Anthem Blue Cross and Blue Shield

Short Option

Application for Short-Term Major Medical Insurance

1. Applicant Information

Last Name	First	M.I.	Social Security Number / /

Home Address *(Street or Rural Route required - do not use P.O. Box)*	City	State	Zip
Billing Address *(If different from above)*	City	State	Zip

❑ Check here if all correspondence is to be mailed to the billing address. | Email Address:

Birthdate *(mm/dd/yyyy)* ______ / ______ / ______	Sex ❑ M ❑ F	Marital Status ❑ Married ❑ Single ❑ Divorced

Telephone Number(s): Day: ( ) Evening: ( ) Fax: ( )

2. Family Information **for persons to be covered**

Last Name(s) First M.I. (Attach additional sheet of paper if necessary)	Social Security Number	Birthdate *(mm/dd/yyyy)*	Sex	Full Time Student?
Spouse		/ /	❑ M ❑ F	N/A
Child		/ /	❑ M ❑ F	❑ Y ❑ N
Child		/ /	❑ M ❑ F	❑ Y ❑ N
Child		/ /	❑ M ❑ F	❑ Y ❑ N

This question is to be completed by Non-U.S. citizens (Foreign Nationals) only:

YES NO
❑ ❑ Have all Foreign Nationals to be covered lived in the U.S.A. for at least the past two years? If NO, please complete the following:

First Name(s) How long has the individual(s) resided in the U.S.A.?

3. Program Selection **(A deductible and policy term must be selected)**

A. Deductible: ❑ $250 ❑ $500 ❑ $1,000

B. Policy Term: ❑ 30 days ❑ 60 days ❑ 90 days ❑ 180 days

C. Desired Effective Date: *(mm/dd/yyyy)* ______ / ______ / ______

4. Premium Calculation and Payment Method **(No additional premium required for more than 3 children)**

$ __________ + $ __________ + $ __________ + $ __________ + $ __________ = $ __________
policyholder spouse child child child total

Payment Method:

❑ Check ❑ Money Order ❑ Charge - full payment ❑ Charge - 1/2 payment (180 day policies only)

Account Number |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_| Exp. Date __________ ❑ VISA ❑ Mastercard

(This information will be blacked out for your protection after charging the initial premium)

If using a credit card, I authorize Anthem Blue Cross and Blue Shield to bill my VISA or Mastercard account for the total premium. FOR 180 DAY POLICIES ONLY: If I choose to charge my premium, I have the option of having the first half billed to my VISA or Mastercard. Should I choose to use this option, I understand that I will pay the remaining second half of the premium with a check or money order when it becomes due.

Date ______ / ______ / ______ **X** ________________________________
mm *dd* *yyyy* Cardholder's Signature

PLEASE COMPLETE AND SIGN THE OTHER SIDE OF THIS APPLICATION

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

5. Eligibility Information

1. Is any person to be covered eligible for Medicare, or will he or she become eligible for Medicare during the term of this policy? ❑ Y ❑ N
   If Yes, name of the eligible person(s): ______________________
2. Is any person to be covered eligible for employer sponsored group health coverage, but not enrolled? ❑ Y ❑ N
   If Yes, name of eligible person(s): ______________________
   Name of Carrier: ❑ Anthem Blue Cross and Blue Shield ❑ Other: ______________ *(Specify name of carrier)*
3. Will this policy replace any current health insurance (including Anthem Blue Cross and Blue Shield)? ❑ Y ❑ N
   If Yes, name of carrier: ____________ Date coverage ends: ________ ID#: ____________
4. Is any person to be covered already insured by any individual or group hospital, major medical, or medical expense insurance that will not terminate prior to the effective date of this policy? ❑ Y ❑ N
   If Yes, state the name of each person: ______________________
5. **Currently**, are you, your spouse, or any dependent child(ren), even if not named on this application, an expectant parent or the child of an expectant parent (includes son or male applicant)? ❑ Y ❑ N
   Name/Relationship ______________________

6. Certification (must be signed and dated to avoid delays in processing)

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. Such answer or statement may also result in the termination or voiding of the policy back to its effective date.

I understand that:

1. **no coverage will be in force until my application is approved by the Company, the appropriate premium is actually received by the Company, and that the effective date will be the date assigned by the Company;**
2. **coverage is not provided and benefits will not be paid for a health condition that exists prior to the date this policy takes effect;**
3. **I can purchase no more than two Short Option policies in a calendar year and if I purchase two 180 day policies, I must have at least a 60 day break between the two;**
4. **children under three months of age are not eligible for this coverage; and**
5. **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.**

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 discontinuance of the policy issued from this application.

X______________________________ ______________
Signature of Applicant or Legal Representative if applicable — Date *(mm/dd/yyyy)*

X______________________________ ______________
Signature of Spouse or Legal Representative if applicable — Date *(mm/dd/yyyy)*

X______________________________ ______________
Signature of Other Adult Person to be covered or Legal Representative if applicable — Date *(mm/dd/yyyy)*

X______________________________ ______________
Signature of Other Adult Person to be covered or Legal Representative if applicable — Date *(mm/dd/yyyy)*

X______________________________ ______________
Signature of Agent if applicable — Date *(mm/dd/yyyy)*

__ __ __ __ __ __ - __ __ __ __ ______________ ( ) ______________
Agent Number — Agent Name (Please print) — Telephone Number

Receipt Date: ____________ Email address: ______________ ( ) ______________
Fax Number

As you consider Anthem's individual health care programs, please be aware of the following:

Effective November 1, 2004:

- There is no longer a $500 penalty for not using the pre-admission process for an inpatient facility stay.

Our service area is Virginia, excluding the city of Fairfax, the town of Vienna, and the area east of State Route 123.

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An independent licensee of the Blue Cross and Blue Shield Association.
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