type="checkbox"/> 500 <input type="checkbox"/> 1,000	<input type="checkbox"/> 250 <input type="checkbox"/> 500	<input type="checkbox"/> 2,500 <input type="checkbox"/> 10,000	
<input type="checkbox"/> 2,500 <input type="checkbox"/> 5,000	<input type="checkbox"/> 1,000 <input type="checkbox"/> 2,500	<input type="checkbox"/> 5,000	

**MEDICAL HISTORY – Please List ALL Medical History
(Do NOT send Medical Records or MQs with Opinion Form)**

Condition/ Diagnosis	Onset Date	Date last Treated	Details of symptoms, Treatment, tests performed, results	Medications (Name,dose,freq)	Current Status

Additional Comments:

THIS UNDERWRITING OPINION IS NOT BINDING IN ANY WAY AND ANY DECISION IS BASED SOLELY ON THE INFORMATION FURNISHED ON THIS FORM. AGENTS SHOULD RETAIN A COPY OF THIS OPINION, AS UNDERWRITING WILL NOT MAINTAIN AN OPINION FILE.

UNDERWRITER OPINION (BEST CASE OR CONSIDER FOR):

PREF 1 **PREF 2** **PREF 3** **STD 1** **STD 2** **STD 3** **MOD 1** **MOD 2** **DECLINE**

WILL CONSIDER WITH SUBMITTED APPLICATION AND MEDICAL RECORDS OR MQs.



INDIVIDUAL

Send to:
Underwriting Department
PO Box 37810
Louisville KY 40233-7810
FAX: 502-261-2002

Request for Underwriting Opinion

INDIANA Request

Date: _____ GA/Agent Name: _____ GA/Agent Ph#: _____

Send Response to GA/Agent Fax #: _____ **Client Name:** _____

This section must be completed for each applicant:

Age: _____ **Sex:** _____ **Height:** _____ **Weight:** _____ **Smoker (Y/N):** _____

Blue Access Blue Traditional

<input type="checkbox"/> Plan 1	<input type="checkbox"/> Plan 2	<input type="checkbox"/> Plan 3	Other
<input type="checkbox"/> 500 <input type="checkbox"/> 1,000	<input type="checkbox"/> 250 <input type="checkbox"/> 500	<input type="checkbox"/> 2,500 <input type="checkbox"/> 10,000	
<input type="checkbox"/> 2,500 <input type="checkbox"/> 5,000	<input type="checkbox"/> 1,000 <input type="checkbox"/> 2,500	<input type="checkbox"/> 5,000	

**MEDICAL HISTORY – Please List ALL Medical History
(Do NOT send Medical Records or MQs with Opinion Form)**

Condition/ Diagnosis	Onset Date	Date last Treated	Details of symptoms, Treatment, tests performed, results	Medications (Name,dose,freq)	Current Status

Additional Comments:

THIS UNDERWRITING OPINION IS NOT BINDING IN ANY WAY AND ANY DECISION IS BASED SOLELY ON THE INFORMATION FURNISHED ON THIS FORM. AGENTS SHOULD RETAIN A COPY OF THIS OPINION, AS UNDERWRITING WILL NOT MAINTAIN AN OPINION FILE.

UNDERWRITER OPINION (BEST CASE OR CONSIDER FOR):

PREF 1 **PREF 2** **PREF 3** **STD 1** **STD 2** **STD 3** **MOD 1** **MOD 2** **DECLINE**

WILL CONSIDER WITH SUBMITTED APPLICATION AND MEDICAL RECORDS OR MQs.

Authorization for Automatic Deposits (Credits)

Future payments can be deposited directly into your bank account. If interested, please fill out the form below, and mail the entire page to:

Anthem Blue Cross and Blue Shield
Accounting Operations, CC2-262
1351 William Howard Taft Road
Cincinnati, OH 45206-1775

Payee Name: _____
Payee ID: _____
Payee Tax ID: _____
Payee Address: _____

This is my authorization to automatically credit my:

Checking Account Savings Account _____
(number)

(_____) _____ in
(Bank Transit/ABA Number) (Financial Institution)

_____ _____
(City) (State)

Please attach a copy of your voided check or deposit slip.

I understand that this will be in effect until I notify Anthem in writing that I no longer desire this service, allowing reasonable time to act on my notification. I also understand that if corrections in the credit amount are necessary, it may involve an adjustment (credit or debit) to my account.

_____ _____
Date Authorized Signature

Broker Self Service

Broker Self Serve allows Agents/Brokers to view and update member information including:

- Benefits & Eligibility – including the online certificate of coverage
- Member Information
- Change Subscriber address
- Claims Details
- PCP Information
- Change PCP Information
- ID Card Ordering
- Change Insurance Information

How to access Broker Self-Serve through www.anthem.com:

- Click on the “Brokers & Producers” tab
- Select the appropriate state from the drop-down box
- Click on Enter Site

From the Broker Welcome page:

- Log in to MyAnthem for Brokers (new users will need to register for access)
- Select “Broker Self-Service (View Customer Claims and Eligibility)” from the Online Broker Services listing

Note: You may already have access to this feature. If you have any questions, please contact Anthem’s eBusiness Solutions Center at (866) 755-2680.

HIPAA Policies (OH only)

On June 30, 1997, Governor Voinovich signed Ohio HB374 into law, with an emergency effective date of July 1, 1997. This state law implemented certain provisions of the federal portability law, known as The Health Insurance Portability and Accountability Act (HIPAA).

Both HIPAA and the Ohio law require insurers to provide coverage, on a guaranteed issue basis (no medical underwriting) with NO pre-existing waiting period, to certain individuals who qualify. These individuals are known as "HIPAA eligibles".

Each year Anthem Blue Cross and Blue Shield has a maximum number of "HIPAA eligibles" that must be accepted during Open Enrollment which begins January 1. The maximum number is calculated in January of each year. Once Anthem reaches the maximum number, a letter is sent to the Department of Insurance and HIPAA Open Enrollment is closed until the following January.

*Anthem group conversion is eligible for HIPAA enrollment anytime during the year.

Listed below are the criteria set forth for "HIPAA Eligible" in the Individual Market.

***** All must apply to be considered eligible for a guaranteed issue policy*****

1. The individual's last coverage MUST have been GROUP HEALTH coverage.
2. The individual MUST have a minimum of 18 months of prior creditable coverage without a significant break of 63 days or more where there was no coverage.
3. The individual MUST NOT have any other health coverage.
4. The individual MUST NOT be eligible for Medicare or Medicaid or for coverage under a group health plan.
5. The individual's most recent coverage MUST NOT have been terminated because of non-payment of premiums or fraud.
6. The Individual MUST have elected and exhausted any COBRA or state continuation benefits. In the event the individual does not have COBRA benefits available to them, this piece of criteria will be waived.

HIPAA Policies Continued (OH only)

The following is a list of the HIPAA products that are available through Anthem:

- Basic Closed Panel HIC (HMO)
- Standard Closed Panel HIC (HMO)
- Basic Individual Indemnity (CMM)
- Standard Individual Indemnity (CMM)

ADDITIONAL CONSIDERATIONS:

- ◆ HIPAA conversion for Anthem group customers is allowed at any time during the year as long as they meet all of the HIPAA criteria.
- ◆ The Basic Closed Panel HIC (HMO) and the Standard Closed Panel HIC (HMO) require the applicant to select a Primary Care Physician (PCP) out of the Blue Preferred (HMO/POS/EPO) directory. The PCP's name and ID# must be noted on the application by the agent.
- ◆ If choosing a HIC plan, the enrollee must reside in the service area.
- ◆ Rates are based upon the "HIPAA eligible" employee.
- ◆ The Ohio Health Reinsurance Program Open Enrollment "Individual" Statement (current calendar year) form must be completed for each individual insured under Open Enrollment legislation.
- ◆ Applications will not be accepted more than 30 days in advance of COBRA expiration or termination of the group insurance.

Cancellations

Cancellation of any HIPAA policy must be made within 10 days after the enrollment application was signed. Written notification must be sent by certified mail to Anthem Blue Cross and Blue Shield, its agents or other representatives. The certificate holder will receive a full refund of premium, unless any claims have been submitted.

Dependent Additions

To add a newly eligible dependent due to a qualifying event, Anthem must be notified within 31 days of the event. The new dependent will be covered as of the date of the event. If the application is received more than 31 days after the qualifying event, that person is not eligible for coverage.

Downgrades

HIPAA downgrades (plan changes) can only be done during the HIPAA renewal period, which is June of each year.

Effective Date Assignment

Effective date assignment for any of the HIPAA products will either be:

- Upon exhaustion of COBRA benefits
- OR**
- Application receipt date by Anthem if COBRA benefits are exhausted

**OHIO HEALTH REINSURANCE PROGRAM
OPEN ENROLLMENT "INDIVIDUAL" STATEMENT
CALENDAR YEAR: _____**

TO BE COMPLETED FOR EACH INDIVIDUAL INSURED UNDER OPEN ENROLLMENT LEGISLATION

Policy Number _____ Effective Date _____

- Ohio Eligible Individual as defined by Section 3923.58(B)
- Federally Eligible Individual as defined by Section 3923.581(A)(2)

1. Is the individual employed? YES NO If yes, please indicate Type? Full Time Part Time Self-employed

2. Is the individual or dependent(s) eligible for benefits through the employer's health plan? YES NO If yes, please detail why coverage is not in force. _____

3. Is the spouse employed? YES NO If yes, please indicate type:
 Full Time Part Time Self-employed

4. Is the spouse, individual or dependent(s) eligible for benefits through the spouse's employer health plan? YES NO
If yes, please detail why coverage is not in force. _____

5. Is this individual, spouse or dependent(s) eligible for any other private or public health benefits plan including Medicare or any state health benefits plan? YES NO
If yes, please detail why coverage is not in force. _____

PLEASE ANSWER THE FOLLOWING QUESTIONS FOR FEDERALLY ELIGIBLE INDIVIDUALS

6. Has this individual accumulated 18 or more months of creditable coverage and the most recent period of creditable coverage was under a group health, governmental or church plan? YES NO

7. Was the previous coverage terminated for reasons other than nonpayment of premium or fraud? YES NO

8. If the individual was eligible for COBRA or state continuation of coverage, did the individual elect this coverage and completely exhaust the coverage in accordance with the provision? YES NO

If no to questions 6, 7 or 8 please explain: _____

CARRIER Anthem Blue Cross and Blue Shield DATE _____

CONTACT NAME Melissa Wise

PHONE (502) 261-2181 FAX NUMBER (502) 261-6606