

## Instructions

1. Print clearly and complete this application in ink.
2. For each person to be covered, provide all requested information.
3. Sign and date any additional attachments.
4. Primary policyholder 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.

# Policy Upgrade Application

This application can be used to upgrade or apply for a better underwriting level for the following policies, or to add the Enhanced Drug Benefit for KeyCare HealthSmart.

- |                            |   |   |                       |
|----------------------------|---|---|-----------------------|
| ■ Basic BlueCare®          | ■ KeyCare® HSA                                    | ■ Lumenos® Health Incentive Account (HIA)           | ■ Option I            |
| ■ Basic KeyCare®           | ■ KeyCare HealthSmart®                            | ■ Lumenos® Health Incentive Account Plus (HIA Plus) | ■ Option II           |
| ■ Essential KeyCare®       | ■ KeyCare HealthSmart® with Enhanced Drug Benefit | ■ Lumenos® Health Savings Account (HSA)             | ■ Virginia Advantage® |
| ■ Healthy Virginian        | ■ KeyCare Preferred®                              |   | ■ Virginia Basic      |
| ■ Individual KeyCare®      |   |   | ■ Virginia Select     |
| ■ KeyCare Flexible Choice® |   |   |                       |

## 1. Primary Policyholder Information

Primary Policyholder Last Name	First	M.I.	Social Security Number : : : :	
Home Address (Street or Rural Route required - do not use P. O. Box)		City	State	Zip
Mailing Address (if different from Home)		City	State	Zip
Identification Number (as shown on your ID card)		Email Address		
Telephone number(s)	( ) Day	( ) Evening	( ) Fax	

## 2. Family Information

Please select one of the following:

- For changes to Deductible, Coinsurance or Out-of-Pocket, complete information for ALL members on the policy.
- To add the Enhanced Drug Benefit to your HealthSmart plan, complete information for ALL members on the policy.
- For applications to lower the underwriting level, complete ONLY the information that applies to those members on the policy requesting to have their underwriting level reviewed.

Last Name(s)	First	M.I.	Social Security Number	Sex M F	Birthdate (mm/dd/yyyy)	Height FT. IN.	Weight LBS.
Primary Policyholder			XXX   XX   XXXX	M F <input type="checkbox"/> <input type="checkbox"/>	/ /		
Name of <input type="checkbox"/> Spouse or <input type="checkbox"/> Domestic Partner			: : : :	M F <input type="checkbox"/> <input type="checkbox"/>	/ /		
Child			: : : :	M F <input type="checkbox"/> <input type="checkbox"/>	/ /		
Child			: : : :	M F <input type="checkbox"/> <input type="checkbox"/>	/ /		
Child			: : : :	M F <input type="checkbox"/> <input type="checkbox"/>	/ /		

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





## 5. Add or Delete Optional Coverage(s)

Optional coverage(s) may be added within 31 days of your policy anniversary date (or policy renewal for Healthy Virginian) or a qualifying event.

A qualifying event occurs when any of the following occurs to a covered person:

- Marriage
- Divorce or legal separation
- Reaching age 65 or becoming eligible for Medicare benefits
- Birth or adoption of a child
- Adding or deleting a dependent from the policy
- Death
- Beginning active duty with the Armed Services
- A change or loss of job for policyholder, spouse or domestic partner
- A court order
- Reaching age 19, (or 23, if a full-time student) if a covered dependent child on Healthy Virginian
- Reaching age 23 if a covered dependent child on any other policy

Please Indicate The Reason For Making Change	
<input type="checkbox"/>	Anniversary or Renewal date, depending on product
<input type="checkbox"/>	Qualifying event Type of qualifying event (see list above) _____ Date of qualifying event: _____

### A. Maternity Coverage

This coverage is available for:

- |                           |                            |                     |                      |
|---------------------------|----------------------------|---------------------|----------------------|
| ■ Basic BlueCare          | ■ KeyCare HSA              | ■ KeyCare Preferred | ■ Option I           |
| ■ Basic KeyCare           | ■ KeyCare HealthSmart      | ■ Lumenos HIA       | ■ Option II          |
| ■ Individual KeyCare      | ■ KeyCare HealthSmart with | ■ Lumenos HIA Plus  | ■ Virginia Advantage |
| ■ KeyCare Flexible Choice | Enhanced Drug Benefit      | ■ Lumenos HSA       | ■ Virginia Basic     |

The start date of this coverage will be the first of the month following approval of this application.

\_\_\_\_\_ Add Maternity coverage\*  
INITIAL HERE

\* For all policies, except Option II, the primary policyholder must initial above and read the following to add Maternity Coverage:

My initials show that I understand the following: 1) conception must occur at least 6 months after the Maternity Coverage start date; and 2) this Maternity Coverage is only available to a female applicant or female spouse/domestic partner age 18 or older, or a female emancipated minor.

Delete Maternity coverage

### B. Dental Coverage

This coverage is available for:

- |                      |                           |                            |                      |
|----------------------|---------------------------|----------------------------|----------------------|
| ■ Basic BlueCare     | ■ KeyCare Flexible Choice | ■ KeyCare HealthSmart with | ■ Lumenos HIA Plus   |
| ■ Basic KeyCare      | ■ KeyCare HSA             | Enhanced Drug Benefit      | ■ Lumenos HSA        |
| ■ Essential KeyCare  | ■ KeyCare HealthSmart     | ■ KeyCare Preferred        | ■ Virginia Advantage |
| ■ Individual KeyCare |                           | ■ Lumenos HIA              | ■ Virginia Basic     |

For Individual KeyCare, Virginia Advantage and Virginia Basic, the effective date of this coverage will be the date of your policy anniversary or the first of the month following receipt of your changes due to a qualifying event.

For all other products, this coverage can be added the first of the following month after approval of this application.

Add Dental coverage

Delete Dental coverage

Please note: If deleting this coverage, it may not be added back to your policy until 24 months after the date it was deleted.

**5. Add or Delete Optional Coverage(s) (continued)**

**C. Supplemental Accident Coverage**

This coverage is available for:

- |                     |                           |                            |                      |
|---------------------|---------------------------|----------------------------|----------------------|
| ■ Basic BlueCare    | ■ Individual KeyCare      | ■ KeyCare HealthSmart      | ■ KeyCare Preferred  |
| ■ Basic KeyCare     | ■ KeyCare Flexible Choice | ■ KeyCare HealthSmart with | ■ Virginia Advantage |
| ■ Essential KeyCare | ■ KeyCare HSA             | Enhanced Drug Benefit      | ■ Virginia Basic     |

*The start date of this coverage will be the date of your policy anniversary or the first date of the month following receipt and approval of your changes due to a qualifying event.*

- Add Supplemental Accident coverage
- Delete Supplemental Accident coverage

*Please note: If deleting this coverage, it may not be added back to your policy until 24 months after the date it was deleted.*

**D. Preventive Care and Immunizations for Children**

This coverage is only available for children ages 6 or younger who have:

- |                           |             |
|---------------------------|-------------|
| ■ Essential KeyCare       | ■ Option I  |
| ■ KeyCare Flexible Choice | ■ Option II |
| ■ Healthy Virginian       |             |

*The start date of this coverage will be the date of your policy anniversary for Option I, Option II, Essential KeyCare and KeyCare Flexible Choice or policy renewal for Healthy Virginian, your newborn's date of birth or the date of placement of an adopted child, or the first of the month following the receipt and approval of your changes due to a qualifying event.*

- Add Preventive Care and Immunizations for Children coverage
- Delete Preventive Care and Immunizations for Children coverage

*This coverage may be deleted at your policy anniversary for Option I, Option II and Essential KeyCare, or policy renewal for Healthy Virginian, or at the end of the month the child(ren) turns age 7.*

**E. Enhanced Drug Benefit**

This coverage is only available for:

- KeyCare HealthSmart with Enhanced Drug Benefit

*The start date of this coverage will be the first of the month following approval of this application.*

- Add Enhanced Drug Benefit coverage\*\*  
(Underwriting is required for this change.)

*\*\* Choosing this disqualifies KeyCare HealthSmart as a high deductible health plan compatible with a Health Savings Account (HSA).*

- Delete Enhanced Drug Benefit coverage

*Please note: Filled prescriptions from the effective date of the deletion of this coverage will become subject to your annual major medical deductible.*

**F. Choose Optional HSA Coverage**

This coverage is only available for:

- Lumenos HSA

Do you want to add a Health Savings Account (HSA)? Please answer below:

- Yes, I would like to establish a HSA. Please forward my information to Anthem's banking partner.
- No, I do not want to establish a HSA. Please do not forward my information to Anthem's banking partner.

## 6. Lifestyle Information

### A. Within the past 12 months, has any person to be covered used any tobacco product(s)?

YES NO

If YES, please complete the following (even if you currently do not use a tobacco product):

First Name: _____ Tobacco Product: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Other: _____
If cigarettes, number smoked per day during the past 12 months: <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-39 <input type="checkbox"/> 40-49 <input type="checkbox"/> 50 or more
First Name: _____ Tobacco Product: <input type="checkbox"/> Cigarettes <input type="checkbox"/> Other: _____
If cigarettes, number smoked per day during the past 12 months: <input type="checkbox"/> 1-10 <input type="checkbox"/> 11-20 <input type="checkbox"/> 21-39 <input type="checkbox"/> 40-49 <input type="checkbox"/> 50 or more

If any person to be covered has used any tobacco product within the past 12 months but has stopped using all tobacco products, please provide the name of the person and the date he/she stopped.

First Name: \_\_\_\_\_ Date Stopped: \_\_\_\_\_

### B. Within the past 12 months, has any person to be covered consumed alcoholic beverages?

*(Note: Even if you drink only on occasion, please provide the number of drinks you consume on such occasions.)*

YES NO

If YES, please complete the following (*One drink equals 12 oz. of beer, 4 oz. of wine, or 1 oz. of liquor.*):

First Name: _____ Number of drinks consumed per week: <input type="checkbox"/> 0-7 <input type="checkbox"/> 8-14 <input type="checkbox"/> 15-20 <input type="checkbox"/> 21-26 <input type="checkbox"/> 27-35 <input type="checkbox"/> 36 or more
First Name: _____ Number of drinks consumed per week: <input type="checkbox"/> 0-7 <input type="checkbox"/> 8-14 <input type="checkbox"/> 15-20 <input type="checkbox"/> 21-26 <input type="checkbox"/> 27-35 <input type="checkbox"/> 36 or more

### C. Within the past 12 months, has any person to be covered used marijuana?

YES NO

If YES, please complete the following:

First Name: _____ Frequency of use per month during the past 12 months: _____
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### D. Within the past 5 years, has any person to be covered used cocaine, heroin, ecstasy, LSD or any other illicit drug(s)?

YES NO

If YES, please complete the following:




First Name(s): _____
----------------------

## 7. Medical Information







 When you see this symbol and are answering YES to that question, an additional questionnaire is required. Please contact your sales agent.

All applicants must answer all 43 questions.

Questions 1-18: In his/her lifetime, has any person to be covered been treated for, diagnosed by or consulted a physician, psychotherapist, counselor, or any other provider, or had indications of having any of the following illnesses, injuries, or conditions?

- | YES   | NO                       |  | YES   | NO                       |   |
|---|--------------------------|--|---|--------------------------|---|
| <input type="checkbox"/>  | <input type="checkbox"/> | 1. Acquired Immunodeficiency Syndrome or Human Immunodeficiency Virus (must have been diagnosed) | <input type="checkbox"/>  | <input type="checkbox"/> | 11. Heart disease, disorders or heart surgery, pacemaker or valve replacements  |
| <input type="checkbox"/>  | <input type="checkbox"/> | 2. Alcoholism  | <input type="checkbox"/>  | <input type="checkbox"/> | 12. Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C  |
| <input type="checkbox"/>  | <input type="checkbox"/> | 3. Cancer, Kaposi's Sarcoma, or Leukemia   |   |                          | <input type="checkbox"/> Chronic <input type="checkbox"/> Alcoholic   |
| <input type="checkbox"/>  | <input type="checkbox"/> | 4. Crohn's disease or Ulcerative Colitis   |   |                          | <input type="checkbox"/> Other: _____   |
|  | <input type="checkbox"/> | 5. Diabetes <input type="checkbox"/> Treated with Insulin  | <input type="checkbox"/>  | <input type="checkbox"/> | 13. Kidney disease or disorders, including kidney stones  |
|   |                          | <input type="checkbox"/> Other: _____  | <input type="checkbox"/>  | <input type="checkbox"/> | 14. Liver disorders or disease (including Cirrhosis), or disease or disorders of the pancreas   |
| <input type="checkbox"/>  | <input type="checkbox"/> | 6. Disorders of the spine or disc(s)   | <input type="checkbox"/>  | <input type="checkbox"/> | 15. Lung disorders or lung disease, including emphysema, tuberculosis, or chronic obstructive pulmonary disease (COPD). (If Asthma, see question 22 below.) |
| <input type="checkbox"/>  | <input type="checkbox"/> | 7. Disease or disorders of the circulatory system  | <input type="checkbox"/>  | <input type="checkbox"/> | 16. Multiple Sclerosis, paralysis, or cerebral palsy  |
| <input type="checkbox"/>  | <input type="checkbox"/> | 8. Drug dependency/habit   |  | <input type="checkbox"/> | 17. Seizures (other than epilepsy)  |
|  | <input type="checkbox"/> | 9. Epilepsy Date of last seizure: _____<br>(mm/yyyy)   |   |                          | Date of last seizure: _____<br>(mm/yyyy)  |
|   |                          | Type:  |   |                          | Type: _____   |
|   |                          | <input type="checkbox"/> Grand Mal <input type="checkbox"/> Petit Mal                            |   |                          |   |
|   |                          | <input type="checkbox"/> Other: _____  | <input type="checkbox"/>  | <input type="checkbox"/> | 18. Spina bifida, cleft palate or lip, or other congenital disorders  |
| <input type="checkbox"/>  | <input type="checkbox"/> | 10. Heart attack, angina, or stroke  |   |                          |   |

Questions 19-37: Within the past 10 years, has any person to be covered been treated for, diagnosed by, or consulted a physician, psychotherapist, counselor, or any other provider, or had indications of having any of the following illnesses, injuries, or conditions?

- | YES   | NO                       |  | YES   | NO                       |  |
|---|--------------------------|--|---|--------------------------|--|
| <input type="checkbox"/>  | <input type="checkbox"/> | 19. Allergies (hay fever, etc.)  | <input type="checkbox"/>  | <input type="checkbox"/> | 28. Disease or disorders of the joints (knees, shoulder, etc.)   |
|   |                          | <input type="checkbox"/> Immunotherapy   | <input type="checkbox"/>  | <input type="checkbox"/> | 29. Disorders of the reproductive system (male or female)  |
|   |                          | Date of last shot: _____<br>(mm/yyyy)  | <input type="checkbox"/>  | <input type="checkbox"/> | 30. Disease or disorders of the stomach or intestines, including gastroesophageal reflux disease (GERD)                            |
|   |                          | <input type="checkbox"/> Seasonal prescription medication  |  | <input type="checkbox"/> | 31. Genital Warts, Herpes Simplex II, or other sexually transmitted disease(s)   |
|   |                          | <input type="checkbox"/> Other: _____  | <input type="checkbox"/>  | <input type="checkbox"/> | 32. Hernia <input type="checkbox"/> Hiatal <input type="checkbox"/> Other (type and location):<br>_____                            |
|  | <input type="checkbox"/> | 20. Anxiety/Depression   |  | <input type="checkbox"/> | 33. Hyperlipidemia, including elevated cholesterol or triglycerides  |
| <input type="checkbox"/>  | <input type="checkbox"/> | 21. Arthritis <input type="checkbox"/> Rheumatoid  |  | <input type="checkbox"/> | 34. Hypertension or high blood pressure  |
|   |                          | <input type="checkbox"/> Osteoarthritis  | <input type="checkbox"/>  | <input type="checkbox"/> | 35. Hyperthyroidism, hypothyroidism, goiter, or other thyroid disease or disorders   |
|   |                          | <input type="checkbox"/> Psoriatic   | <input type="checkbox"/>  | <input type="checkbox"/> | 36. Implant(s), prosthetic device(s), internal fixation device(s), or retained hardware (i.e. pins, wires, screws, shunts, stents) |
|   |                          | <input type="checkbox"/> Other: _____  |  | <input type="checkbox"/> | 37. Other nervous or mental conditions, including bipolar disorder, obsessive-compulsive disorder, or mental retardation           |
|  | <input type="checkbox"/> | 22. Asthma   |   |                          |  |
| <input type="checkbox"/>  | <input type="checkbox"/> | 23. Back pain or other back disorders  |   |                          |  |
| <input type="checkbox"/>  | <input type="checkbox"/> | 24. Bone diseases or disorders   |   |                          |  |
| <input type="checkbox"/>  | <input type="checkbox"/> | 25. Disease or disorders of the ears, nose, or throat  |   |                          |  |
| <input type="checkbox"/>  | <input type="checkbox"/> | 26. Disease or disorders of the eye (does not include corrective vision for near and farsightedness) |   |                          |  |
| <input type="checkbox"/>  | <input type="checkbox"/> | 27. Disease or disorders of the gallbladder, including gallstones                                    |   |                          |  |

**7. Medical Information (continued)**

YES NO

- 38. Within the past 10 years, has any person to be covered had any of the following symptoms: unexplained weight loss, night sweats, persistent fever or cough, prolonged fatigue, mouth infection (including oral thrush if an adult), tumors, chronic/recurrent skin rashes or lesions, recurrent episodes of diarrhea, lymph node enlargement, or unexplained recurrent headaches?
- 39. Within the past 5 years and NOT already answered or described in Questions 1-38, has any person to be covered been treated for, diagnosed by or consulted a physician, psychotherapist, counselor, or any other provider, or had indications of having any illness, injury, or medical abnormality?
- 40. Within the past 5 years and NOT already answered or described in this application, has any person to be covered had abnormal results in any of the following tests: blood work, laboratory results, X-ray, EKG, blood flow studies, MRI scan, or CAT scan?
- 41. Within the past 5 years and NOT already answered or described in this application, has any person to be covered had surgery, been confined in a hospital, or been treated in an emergency room?
- 42. Has any person to be covered been advised of the need for future tests, procedures, surgery, or hospitalization?
- 43. Currently, are you, your spouse/domestic partner, or any dependent child(ren), even if not named in this application, an expectant parent or the child of an expectant parent (includes son or male applicant)?

If YES, name of pregnant individual: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

**8. Medical Charts**

(Use an additional sheet of paper if necessary. All additional pages must be signed and dated by the primary applicant.)

**A. Medical Details**

Where "YES" was answered to any of the questions 1 through 42 in Section 7, list complete details in the chart below. Not providing complete details will delay the application process. Completion of "Dates of Use" section is required if different than "Dates of Condition." (See example below as a guideline.)

Question Number	Patient First Name (and Jr./Sr. if applicable)	Physician Name, Telephone No. (with area code) City & State	Specific Illness/Injury or Condition	Name of Medication and Dates of Use		Dates of Condition		Did Patient Have Surgery?		Surgery/ Procedures and Dates  mm/yyyy
				BEGIN mm/yyyy	END/ CURRENT mm/yyyy	BEGIN mm/yyyy	END/ CURRENT mm/yyyy	YES	NO	
EXAMPLE: #35	John Jr.	Dr. John Doe (804) 555-1000 Richmond VA	Underactive Thyroid		Synthroid 08/2007	06/2007		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Removed Goiter 09/2007
					<input checked="" type="checkbox"/> CURRENT		<input checked="" type="checkbox"/> CURRENT	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
					<input type="checkbox"/> CURRENT		<input type="checkbox"/> CURRENT	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/> CURRENT		<input type="checkbox"/> CURRENT	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/> CURRENT		<input type="checkbox"/> CURRENT	<input type="checkbox"/>	<input type="checkbox"/>	
					<input type="checkbox"/> CURRENT		<input type="checkbox"/> CURRENT	<input type="checkbox"/>	<input type="checkbox"/>	

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

**8. Medical Charts (continued)**

**B. Prescription Drugs**

YES NO  
  FOR MEDICATION(S) NOT already described in this application, within the past 12 months has any physician or provider prescribed, dispensed or injected any medication for any person to be covered?

Patient First Name (and Jr./Sr. if applicable)	Physician Name, Telephone No. (with area code) City & State	Name of Medication and Dates of Use		Condition For Which Medication Was Given
		BEGIN mm/yyyy	END/ CURRENT mm/yyyy	
			<input type="checkbox"/> CURRENT	
			<input type="checkbox"/> CURRENT	
			<input type="checkbox"/> CURRENT	
			<input type="checkbox"/> CURRENT	

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

**C. Physician Information**

If not already described in this application, please provide the following information about any physician(s) seen within the past 2 years for ALL applicants:

Patient First Name (and Jr./Sr. if applicable)	Name of Physician	Telephone Number (with area code)	Specialty

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

---

## 9. Certification and Authorization

*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;
3. if the Maternity Coverage was chosen, conception must occur at least six months after the Maternity Coverage start date;
4. no sales agent or broker is authorized to do any of the following: accept risks; make decisions about policy eligibility; change any policy provision; add terms to any policy; or terminate any policy;
5. benefits provided by this coverage combined with benefits payable under any other health care policy or HMO program will not exceed the allowable charge; and
6. 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/domestic partner, 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. 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.

**9a. Certification (continued)**

<input checked="" type="checkbox"/>	_____	_____	_____	_____
	Signature of Applicant or <i>print and sign name</i> of Legal Representative		Date (mm/dd/yyyy)	
<input checked="" type="checkbox"/>	_____	_____	_____	_____
	Signature of Spouse/Domestic Partner or <i>print and sign name</i> of Legal Representative		Date (mm/dd/yyyy)	
<input checked="" type="checkbox"/>	_____	_____	_____	_____
	Signature of Other Adult Person to be covered or <i>print and sign name</i> of Legal Representative		Date (mm/dd/yyyy)	
<input checked="" type="checkbox"/>	_____	_____	_____	_____
	Signature of Other Adult Person to be covered or <i>print and sign name</i> of Legal Representative		Date (mm/dd/yyyy)	
<input checked="" type="checkbox"/>	_____	_____	_____	_____
	Signature of Agent if applicable		Date (mm/dd/yyyy)	

_____	_____	_____	_____
Agency Number	Agent Number	Agent Name (Please print.)	Receipt Date
( )	( )		
_____	_____	_____	_____
Telephone Number	Fax Number	Email address	

**B. Authorization**

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

The following authorization must be signed by the applicant and other adult persons, including adult dependents (e.g. age 18 or older in Virginia) to be covered. If the applicant does not sign this authorization, coverage may not be issued. If any other adult person to be covered refuses to sign the authorization, any coverage issued will not be extended to that person.

I hereby authorize that:

1. at the request of Anthem Blue Cross and Blue Shield, any provider of health services or supplies, insurance company, organization, institution, or person can release information to Anthem Blue Cross and Blue Shield about health-related services and supplies provided to me, persons covered, or persons to be covered. This authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record;
2. the Medical Review and Underwriting departments or agents of Anthem Blue Cross and Blue Shield, upon receiving this information, can use it to review, investigate, or evaluate any application for an insurance policy, a policy reinstatement, or a request for change in policy benefits;
3. unless previously revoked, this authorization is valid for 30 months from the date I signed it; and
4. a copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

<input checked="" type="checkbox"/>	_____	_____	_____
	Signature of Applicant or <i>print and sign name</i> of Legal Representative		Date (mm/dd/yyyy)
<input checked="" type="checkbox"/>	_____	_____	_____
	Signature of Spouse/Domestic Partner or <i>print and sign name</i> of Legal Representative		Date (mm/dd/yyyy)
<input checked="" type="checkbox"/>	_____	_____	_____
	Signature of Other Adult Person to be covered or <i>print and sign name</i> of Legal Representative		Date (mm/dd/yyyy)
<input checked="" type="checkbox"/>	_____	_____	_____
	Signature of Other Adult Person to be covered or <i>print and sign name</i> of Legal Representative		Date (mm/dd/yyyy)

***If a legal representative signs on behalf of the applicant or any other adult person to be covered, a copy of the legal representative's authority must be attached to the application.***

*This authorization is subject to revocation at any time by written notice to Anthem Blue Cross and Blue Shield except to the extent that Anthem Blue Cross and Blue Shield has already taken action in reliance on this authorization. Any information received by Anthem Blue Cross and Blue Shield pursuant to this authorization is subject to restrictions on disclosure to others as set forth under Federal and state laws.*



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