

Instructions

1. Print clearly and complete this application in ink.
2. For each person to be covered, provide all requested information.
3. Enclose your initial premium. Your check will be cashed upon receipt.
4. Primary applicant listed in Section 1 must initial and date any corrections. Do not use correction fluid.
5. Important: Failure to follow these instructions will cause a delay in processing your application.

Conversion Program

1. Applicant Information For Each Person To Be Covered

Check here if this is a change or an addition to an existing policy or a previously submitted application.

Last Name(s)	First	M.I.	Social Security Number	Sex M F	Birthdate (mm/dd/yyyy)	Current Age	Full-Time College Student? YES NO
Primary Applicant			: : : :	M F <input type="checkbox"/> <input type="checkbox"/>	/ /		N/A
Spouse or Domestic Partner			: : : :	M F <input type="checkbox"/> <input type="checkbox"/>	/ /		N/A
Child			: : : :	M F <input type="checkbox"/> <input type="checkbox"/>	/ /		Y N <input type="checkbox"/> <input type="checkbox"/>
Child			: : : :	M F <input type="checkbox"/> <input type="checkbox"/>	/ /		Y N <input type="checkbox"/> <input type="checkbox"/>
Child			: : : :	M F <input type="checkbox"/> <input type="checkbox"/>	/ /		Y N <input type="checkbox"/> <input type="checkbox"/>

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

Home Address (Street or Rural Route required - do not use P. O. Box)	City	State	Zip
Billing Address (If different than above)	City	State	Zip
<input type="checkbox"/> Check here if correspondence should be mailed to the billing address.		Email Address	
Primary Applicant's Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Other: _____			
Telephone number(s)	()	()	()
	Day	Evening	Fax

2. Program Selection (No medical qualification needed)

A. Please choose a deductible: \$750 \$1,500 \$2,500

B. Type of Coverage (Select One):

- Single Single + One Minor Applicant & Spouse or Domestic Partner only Single + Multiple Minors Family

C. Desired Start Date (mm/dd/yyyy) _____ NOTE: We will notify you of your actual start date in writing.

3. Optional Coverage

Add Preventative Care and Immunizations for Children coverage to my policy (covers all children on policy through age 6).

4. Other Insurance Information

This Section is very important and must be completed.

A. YES NO

- Will this program be in addition to any current health care coverage?

If YES, please provide type of coverage and name of insurance company:

- Group Individual COBRA Insurance company: _____

B. YES NO

- Will this program replace coverage currently in use?

If YES, please provide reason for changing coverage:

- My current employer's Anthem Blue Cross and Blue Shield (or its subsidiaries) group coverage is being replaced by a new insurance carrier. I am either no longer insurable under the replacement coverage, or the replacement carrier requires a new waiting period.
- I am leaving my employer and will no longer be eligible for group coverage.
- My Virginia residence makes me no longer eligible for my coverage through Blue Cross Blue Shield of _____ (or its subsidiaries).
- I am no longer eligible as a dependent.
- Other:

C. YES NO

- Is any person to be covered eligible for Medicare? (*Medicare is a health insurance program for people 65 years of age and older, certain younger disabled people, and people with permanent kidney failure.*)

If YES, list first name(s):

D. YES NO

- Is any person to be covered eligible for or enrolled in Medicaid? (*Medicaid is a jointly-funded, Federal-State health insurance program for certain individuals and families with low incomes or resources.*)

If YES, list first name(s):

E. YES NO

- Has any applicant been covered by Anthem Blue Cross and Blue Shield within the past 12 months?

If YES, list the complete policy numbers for all Anthem policies:

F. YES NO

- Is employer provided health insurance coverage available to any person either as an employee or a dependent, even if they haven't taken it?

If YES, complete the chart below. (*If everyone listed on the application is eligible for the same coverage, simply write "All" on the first line.*)

First Name	Type of Coverage	Employer Offering Coverage Name & Phone Number
	<input type="checkbox"/> Active Employee <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree	
	<input type="checkbox"/> Active Employee <input type="checkbox"/> COBRA <input type="checkbox"/> Retiree	

4. Other Insurance Information (continued)

G. YES NO

Has any person to be covered had any health insurance coverage within the past 12 months?

If YES, complete the chart below for each person to be covered who has had insurance coverage within the past 12 months. If any person has had more than one policy within the past two years, please complete a line for each policy. (If everyone listed on the application had the same coverage, please write "All" on the first line.)

If NO, skip to Section 5.

First Name(s)	Beginning Date of Coverage	Ending Date of Coverage	Type of Coverage	Insurance Company or HMO	Reason for Ending Coverage
	<input type="checkbox"/> More than 2 years ago OR <input type="checkbox"/> ____ / ____ / ____ MM DD YYYY	<input type="checkbox"/> Will end when this coverage begins <input type="checkbox"/> Will keep current coverage OR <input type="checkbox"/> ____ / ____ / ____ MM DD YYYY	<input type="checkbox"/> Employer provided <input type="checkbox"/> Individually purchased (<i>not through employer</i>) <input type="checkbox"/> COBRA <input type="checkbox"/> Other: _____	<input type="checkbox"/> Anthem Blue Cross Blue Shield <input type="checkbox"/> Another Blue Cross Blue Shield <input type="checkbox"/> Other: _____	<input type="checkbox"/> Cost/Benefits <input type="checkbox"/> Left job/Retirement <input type="checkbox"/> Coverage no longer offered <input type="checkbox"/> Aging off parents/guardian policy <input type="checkbox"/> COBRA ended <input type="checkbox"/> Other: _____
	<input type="checkbox"/> More than 2 years ago OR <input type="checkbox"/> ____ / ____ / ____ MM DD YYYY	<input type="checkbox"/> Will end when this coverage begins <input type="checkbox"/> Will keep current coverage OR <input type="checkbox"/> ____ / ____ / ____ MM DD YYYY	<input type="checkbox"/> Employer provided <input type="checkbox"/> Individually purchased (<i>not through employer</i>) <input type="checkbox"/> COBRA <input type="checkbox"/> Other: _____	<input type="checkbox"/> Anthem Blue Cross Blue Shield <input type="checkbox"/> Another Blue Cross Blue Shield <input type="checkbox"/> Other: _____	<input type="checkbox"/> Cost/Benefits <input type="checkbox"/> Left job/Retirement <input type="checkbox"/> Coverage no longer offered <input type="checkbox"/> Aging off parents/guardian policy <input type="checkbox"/> COBRA ended <input type="checkbox"/> Other: _____

5. HIPAA Qualification Information

HIPAA is the Health Insurance Portability and Accountability Act. HIPAA enacted reforms in both the group and individual health insurance markets, in part, to help many individuals maintain insurance coverage if they lose or leave their jobs.

Please read section A below to determine if you are an “Eligible Individual” as defined by HIPAA.

A. In this section, when we say Eligible Individual, we mean someone who meets **ALL of the requirements (1 through 7)** listed below.

HIPAA Requirements: A HIPAA Eligible Individual is defined as someone who:

1. has had 18 months of prior creditable coverage (including group health plans, qualifying health insurance coverage, Medicare, Medicaid CHAMPUS/TRICARE, or other publicly sponsored program)*;
2. was most recently covered under an employer group health plan, governmental plan or church plan*;
3. has elected and exhausted COBRA or similar state continuation of benefits coverage, if it was available;
4. is not eligible for any other group coverage, Medicare, or Medicaid;
5. does not have other health insurance;
6. has had no more than a 63 day break in coverage, unless waiting for a period of time to expire before group coverage was effective; and
7. has not had previous coverage terminated for fraud or non-payment of premium.

* *If the most recent creditable coverage is individual health insurance, and the insurer offering it exits the individual health insurance market and cancels the policyholder's coverage, then only 12 months, and not 18 months, of prior creditable coverage is required.*

If you meet all seven HIPAA requirements listed above, you are a HIPAA Eligible Individual. Please list the first names of all qualifying HIPAA Eligible Individuals in the space below.

First Name(s) of HIPAA Eligible Individual(s)

Important: Please attach copies of any certification or other documentation of prior creditable coverage furnished by previous carriers or employers, if available. This will help us process your application.

6. Certification

This section must be signed and dated to avoid delays in processing.

A. Certification

I and my agent (if applicable) certify that I have read or have had read to me this completed application. I understand that any answer or statement made within this application that is untrue and is material to the risk assumed by Anthem Blue Cross and Blue Shield may prevent the recovery of benefits under the policy for that individual or individuals to be covered. Such answer or statement may also result in the termination or voiding of the policy back to its start date for the individual or individuals for whom the untrue and material information was provided.

I understand that:

1. no coverage will be in force until my application is approved by the Company and that the start date will be the date assigned by the Company;
2. the Anthem policy does not provide coverage for pre-existing health conditions for the first 12 months after the policy start date. I understand that if I have been covered by eligible health insurance before the Anthem policy, the 12 month waiting period may not apply to me, or the waiting period may be shorter than the entire 12 months; and
3. my enclosed premium will be applied to coverage for approved person(s); the premium will be refunded if no persons are approved for the coverage selected AND no other coverage is accepted.

I understand that the policy that I am applying for is an individual health insurance policy. As such, I understand that the policy, if issued, shall not be used as an employer-provided health care benefit plan. I certify that no employer of any person covered under this policy may pay any premium for this coverage, directly or indirectly, including through wage adjustment. I understand that "employer" does not include a trade or business wholly owned by an individual, or individual and spouse, that has no other employees or that does not offer health benefits to any other employees. Also, as it pertains to this provision, a church may purchase an individual policy if only purchasing it for one employee.

I understand that premiums not paid in accordance with this provision shall result in the non-renewal or discontinuance of the policy issued from this application.

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Anthem Blue Cross and Blue Shield. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: _____(Date)

PLEASE NOTE: A copy of the "Notice to Applicant" was delivered to me upon signature.

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Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc.
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