

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. Policy Selection

A. Choose Policy (For more information, please refer to your sales brochure.)	
<input type="checkbox"/> Lumenos Health Savings Account Standard	<input type="checkbox"/> Virginia Standard
B. Choose Deductible/Coinsurance	
Based on Single (one person) / Family coverage (two or more people)	
Single <input type="checkbox"/> \$1,500/20% <input type="checkbox"/> \$3,000/20% <input type="checkbox"/> \$5,000/0%	<input type="checkbox"/> \$750/20% <input type="checkbox"/> \$1,500/20% <input type="checkbox"/> \$2,500/20% <input type="checkbox"/> \$5,000/0%
Family <input type="checkbox"/> \$3,000/20% <input type="checkbox"/> \$6,000/20% <input type="checkbox"/> \$10,000/0%	
C. Choose Optional Coverage	
<input type="checkbox"/> Add Dental coverage	
<input type="checkbox"/> Add Supplemental Accident coverage (Available for Virginia Standard only.)	
<input type="checkbox"/> _____ Add Maternity coverage * <small>INITIAL HERE</small>	
* The primary applicant above 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. If the female to be covered is an "Eligible Individual" as outlined in Section 4 of this application, and conception occurred prior to the effective date, I understand the 6 month waiting period is waived; 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.	
D. Choose Optional HSA Coverage (Available for Lumenos Health Savings Account Standard only.)	
Do you want to add a Health Savings Account (HSA)?	
<input type="checkbox"/> Yes, I would like to establish a HSA. Please forward my information to Anthem's banking partner.	
<input type="checkbox"/> No, I do not want to establish a HSA. Please do not forward my information to Anthem's banking partner.	
E. Desired Start Date	
(mm/dd/yyyy) _____ NOTE: Your actual start date will be no earlier than the day after your application is received by Anthem or an Anthem representative, and no later than 75 days after the signature date on the application. We will notify you of your actual start date in writing.	

3. Other Insurance Information

This Section is very important and must be completed.

A. 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):

B. 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	

C. YES NO

- Has any person to be covered had any health insurance coverage within the past 90 days?

If YES, complete the chart below for each person to be covered who has had insurance coverage within the past 90 days. 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 4.

First Name(s)	Beginning Date of Coverage	Ending Date of Coverage	Type of Coverage	Insurance Company or HMO	Reason for Ending/ Replacing Coverage
	<input type="checkbox"/> More than 2 years ago OR <input type="checkbox"/> ___ / ___ / ___ MM DD YYYY	<input type="checkbox"/> Will replace current coverage 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"/> 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 replace current coverage 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"/> 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: _____

4. 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.

5. 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 Anthem Blue Cross and Blue Shield and that the start date will be the date assigned by Anthem Blue Cross and Blue Shield;
2. the Anthem Blue Cross and Blue Shield 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 am a HIPPA Eligible Individual or have been covered by eligible health insurance before the Anthem Blue Cross and Blue Shield policy, the 12 month waiting period may not apply to me;
3. if the Maternity Coverage was chosen, conception must occur at least six months after the Maternity Coverage start date. If you are an "Eligible Individual," as outlined in Section 4 of this application, and conception had occurred prior to the start date, the six month waiting period is waived;
4. 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;
5. the Anthem Blue Cross and Blue Shield 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; and
6. benefits provided by Anthem Blue Cross and Blue Shield combined with benefits payable under any other health care policy or HMO program will not exceed the allowable charge.

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.

5. Certification (continued)

X Signature of Applicant or <i>print and sign name</i> of Legal Representative	/ / Date (mm/dd/yyyy)
X Signature of Spouse/Domestic Partner or <i>print and sign name</i> of Legal Representative	/ / Date (mm/dd/yyyy)
X Signature of Other Adult Person to be covered or <i>print and sign name</i> of Legal Representative	/ / Date (mm/dd/yyyy)
X Signature of Other Adult Person to be covered or <i>print and sign name</i> of Legal Representative	/ / Date (mm/dd/yyyy)
X 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	

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.

6. For Lumenos Applicants Only

NOTICE: THIS IS A LIMITED BENEFIT DISCLOSURE FORM. PLEASE SIGN AND DATE BELOW. THE POLICY YOU ARE APPLYING FOR IN THIS APPLICATION DOES NOT MEET THE MINIMUM STANDARDS REQUIRED BY THE BUREAU OF INSURANCE, VIRGINIA STATE CORPORATION COMMISSION, FOR INDIVIDUAL ACCIDENT AND SICKNESS POLICIES.

Minimum Standards were established by the Bureau to insure the availability of health insurance contracts providing a minimum of basic benefits needed for health care. This policy does not meet the Virginia minimum standards for the following reasons:

- the majority of providers are in-network, however a person covered by the attached policy has the option to choose an **out-of-network** provider and still have coverage. Depending on the policy you choose, the responsibility for the cost of covered services may exceed the 25% maximum set by regulation adopted by the Virginia State Corporation Commission; and
- in certain circumstances, if your policy requires a copayment for provider visits, that copayment may be a greater percentage than the 25% mentioned above. In other circumstances, it may be less than 25%.

All other aspects of this policy equal or exceed the minimum requirements of the Bureau of Insurance, State Corporation Commission, for an individual major medical expense policy.

I have read this limited benefit disclosure provision and realize that this policy does not meet minimum standards required by Virginia law and that it can only be sold as a LIMITED BENEFIT POLICY.

X Signature of Applicant or <i>print and sign name</i> of Legal Representative	/ / Date (mm/dd/yyyy)
X Signature of Spouse/Domestic Partner or <i>print and sign name</i> of Legal Representative	/ / Date (mm/dd/yyyy)
X Signature of Other Adult Person to be covered or <i>print and sign name</i> of Legal Representative	/ / Date (mm/dd/yyyy)
X Signature of Other Adult Person to be covered or <i>print and sign name</i> of Legal Representative	/ / Date (mm/dd/yyyy)

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Express Payment Authorization and Credit Card Payment

Take advantage of our easy payment methods!

You can choose to make your **initial premium payment** by check (which will be cashed upon receipt but does not imply approval of your application), money order, or credit card. If choosing to pay by credit card, simply complete all of the credit card payment information in this section of the application.

For **future payments**, consider the convenience of our **free Express Payment service!** You'll find the Express Payment authorization form below. Express Payment saves you time, hassles, and the cost of checks and postage. And you can choose to have your premium deducted on the first or fifth day of the month

A. Express Payment Authorization (Optional)

It's convenient! You can authorize Anthem Blue Cross and Blue Shield to automatically deduct your premium payment from your checking account each month. Once your application is approved, we will work with your bank to initiate this service. Until the service is effective, you will receive a bill in the mail for your monthly premium. We will notify you when your Express Payment service is in effect.

Simply 1) complete the information below, 2) attach a voided check, and 3) remember to include your first month's premium when you return your completed application.

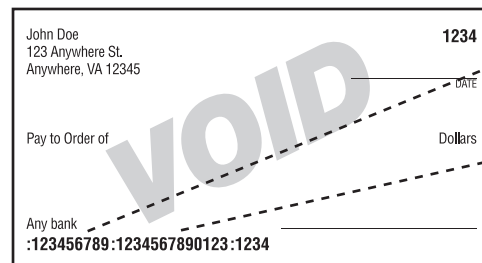
Applicant's Full Name: _____

Full Bank Name: _____

Routing #: _____

Account # (5-17 digits): _____

Date of Month for Express Payment to occur: 1st 5th



Bank Routing/
Transit Number

Bank Account
Number

Be sure to attach a voided check.

I wish to take advantage of the Express Payment bank draft program to pay my Anthem Blue Cross and Blue Shield (Anthem) premiums every month. To do so, I authorize my bank as named above to deduct my Anthem health insurance premium every month directly from my bank account.

The appropriate bank account number and related bank routing number are shown on my enclosed blank, voided check. I understand that I am to pay my premiums directly to Anthem on schedule until my Express Payment bank draft becomes effective. If any premium is owed by me to Anthem when my Express Payment bank draft starts, I authorize my bank to draft both the past due premium along with the current premium. I agree that if my bank does not draft my account and pay my premium, I am responsible for making the correct premium payment to Anthem, no matter what the reason is for my bank's failure to draft and pay. I understand that failure to pay premiums when due can result in the termination of my Anthem health insurance coverage, and I understand my bank is not liable for that loss. This authorization is in effect until I notify Anthem by telephone or in writing delivered to Anthem by mail or by fax.

X _____ / /
Signature (exactly as it appears on bank records) Date (mm/dd/yyyy)

B. Credit Card Authorization for Initial Payment (Optional)

You may choose to make your initial premium payment by check, money order or credit card. Credit card payment is available for your initial premium payment only. If choosing to pay by credit card, you must complete **all** of the following information:

VISA MasterCard

Card Number _____

Expiration Date (mm/yyyy) _____

I authorize Anthem Blue Cross and Blue Shield to bill my VISA or MasterCard account for the initial application payment. If the results of the health underwriting for my policy result in a different premium than my original premium quote, I also authorize Anthem Blue Cross and Blue Shield to bill my VISA or MasterCard for this difference if necessary.

X _____
Applicant's Name (Please print)

Cardholder's Signature _____

_____ / /
Date (mm/dd/yyyy)

Definition of Terms

These terms have been used in the application and have been defined here for your convenience.

- 1. Primary applicant**
The first person listed on the application. This person will be considered the policyholder if approved.
- 2. Domestic partner**
An individual with whom you have been living together six or more months and plan to continue living together, are financially interdependent, is at least 18 years old, not married to anyone else and not related by blood in a way that would prohibit marriage.
- 3. Deductible**
The amount you pay toward health care services each calendar year before receiving certain benefits.
- 4. Coinsurance**
The percentage of the allowable charge you pay for services covered by your policy after you meet your deductible.
- 5. Supplemental Accident coverage**
Coverage for services or supplies used to diagnose or treat an injury caused by an accident. Examples of accidents include: animal bites, choking on food or foreign objects, frostbite, and poisoning.
- 6. Employer coverage**
Insurance that is provided through an employer. The employer pays for some part of the premium for coverage.

Checklist

Please review this checklist before you return your application:

- Did you provide all requested information for each person to be covered? Failure to provide all requested information will cause a delay in the processing of your application.
- Did the Primary Applicant in **Section 1** initial and date any corrections to the application and sign and date any additional attachments?
- Did you read **Section 5** carefully? All adults (*age 18 and over in the state of Virginia*) to be covered must sign and date the **Certification Section**.
- Include the initial premium payment in the form of a check or money order made payable to Anthem, or use the convenient credit card payment option located behind the application. Please refer to the rate quote we mailed to you for the estimated initial premium. If you are approved and your actual premium differs from the estimate, we will notify you once your application has been processed. If your application is not approved, this initial payment will be refunded to you.
- Complete the Express Payment Authorization located behind the application to take advantage of our convenient monthly payment option (*beginning after your initial premium payment mentioned above*).

If you need assistance,

we will be glad to help.