

Indiana Insurance Group

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

Indiana Insurance Group

FAX# 317-842-2243

Dear Indiana Insurance Group,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

I will contact Indiana Insurance Group at 317.842.2210 to verify receipt of my application.

**I understand that Indiana Insurance Group will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend

I understand that the original, signed application and premium payment must still be mailed to Indiana Insurance Group. :

Indiana Insurance Group

Attn: New Enrollment

Scott Blackford

#187 11650 Olio Rd., Suite 1000

Fishers, IN 46037

I will send the original, signed application and premium payment, as soon as I have been contacted by Indiana Insurance Group with confirmation that my application has been received by fax and reviewed for completeness.

Indiana Insurance Group

Application Instructions for Celtic

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Indiana Insurance Group for review along with the completed application. If you do not have access to a fax machine, send the completed application to Indiana Insurance Group along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Celtic** if you are not paying by credit card for the first month.

Mail completed applications and check to:

Indiana Insurance Group
Attn: New Enrollment
Scott Blackford
#187 11650 Olio Rd., Suite 1000
Fishers, IN 46037

Indiana Insurance Group will review your application for completeness and accuracy before we submit it to Celtic for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 317.842.2210 or e-mail us at info@indianainsurancegroup.com.

Your Individual Application Kit is enclosed

Here is a checklist to review before you return your application.

- Print clearly and complete the application in blue or black ink.
- If you make any changes while completing this form (for example, if you cross out something you wrote), be sure to **initial and date** those changes.
- If any **corrections** are needed or if the form is incomplete, the application may have to be returned to you, or we may try to call you, to obtain the necessary information. In that case, we will record your information on a form that will be attached to your application.
- You may request an effective date of any day of the month after the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.
- The primary applicant and spouse/domestic partner, if applicable, and any dependent children age 18 or over must sign and date the application in two places (in Section L).**
- List the height and weight for each applicant.
- List the date of birth for each applicant.
- For applicants age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, if you have had creditable health coverage in the past 63 days, please fill out Section I to apply for preexisting credit. Creditable Coverage is defined as prior coverage from a group plan, Medicare, Medicaid, health plan for active military personnel, including TRICARE, Indian Health Service, state risk pool, Federal Employees Health Benefits Program, state children's health insurance program, public health plan, U.S. Government plans, foreign health plans, individual insurance policy or Peace Corps service. Prior coverage does not count as Creditable Coverage if there was a break of 63 days or more prior to applying for this coverage.
- Select the plan, deductible amount and any applicable riders requested.
- Answer all health history questions in Section K. Failure to do so will delay the processing of your application.
- If you answered "yes" to any of the health history questions, give complete details on page 11.
- For Automatic Bank Draft, complete the Authorization located in Section H and include a **voided check**. We cannot accept deposit slips. (Your account will be drafted from the assigned effective date to the current billing date if your application is approved by Underwriting.)
- The initial premium is required with the application. Please provide your credit card authorization per the instructions in Section H. If you pay by check, please make the check payable to Anthem Blue Cross and Blue Shield, include your Social Security number on the front of the check, and affix the check to the front of the application.
- If you are eligible for Medicare, you are not eligible to apply for our individual products.

If you need assistance filling out the application, please contact your agent.

THIS PAGE IS INTENTIONALLY BLANK.

Indiana Individual Enrollment Application



Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one): Change Anthem Individual policy coverage Add dependent(s) to current coverage
 New Coverage Policy No. _____ Policy No. _____

Effective date requested: If your application is approved, your coverage can start on any day of the month **after** the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.
Please choose the date you would like your coverage to start: ____/____/____ **MM/DD/YYYY**

Section B – Applicant Information

Risk Tier	Last Name	First Name	MI	Social Security Number*	
Home Address (street and P.O. Box if applicable)					
City		State	Zip	County	
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Height (Ft. / In.) /	Weight	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth / /
Daytime Phone Number ()	Evening Phone Number ()	E-mail* If possible, do you want E-mail notification? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Are all applicants listed on this application United States citizens? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, who? _____ and how many years/months have they resided in the United States? ____ years and ____ months					
Tobacco Use: Have you used tobacco in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If cigarettes, how many do you smoke per day? _____					

Section C – Spouse or Domestic Partner Information

Risk Tier	Last Name	First Name	MI	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	
Social Security Number*	Height (Ft. / In.) /	Weight	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth / /
Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No			Tobacco Use: Have you used tobacco in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If cigarettes, how many do you smoke per day? _____		

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary.)

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage through the end of the calendar month in which they turn age 26. An eligible dependent may be your children, your spouse or domestic partner's children or a child subject to legal guardianship. In addition, other** eligible dependents, including your grandchildren or other blood relative, who depend on you for 50% of their financial support, can also be covered under this coverage. (List all dependents beginning with the eldest.) **Requires submission of completed Affidavit of Dependency for Indiana Individual Policies.

Risk Tier	First, MI (last name if different)	Relationship to Applicant	Social Security Number*	Sex	Marital Status	Age	Date of Birth mm/dd/yyyy	Height Ft. / In.	Weight Lbs.
		<input type="checkbox"/> Child <input type="checkbox"/> Other		M <input type="checkbox"/> F <input type="checkbox"/>	<input type="checkbox"/> Single <input type="checkbox"/> Married				
		<input type="checkbox"/> Child <input type="checkbox"/> Other		M <input type="checkbox"/> F <input type="checkbox"/>	<input type="checkbox"/> Single <input type="checkbox"/> Married				
		<input type="checkbox"/> Child <input type="checkbox"/> Other		M <input type="checkbox"/> F <input type="checkbox"/>	<input type="checkbox"/> Single <input type="checkbox"/> Married				
		<input type="checkbox"/> Child <input type="checkbox"/> Other		M <input type="checkbox"/> F <input type="checkbox"/>	<input type="checkbox"/> Single <input type="checkbox"/> Married				
		<input type="checkbox"/> Child <input type="checkbox"/> Other		M <input type="checkbox"/> F <input type="checkbox"/>	<input type="checkbox"/> Single <input type="checkbox"/> Married				

*This information is used for internal purposes only and will not be disclosed.

Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Life products underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Section E – Medical Coverage

Plan Name, In Network Coinsurance, Deductible Options

Optional Benefits

Select ONE Plan...then select ONE Individual Deductible and any optional benefits.

Total Family Deductible is two (2) times the amount shown.

SmartSense® Plus

- (50% coinsurance) \$500 \$1,000 \$1,500 \$2,500
- (30% coinsurance) \$500 \$1,000 \$1,500 \$2,500
 \$3,500 \$5,000 \$10,000

Upgrade Drug Coverage

Premier Plus

- (20% coinsurance) \$500 \$1,000 \$1,500 \$2,500
 \$1,500 - no office visit copay
- (0% coinsurance) \$2,500 \$3,500 \$5,000 \$10,000
 \$2,500 - no office visit copay

Upgrade Drug Coverage

Add Maternity Coverage
 (available on \$2,500 or higher deductible options)

CoreShare

- (50% coinsurance) \$750 \$1,500 \$2,500 \$3,500 \$5,000
- (0% coinsurance) \$7,500 \$10,000 \$15,000 \$25,000

HSA Compatible Plans

Select ONE Plan...then select ONE Deductible (Individual/Family).

Lumenos® HSA Plus

- (50% coinsurance) \$1,500/3,000
- (20% coinsurance) \$1,750/3,500
- (0% coinsurance) \$1,500/3,000 \$2,500/5,000
 \$3,500/7,000 \$5,500/11,000

YES, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Anthem's banking partner. (Please fill in your social security number in Section B.)

NO, I DO NOT want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Anthem's banking partner.

Section I – Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare? Yes No
 If yes, give name. _____

Did you or your eligible dependents have creditable coverage within the past 63 days, including any Anthem coverage? (You may be eligible for preexisting credit. Preexisting condition limitations do not apply to applicants under the age of nineteen (19), if applying for non-grandfathered coverage.) Yes No

**The following information must be completed in order for credit to be given.
 Please provide the previous 18 months of coverage.**

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
---	--------------------------

Name and phone number of prior carrier(s)	Reason for cancellation
---	-------------------------

Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Effective Date of Coverage	Cancellation Date of Coverage
--	----------------------------	-------------------------------

Will you be canceling this coverage if approved for Anthem coverage? Yes No

Complete this section if you've had more than one carrier in the last 18 months (attach a separate sheet if necessary).

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
---	--------------------------

Name and phone number of prior carrier(s)	Reason for cancellation
---	-------------------------

Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Effective Date of Coverage	Cancellation Date of Coverage
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Will you be canceling this coverage if approved for Anthem coverage? Yes No

Section J – Healthy Lifestyle (optional)

You and your spouse or domestic partner may qualify for a better rate based on your lifestyle. Complete the section below if you would like to be considered for this special rate.

	Applicant	Spouse or Domestic Partner
1. Have you been tobacco-free for the last 3 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you exercise regularly?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you in excellent health with no ongoing medical conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. How many times a week do you exercise?	<input type="checkbox"/> 0-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-7	<input type="checkbox"/> 0-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-7

Section K – Health History (IMPORTANT: This section has two steps)

STEP 1: Health history questions must be answered by each/every person applying for coverage.

Health History Questionnaire — All Questions Must Be Answered Or The Application Will Be Returned.

GIVE COMPLETE DETAILS IN STEP 2 (page 11) FOR ALL QUESTIONS ANSWERED “YES”.

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

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. We are relying on the information you provide to determine whether you are eligible for coverage. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician(s) to clarify your specific condition. We have the right to review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, do not assume we will review all of your medical records before approving your application. If we issue coverage to you and then discover an act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact, we may rescind your coverage, even after it has been issued. This means that you may lose your health benefits including coverage for treatment already received. Rescission may occur even if we review your medical records or seek medical confirmation of your health information as part of processing your application. Even if you currently have health insurance coverage or had prior coverage with Anthem Blue Cross and Blue Shield, you must fully disclose and answer all health history questions.

	YES	NO		YES	NO
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	<input type="checkbox"/>	<input type="checkbox"/>	6. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following? <i>(all answers must be checked yes or no)</i>		
2. Within the last 12 months have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	A. Headaches requiring prescription medication	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you been prescribed or taken any prescription medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (This includes any prescription samples provided by your physician. If yes, explain in Step 2.)	<input type="checkbox"/>	<input type="checkbox"/>	B. Loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you pregnant or an expectant father, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	<input type="checkbox"/>	<input type="checkbox"/>	C. Sleep apnea/breathing difficulties while sleeping	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have implants, prosthesis or retained hardware?			D. Recurrent fainting, weakness or dizziness	<input type="checkbox"/>	<input type="checkbox"/>
A. Breast implants	<input type="checkbox"/>	<input type="checkbox"/>	E. Paralysis or numbness/tingling in limbs	<input type="checkbox"/>	<input type="checkbox"/>
B. Eye/limb prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	F. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	<input type="checkbox"/>	<input type="checkbox"/>	G. Increased/irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>
D. Joint replacement/internal fixations (i.e. pins, plates, rods etc.), neurostimulators	<input type="checkbox"/>	<input type="checkbox"/>	H. Low or high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
E. Any other prosthesis or implant (other than dental)	<input type="checkbox"/>	<input type="checkbox"/>	I. High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
			J. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
			K. Heartburn (recurrent)	<input type="checkbox"/>	<input type="checkbox"/>
			L. Abnormal and/or Recurrent bleeding (unrelated to menstruation)	<input type="checkbox"/>	<input type="checkbox"/>
			M. Recurrent diarrhea and/or recurrent vomiting	<input type="checkbox"/>	<input type="checkbox"/>
			N. Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
			O. Blood, sugar, and/or protein in urine	<input type="checkbox"/>	<input type="checkbox"/>
			P. Recurrent pain (including back pain)	<input type="checkbox"/>	<input type="checkbox"/>
			Q. Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
			R. Mass, cyst(s), or lump(s) in any body part including breast	<input type="checkbox"/>	<input type="checkbox"/>

Section K – Health History (IMPORTANT: This section has two steps) (continued)

	YES	NO		YES	NO
7. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?			9. Within the last 5 years, have you been advised by a health care professional to reduce alcohol intake?	<input type="checkbox"/>	<input type="checkbox"/>
A. Abnormal Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	10. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	<input type="checkbox"/>	<input type="checkbox"/>
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	<input type="checkbox"/>	<input type="checkbox"/>	11. Within the last five years have you had counseling or treatment for any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in Step 2.)	<input type="checkbox"/>	<input type="checkbox"/>
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)?	<input type="checkbox"/>	<input type="checkbox"/>	A. Obsessive Compulsive Disorder	<input type="checkbox"/>	<input type="checkbox"/>
D. Male infertility	<input type="checkbox"/>	<input type="checkbox"/>	B. Minor depression	<input type="checkbox"/>	<input type="checkbox"/>
E. Female fertility/infertility	<input type="checkbox"/>	<input type="checkbox"/>	C. Anxiety/panic attacks	<input type="checkbox"/>	<input type="checkbox"/>
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart, circulatory or blood disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	D. Attention Deficit Disorder (ADD/ADHD)	<input type="checkbox"/>	<input type="checkbox"/>
G. Kidney, bladder or prostate disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	12. In the last 5 years have you had consultation, been diagnosed, had treatment or treatment recommended for any of the following:		
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	A. Schizophrenia, Major Depression/ BiPolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	B. Eating disorder (i.e. anorexia/bulimia)	<input type="checkbox"/>	<input type="checkbox"/>
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	13. Within the last 5 years, have you consulted with a health care provider for, or been diagnosed with, or treated for drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	14. Within the 5 years been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	<input type="checkbox"/>	<input type="checkbox"/>
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	15. Within the 5 years been diagnosed with hepatitis? (check all types that apply)	<input type="checkbox"/>	<input type="checkbox"/>
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	<input type="checkbox"/>	<input type="checkbox"/>	A. Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>
N. Psoriasis, rosacea, acne or skin disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	B. Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
O. Cataract, glaucoma, eye or ear disorder(s)	<input type="checkbox"/>	<input type="checkbox"/>	C. Hepatitis C, D, E	<input type="checkbox"/>	<input type="checkbox"/>
P. Diabetes, thyroid, endocrine glands	<input type="checkbox"/>	<input type="checkbox"/>			
8. Within the last 5 years, have you consulted with a health care provider for, or been diagnosed with, or treated for alcoholism or abuse of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>			

Section K – Health History (IMPORTANT: This section has two steps) (continued)

	YES	NO		YES	NO
16. Within the 5 years been diagnosed with, or treated for any of the following?			17. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	<input type="checkbox"/>	<input type="checkbox"/>
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment	<input type="checkbox"/>	<input type="checkbox"/>	18a. Within the last five years, have you had any illness, physical injury, persisting or new physical and/or health problems not mentioned elsewhere on this application that have not been evaluated or that you plan to have evaluated by a licensed health practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
B. Ankylosing Spondylitis, Alzheimer’s Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Diabetes, Emphysema, Gaucher’s Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson’s Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma.	<input type="checkbox"/>	<input type="checkbox"/>	18b. Within the last two years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	<input type="checkbox"/>	<input type="checkbox"/>
			19. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>

Prescription Medications

List **ALL** prescription medications taken within the last 12 months by any family member listed on this application (if not indicated in Step 2.)

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (mm/dd/yyyy)	Date Discontinued (mm/dd/yyyy)	Name, Phone No. of Physician or Hospital
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____
					Name: _____ Phone: _____

Please check box if an additional sheet(s) of paper has been completed for this section.

Section K – Health History (IMPORTANT: This section has two steps) (continued)

STEP 2: If you answered “YES” to any of the health history questions, give complete details (see the example below)

Question Number	Patient First Name	Physician Name & Telephone (with area code)	Specific Diagnosis & Treatment	Name & Dosage of Medication & Dates of Use		Duration of Condition		Was Surgery Performed?		Description of Surgery/ Procedures & Date(s) (mm/yyyy)	Current Status
				Begin (mm/yyyy)	End (mm/yyyy)	Begin (mm/yyyy)	End (mm/yyyy)	YES	NO		
#18b	Mary	Dr Joe Doe 555 555-1000	Tonsillitis	Amoxicillin 250 mg 4x day		08/2009	09/2009	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy 09/2009	Good
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
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								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		
								<input type="checkbox"/>	<input type="checkbox"/>		

Please check box if an additional sheet(s) of paper has been completed for this section.

Section L – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- 1. I understand that it is mandatory that I notify Anthem, in writing, immediately if I (the applicant) or any other person for whom coverage is sought received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date. I understand that in this situation, Anthem has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be delayed or reformed or, for applicants age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, benefits denied due to the illness, injury or condition being treated as a preexisting condition.**
- I understand that sending my initial premium with this application, and the receipt of my payment by Anthem, does not mean that coverage has been approved. I may not assign any payment under my Anthem program. I am applying for the coverage selected on this application. I understand that any premium quote provided is preliminary and review of my application by medical underwriting may change the premium or result in a denial of coverage. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that if my application is denied, my bank account or credit card will not be charged.
- 3. For applicants age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, I understand that preexisting conditions are limited to 12 months after enrollment for conditions in existence within 12 months immediately prior to my enrollment for which medical advice, diagnosis, care or treatment was recommended or received. Pregnancy is considered a preexisting condition.**
- I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
- I understand Anthem may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem automatic debit process and will only occur each time I send a check to Anthem. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
- 7. I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.**
- I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is mentally competent; he or she is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
- If I purchase optional dental coverage for the Dental Blue[®] Essential, I understand that I will have a twelve month waiting period for coverage of Major Restorative Services. *(For a description of Preventive, Diagnostic and Major Restorative services please refer to your marketing materials.)*
- By signing this application I certify that I understand that Anthem Life has the right to deny my application for Term Life Insurance Coverage, and if it does, I will be notified in writing. I understand that if Anthem Life declines this coverage, no benefits will be payable. I understand that I alone am responsible for reading and accurately completing this application, and I must communicate any changes to my status. I also understand that all other conditions of my medical application apply for the life application.
- If the plan I purchase offers a maternity rider, and I purchase that maternity rider, I understand that 1) these benefits apply only to me or my covered spouse and not to any dependent child and 2) these benefits will not begin until after my membership has been in effect for 18 months.
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).

If tobacco use question in Section B or Section C is answered "NO", I understand that the signature(s) shown on the following page will attest to non-tobacco usage for the past 12 months.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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

Section L – Significant Terms, Conditions and Authorizations (TERMS) (continued)

SIGN HERE	Signature of Applicant <i>(or Custodial Parent's or Guardian's signature if applicant is under age 18)</i> X	Date
	Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) X	Date
	Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

Section M – Agent Certification

To be completed by your Anthem-appointed agent:

1. Does the applicant intend to replace, discontinue or change any existing life policy or annuity contract? Yes No

2. Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting? Yes No

3. I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent Signature X		Date
Agent Name (please print) Scott Blackford	Agent Street Address/Suite No./Personal Mail Box(PMB)No. Scott Blackford, #187 11650 Olio Rd., Suite 1000	
Agent ID No. 705657	City/State/Zip Fishers, IN 46037	County Code Area
Agent Phone No. 317.842.2210	Agent Fax No. 317-842-2243	Agent Email Address info@indianainsurancegroup.com

Authorization for Use of Protected Health Information

The following authorization must be signed by all of the following persons if they are applying for coverage or changing existing coverage:

- the applicant;
- the applicant's spouse or domestic partner; and
- any Dependent Child age 18 or over.

If the authorization is not signed by all of the persons listed above who are seeking coverage, the application may be returned to you as incomplete or acted upon without regard to any person whose required signature was not included. This Authorization will expire 24 months following Anthem Insurance Companies, Inc.'s or Anthem Life Insurance Company's acceptance of coverage, if not previously revoked.

By signing below:

I authorize Anthem Insurance Companies, Inc. or Anthem Life Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Insurance Companies, Inc. or Anthem Life Insurance Company, to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations.

I also authorize any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans, medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations to furnish any medical records or health history information concerning me and any family member listed on my Application to Anthem Insurance Companies, Inc. or Anthem Life Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Insurance Companies, Inc. or Anthem Life Insurance Company. This information is needed to determine eligibility for coverage and Anthem Insurance Companies, Inc. or Anthem Life Insurance Company's acceptance of coverage requested for myself and/or any family members listed on my Application or so that a determination of coverage regarding a claim for specified benefits can be made.

This authorization is subject to revocation at any time by written notice to Anthem except to the extent that Anthem has already taken action in reliance on this authorization. If I revoke this authorization after I initially apply for coverage, I understand that I/we will not be considered for coverage. If I revoke this authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that if my and/or my family's information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans governed by federal privacy regulations, my/our information might be re-disclosed by any of those recipients and will not be protected by federal privacy regulations. A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

SIGN HERE	X Printed name of Applicant/Member	X Signature of Applicant/Member or his/her Legal Representative	Date
	X Printed name of Spouse or Domestic Partner or Dependent Child* age 18 or over listed on Application	X Signature of Spouse or Domestic Partner or Dependent Child* or his/her Legal Representative	Date
	X Printed name of Dependent Child* age 18 or over listed on Application	X Signature of Dependent Child* or his/her Legal Representative	Date

**If listed on your application or change form, your spouse/domestic partner and each dependent child age 18 or over must sign above.
If a legal representative signs on behalf of the applicant or spouse or domestic partner, a copy of the legal representative's authority must be attached to the application.
A photocopy of this form will be as valid as the original. You or an authorized representative have the right to receive a copy of this Authorization upon request.*

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If you have an Anthem agent, please mail directly to:
your Anthem agent.

If you do NOT have an Anthem agent, please mail to:

Anthem Blue Cross and Blue Shield
P.O. Box 37810
Louisville, KY 40233-7810