Application Submission Instructions

Please complete the attached application and send to HealthPlanOne either via fax or mail:
(must submit by mail if enclosing a check or money order)

HealthPlanOne
35 Nutmeg Drive, Suite 220
Trumbull, CT 06611

Fax (Toll Free): 888.812.6887

Please make check payable to the carrier to which you are applying.

Any questions? Please call HealthPlanOne at 1-877.567.5267. Thank you!

Anthem Health Plans of Kentucky, Inc.
13550 Triton Park Boulevard
Louisville, KY 40223

Kentucky
Individual Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Anthem Blue Cross and Blue Shield (Anthem), premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above, we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 212-1793. If you have questions about a previously submitted application, please call 1 (855) 330-1095.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage ☐ Change policy coverage Policy No._____ ☐ Add dependent(s) to current coverage Policy No._____

Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. The earliest Effective Date for the annual Open Enrollment period is the first day of the following calendar year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable premium payment.

Applications can be received during the Open Enrollment period. Outside the Open Enrollment period referenced above, the applicant may still apply for a health plan if he/she experiences a qualifying event as defined below. Following a qualifying event, an applicant has 60 days to submit an application. In the case of a future Loss of Minimum Essential Coverage or renewal of non-calendar year health plan coverage, an application may be submitted up to 60 days in advance of the qualifying event date.

No qualifying event is required to apply for new dental coverage.

For existing dental plan members, dental coverage changes and/or addition of dependents may only occur during the Open Enrollment period or if you experience a qualifying event. Following a qualifying event, an applicant has 60 days to submit an application.

Please indicate the reason you are submitting this application:

☐ Open Enrollment Period

☐ Special Enrollment Period

If Special Enrollment Period, please provide the qualifying event date, qualifying event and, if applicable, the coverage effective date:

1. **Date of the qualifying event** (which includes the date of Loss of Minimum Essential Coverage):

   _____

2. **Qualifying Event:**

   ☐ Involuntary Loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;

   ☐ Loss of Minimum Essential Coverage due to dissolution of marriage/domestic partnership;

   ☐ Marriage/Domestic Partnership;

☐ Birth or adoption or placement for adoption or appointment of guardianship;

☐ Moved to a new exchange service area or immigration status changed to lawfully present;

☐ Released from incarceration;

☐ Death of a family member enrolled under your current coverage;

☐ Renewal of non-calendar year health plan coverage;

☐ Court ordered coverage including child support order;

☐ Other Qualifying Event: _____ (Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events).

3. Coverage Effective Date:

If you are applying due to a qualifying event and your application is processed, your coverage effective date will be based on when the application is received. If the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. If the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month. **However the following qualifying events allow for different effective dates:**

- In the case of marriage, domestic partnership, or Loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application.

For the following qualifying events, select one of the effective date options as described in the chart below.

- In the case of birth, or adoption, or placement for adoption, or appointment of guardianship; ☐ A ☐ B ☐C ☐D
- In the case of court ordered coverage including child support order; ☐ A ☐C
- In the case of death of a family member enrolled under your current coverage; ☐ B ☐C

Effective date options

A	Coverage is effective on the date of birth, or adoption, or placement for adoption, or the filing of an application for appointment of guardianship, or date of court order.
B	First day of the month following receipt of your application.
C	Based on when the application is received. If the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. If the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month.
D	First day of the month following the date of the qualifying event.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number* (required)
Home Address			
City	State	ZIP	County
Billing Address (street and P.O. Box if applicable)			
City	State	ZIP	
Marital Status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of Birth	
Primary Phone Number	Secondary Phone Number	E-mail	

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner
Social Security Number* (required)	Sex ☐ M ☐ F	Date of Birth	

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. An eligible dependent may be your children, or your spouse's or domestic partner's children (to the end of the calendar month in which they turn age 26). A subscriber has the option to cancel dependent coverage effective on the next available date after notice is received by Anthem. (List all dependents beginning with the eldest.)

Last Name	**First Name**	**MI**	**Sex**	**Date of Birth** **mm/dd/yyyy**	**Social Security Number* (required)**	**Relationship to Applicant**
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ Other:_____

Last Name	First Name	MI	Sex	Date of Birth mm/dd/yyyy	Social Security Number* (required)	Relationship to Applicant
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ Other:_____

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Are all applicants listed on this application legal residents of the United States and residents of the state in which you are applying for coverage? ☐ Yes ☐ No

If **NO**, who? _____

Are all applicants listed on this application United States citizens, nationals or present non-citizens? ☐ Yes ☐ No

If **NO**, who? _____

Are any of the applicants listed on the application currently incarcerated as a result of a conviction (not just pending disposition of charges)? ☐ Yes ☐ No

If **YES**, who? _____

Has any applicant used tobacco products 4 or more times per week, on average, in the last 6 months (excluding religious or ceremonial usage)? ☐ Yes ☐ No

If **YES**, who? _____

Preferred spoken language? (Optional)

☐ English (ENG) ☐ Spanish (SPN)

Preferred written language? (Optional)

☐ English (ENG) ☐ Spanish (SPN)

Section E – Medical Coverage

Plan Name and Deductible/Coinsurance Options

Select ONE Plan…then select ONE Individual Deductible/Coinsurance option.

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

☐ **Anthem Bronze Pathway PPO**

☐ $4,500/20% - (1X1A) ☐ $5,900/20% - (1X16)
☐ $6,000/30% - (1X18)

☐ **Anthem Silver Pathway PPO**

☐ $2,000/20% - (1X1U) ☐ $2,500/10% - (1X1P)
☐ $3,750/0% - (1X1J) ☐ $4,000/10% - (1X1H)

☐ **Anthem Gold Pathway PPO**

☐ $1,000/10% - (1X1V) ☐ $1,500/10% - (1X2A)

☐ **Anthem Catastrophic Pathway PPO** (only available for Applicants under age 30 or otherwise qualified)

☐ $6,850/0% - (1X1X)

HMO Plans

Applicants must reside or live in one of the following counties to enroll: Allen, Anderson, Ballard, Bell, Boone, Bourbon, Boyd, Bullitt, Butler, Campbell, Carter, Christian, Clark, Clay, Daviess, Edmonson, Elliott, Estill, Fayette, Floyd, Franklin, Garrard, Greenup, Hardin, Harlan, Henderson, Henry, Hopkins, Jackson, Jefferson, Jessamine, Johnson, Kenton, Knott, Knox, Larue, Laurel, Lawrence, Leslie, Letcher, Logan, Madison, Magoffin, Martin, McCracken, McCreary, McLean, Mercer, Montgomery, Morgan, Muhlenberg, Nelson, Nicholas, Ohio, Oldham, Perry, Pike, Pulaski, Rockcastle, Russell, Scott, Shelby, Simpson, Spencer, Todd, Trimble, Warren, Washington, Webster, Whitley, and Woodford.

☐ **Anthem Bronze Pathway HMO**

☐ $5,000/40% - (1GG7)

☐ **Anthem Silver Pathway HMO**

☐ $3,500/25% - (1GHT) ☐ $4,250/30% - (1WZM)

☐ **Anthem Gold Pathway HMO**

☐ $1,450/20% - (1GH9)

HSA Plans

☐ **Anthem Bronze Pathway PPO 20% for HSA** - (1X14)

☐ **Anthem Bronze Pathway PPO 0% for HSA** - (1X12)

☐ **Anthem Silver Pathway PPO 10% for HSA** - (1X1F)

☐ **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.

If you select an HMO plan, please choose a Primary Care Physician for each family member from the Provider Directory, which can be found at www.anthem.com, or by calling 1 (855) 854-1438. If you do not choose a PCP, then one will be selected for you.

Applicant	Primary Care Physician (PCP)	PCP ID	Current Patient	PMG/IPA ID*
Primary Applicant			☐ Yes ☐ No	
Spouse/ Domestic Partner			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	

**PMG = Participating Medical Group, IPA = Independent Practice Association*

☐ Please check box if any additional sheets of paper have been completed for this section. If so, please attach and return the additional sheets with this application.

Section F – Dental and Vision Coverage

Dental

☐ **Yes, I wish to purchase additional dental coverage to supplement the pediatric Essential Health Benefits to age 21 which are included in the medical plans above.**

Select ONE Plan:

- ☐ **Anthem Dental Family** -(1FSR)
- ☐ **Anthem Dental Family Enhanced** -(1FSS)
- ☐ **Dental Prime Plan A*** -(1RC0)
- ☐ **Dental Prime Plan B*** -(1RC1)
- ☐ **Dental Prime Plan C*** -(1RC2)

Select who you are enrolling (applies to individuals listed on this application only):

- ☐ Applicant only
- ☐ Applicant & Spouse or Domestic Partner only
- ☐ Applicant & all dependent children listed
- ☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

*These plans do not include pediatric dental Essential Health Benefits that are required by the Affordable Care Act.

Vision

Supplemental vision coverage is also available. In order to enroll in this coverage, you must enroll in at least one of the medical or dental coverage options in this application. If you have enrolled in one of the medical or dental plans and would like to add vision coverage, please select your plan option below.

☐ **Blue View Vision Individual*** -(1RY5)

Select who you are enrolling (applies to individuals listed on this application only):

- ☐ Applicant only
- ☐ Applicant & Spouse or Domestic Partner only
- ☐ Applicant & all dependent children listed
- ☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

*These plans do not include pediatric vision Essential Health Benefits that are required by the Affordable Care Act.

Section G – Other Health and Dental Coverage

1) Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

   If **YES**, who? _____

2) Are you or anyone applying for coverage currently receiving Social Security Disability, Medicare or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits? ☐ Yes ☐ No

   If **YES**, who and reason:

   _____
   _____
   _____

   Start date of benefits/coverage: ____/____/_____ End date of benefits/coverage: ____/____/_____

3) Do you or anyone applying for coverage, currently have health care coverage? ☐ Yes ☐ No

   If **YES**, please provide the following for health 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)	

Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	
Will you be terminating this health coverage if approved for Anthem coverage? ☐ Yes ☐ No		If **YES**, what is the termination date?

4) Do you or anyone applying for coverage, currently have dental coverage? ☐ Yes ☐ No

If **YES**, please provide the following for dental 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)		
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	
Will you be terminating this dental coverage if approved for Anthem Dental coverage? ☐ Yes ☐ No		If **YES**, what is the termination date?

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

Please read this section carefully before signing the application.

- I understand that although Anthem requires payment with my application, 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, 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.
- 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.
- I understand I am applying for individual health and/or dental/vision 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.
- ☐ By checking this box, I authorize and expressly consent that Anthem and its affiliated companies may send e-mail communications instead of sending communications by mail, including but not limited to legally required Plan Notices and underwriting, enrollment and billing and explanation of benefits statements, to the e-mail address I have provided on this Application. I understand that I can revoke this authorization or request paper copies at any time free of charge by contacting Anthem customer service or online at www.anthem.com.

- 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).
- Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- I certify each Social Security Number listed on this application is correct.

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.

This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

SIGN HERE

Signature of Applicant* or Legal Representative X	Date
Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

To be completed by your Anthem-appointed agent/broker:

Did you see the proposed subscriber and spouse/domestic partner, if applying at the time this application was executed? ☐ Yes ☐ No

If **NO**, please explain: _____

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

Agent/Broker Signature **X**				Date
Agent/Broker Name (please print) HEALTHPLANONE, LLC		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No. 35 NUTMEG DRIVE SUITE 220		
Agent/Broker ID/TIN DCFPRSJSRZ	Agency ID/Parent TIN DCFPRSJSRZ	City TRUMBULL	State CT	ZIP 06611
Agent/Broker Phone No. 877-567-5267	Agent/Broker Fax No. 888-812-6887	Agent/Broker E-mail SALES@HEALTHPLANONE.COM		
GA (if applicable)		GA code (if applicable)		

Please mail this application to the following address:

Anthem Blue Cross and Blue Shield

P. O. Box 659806

San Antonio, TX 78265-9106

Or

Fax to: 1 (800) 848-2512

Payment Methods for Individual Applications – Kentucky

Anthem BlueCross BlueShield

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Automatic Premium Payment (complete Section A)

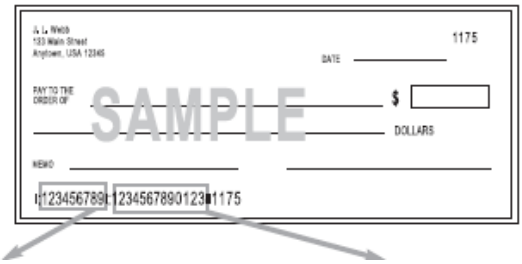
☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account

☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)



Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield ("Anthem") to pay and charge to my account checks drawn on that account by and made payable to the order of Anthem Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing Anthem a 30-day written notice. I agree that Anthem shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Anthem's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield ("Anthem") to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **Anthem accepts Visa ☐ and MasterCard ☐.**

Card Number:

Expiration Date:

Billing address for this Credit / Debit Card:

City:

Zip Code:

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize Anthem either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Anthem uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.