Information for Applicants Requesting a Special Enrollment Period

Anthem

When applying to enroll for coverage during a Special Enrollment Period (SEP), an applicant must be eligible to enroll and provide supporting documentation of a qualifying event. Without this documentation the applicant may not be able to enroll.

Please review the list below which outlines examples of what may be used as supporting documentation. Be sure to send in a copy of the documentation supporting the qualifying event when the completed application is submitted or upload a copy of the documentation when submitting an online application.

For paper applications, please submit legible copies of everything and keep all original documents for your personal records, because no documentation will be returned. Please write the applicant's name on the top of each page of the supporting documentation.

After reviewing the information provided, we may request additional documentation to confirm eligibility. Please note that loss of health coverage due to fraud, intentional misrepresentation of a material fact or failure to pay a premium do not constitute qualifying events.

If you have further questions about qualifying events or the supporting documentation that is required, please call your agent or customer service at 1-855-837-8540.

Supporting documentation by type of qualifying event
OFF Exchange for all SEP applicants for Anthem Blue Cross and Blue Shield plans in Georgia

Qualifying Event	Description and examples of supporting documentation
Lost or will lose Minimum Essential Coverage: Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay a premium	**Loss of Minimum Essential Coverage due to change in employment status:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals) and reason for loss of Minimum Essential Coverage (i.e., reduction in employment hours, etc.) **or** • Letter that provides notice of **offer** of COBRA or state continuation benefits **Loss of Minimum Essential Coverage due to loss of dependent eligibility status:** **Due to death:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals), and • Copy of death certificate or obituary **Due to Medicare enrollment:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals), and • Copy of Medicare card or approval letter from Social Security **Due to an over-age dependent:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals) **Due to legal separation, divorce, dissolution of domestic partnership:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, if available) confirming loss of coverage (date and individuals), and • Divorce decree, legal separation agreement, or notarized/legal termination of domestic partnership **Loss of Minimum Essential Coverage due to exhaustion of COBRA or state continuation benefits:** • Letter that provides notice of termination of COBRA or state continuation benefits

Qualifying Event	Description and examples of supporting documentation
Permanent move to new service area	*Note: Applicant must have had Minimum Essential Coverage for one or more days in the 60 days prior to the permanent move, unless he or she is moving from a foreign country or a United States territory (see below).* ◦ Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming coverage (date and individuals) within the past 60 days. If the minimum essential coverage has not yet been terminated, supporting documentation must show the applicant had minimum essential coverage for one or more days in the 60 days prior to the permanent move. **And:** ◦ Documentation of applicant's old address and new address (if not present on employer letter or previous carrier documentation) which may be validated by any of the following: — Recent utility bill (electric, water, phone, internet, cable) — Signed residential lease, rental agreement/contract, mortgage or nursing home/assisted living facility residency documentation — A deed showing applicant ownership of property in the new service area — New driver's license with new address in the service area — Receipt of property tax paid — Insurance documents, such as homeowner's, renter's, or life insurance policy or statement — Mail from the Department of Motor Vehicles, such as a driver's license, vehicle registration, or change of address card — State ID — Official school documents, including school enrollment, report cards, or housing documentation — Mail from a government agency to your address, such as a Social Security statement, or a notice from TANF or SNAP agency — Mail from a financial institution, such as a bank statement — U.S. Postal Service change of address confirmation letter — Pay stub showing address — Voter registration card showing name and address — Moving company contract or receipt showing address — Document from the Department of Corrections, jail, or prison indicating recent release or parole, including an order of parole, order of release, or an address certification — If you are homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify your residency. This person must prove their own residency by including one of the documents listed above. — If you are living in the home of another person, like a family member, friend or roommate, a letter/statement from that person stating you are living with them. This person must prove their own residency by including one of the documents listed above. — Letter from a local non-profit social services provider, certified application counselor, navigator or federally qualified health center that can verify your address. If you are homeless, you can provide a letter from a government entity or not-for-profit organization, including shelters, verifying your address. — Consumers living in rural areas may provide a rural route mail delivery address. The supporting documentation needs to include the name of the applicant along with the residential address listed on the application (the new address), and documentation of the previous address, which should include the applicant's name and the residential address before the move. For **child only applications**, the name of the parent/guardian in the signature section of the application must match the name on the supporting documentation.

Qualifying Event	Description and examples of supporting documentation
Required by a court order to provide an eligible child(ren) coverage, including a child support order or appointment of guardianship of a child If you have existing coverage and are adding one or more dependents, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) that doesn't have current coverage.	Legal documentation of guardianship that indicates the subscriber or the subscriber's spouse is a guardian of the applicant or court order that indicates the subscriber is required to cover the applicant. Contact us if you are applying for a child only policy.
Had a baby, adoption of a child or placement of a child with you for adoption If you have existing coverage and are adding one or more dependents, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) that doesn't have current coverage.	**Birth:** Birth certificate **or** medical records from hospital or pediatrician which indicate the names of the parents, the name of the baby, and date of birth. NOTE: *For current Anthem members, a mother's delivery claim may be considered as supporting documentation.* **Adoption/placement for adoption:** Adoption certificate or document establishing placement of a child with applicant for adoption.
Got married or in a domestic partnership that becomes eligible for coverage If you have existing coverage and are adding one or more dependents, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) that doesn't have current coverage.	Certificate of marriage, domestic partnership ***Note: At least one spouse or domestic partner must either demonstrate that they had Minimum Essential Coverage or that they lived in a foreign country or US territory for one or more days in the 60 days prior to the date of the marriage or domestic partnership.***
Moved to the U.S. from a foreign country or U.S. territory	◦ Documentation of the move (including date of move) which may be validated by a passport, VISA, or airplane ticket, **and** ◦ Documentation of the new address which may be validated by any of the following: — Signed residential lease, rental agreement/contract, mortgage — A deed showing applicant ownership of property in the new service area — If you are homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify your residency. This person must prove their own residency by including one of the documents listed above. — If you are living in the home of another person, like a family member, friend or roommate, a letter/statement from that person stating you are living with them. This person must prove their own residency by including one of the documents listed above. — Letter from a local non-profit social services provider, certified application counselor, navigator or federally qualified health center that can verify your address. If you are homeless, you can provide a letter from a government entity or not-for-profit organization, including shelters, verifying your address. ◦ **And** one additional supporting document of new address which may be validated by one of the following in the applicant's name: — Recent utility bill (electric, water, phone, internet, cable) — New driver's license with new address in the service area — Receipt of property tax paid

Qualifying Event	Description and examples of supporting documentation
Continued	— Insurance documents, such as homeowner's, renter's, or life insurance policy or statement — Mail from the Department of Motor Vehicles, such as a driver's license or vehicle registration — State ID — Official school documents, including school enrollment, report cards, or housing documentation — Mail from a government agency to your address, such as a Social Security statement, or a notice from TANF or SNAP agency — Mail from a financial institution, such as a bank statement — Pay stub showing address or letter/employment contract from employer — Voter registration card showing name and address — Moving company contract or receipt showing address
Release from jail or prison (incarceration)	Papers from local, state or federal department of corrections or prisons showing the applicant's date of legal discharge.
Death of a family member enrolled under current coverage	◦ Letter from employer on business letterhead or information from a previous carrier (recent billing statement, ID card) confirming coverage (date and individuals), **and** ◦ Copy of death certificate or obituary
Immigration status changed	Change in status validated by any of the following: ◦ Valid U.S. passport or passport card ◦ Valid I-551, permanent resident card (issued by the Department of Homeland Security/U.S. citizenship and immigration services). Non-expiring I-551 (issued 1977-1989) cards are acceptable. ◦ U.S. Certificate of Naturalization (federal form N-550). ◦ Certificate of U.S. Citizenship (federal form N-560). ◦ Employment Authorization Document ◦ Unexpired foreign passport with a valid unexpired U.S. visa affixed accompanied by the approved I-94 form documenting the applicants most recent admittance into the U.S.
Current policy does not renew on a calendar year basis (renews on a date other than January 1st)	Information from previous carrier (recent billing statement, ID card, renewal letter) confirming coverage (date and individuals) and renewal date of coverage.
Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events.	An official form such as a letter or other supporting documentation from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected.

Primary applicant name: _____

Welcome

Georgia Individual Application

Thanks for choosing us. We're glad you're here.

If you have any questions while filling out this form, give us a call at 1 (877) 206-0913. But if you've worked with an agent or broker, contact them first.

Did you know?

Anthem now offers individual term life insurance coverage. Apply online at anthem.com or call us for additional information at 1 (877) 206-0913. Term Life Insurance underwritten by Georgia Life Insurance Company doing business as Anthem Life.

About this form

Use this form to apply for **new** medical, dental or vision coverage or to **change** existing coverage with Anthem Blue Cross and Blue Shield (Anthem).

You can apply or change coverage:

1. **During the annual Open Enrollment period**
   Your coverage will start based on when we receive your complete application. The earliest date coverage can start is January 1st.
2. **When you have a Special Enrollment period due to a qualifying event**
   When you're done with this form, fill out **Appendix A: Special Enrollment,** which includes information about qualifying events, when coverage starts, and limits on the plans you may select for certain qualifying events.
3. **For new dental and vision**
   - For new dental and vision coverage, you can apply any time of year.
   - If you apply with medical coverage, your start dates will match.
   - If you apply without medical coverage, your start date will be based on when we receive your complete application. Coverage starts the 1st day of the month after the date we receive your complete application.

Tips for filling out this form

- Answer all questions. Please print clearly using blue or black ink only.
- Please submit all pages.
- You can also apply online at anthem.com.
- Refer to your Health Plan Guide for plan and enrollment details. Don't have a copy? Ask your agent or contact us.
- If you're enrolling in an HMO plan, you may need to choose a Primary Care Physician (PCP). View a list of doctors for your plan on anthem.com or call us. If you don't choose a PCP and it's required for your plan, we'll pick one located close to you.

Some frequently asked questions

1. **Do I need to include a payment?**
   Yes. We can't process your application without your first month's premium payment. Without it, your enrollment will be delayed. We won't charge your card or cash your check or money order until you've been enrolled.
   If you're already a member, we need your payment before the requested effective date for your change.
2. **Why do you need my Social Security Number (SSN)?**
   The IRS requires us to collect it. It won't be shared unless required by law.
   If you enroll in a health savings account (HSA) compatible plan with us, we may give it to our HSA banking partner.

Georgia Individual Application

Please indicate the reason for this application:
☐ Open Enrollment
☐ Special Enrollment Period (also complete Appendix A)

Step 1: Who is applying?

☐ New coverage
☐ Change coverage
☐ Add dependent to existing coverage
Subscriber ID no. _____

Primary applicant

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security Number** - -

Marital status ☐ Single ☐ Married ☐ Domestic Partner	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of GA** ☐ Yes ☐ No	**County** (for home address)

Home address (not a P.O. Box)	**City**	**State**	**ZIP**
Billing address (optional - if different than home address)	**City**	**State**	**ZIP**
Mailing address (optional - if different than home address)	**City**	**State**	**ZIP**

Email address: _____

For myself and any dependents, I'm providing my email address because I WANT TO GET INFORMATION ABOUT MY BENEFITS BY EMAIL OR ELECTRONICALLY. SUCH ELECTRONIC MAILINGS OR COMMUNICATIONS MAY EVEN INCLUDE CANCELLATION OR NONRENEWAL NOTICES. This may include my certificate or Evidence of Coverage, billing, explanation of benefits, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I also understand that by providing my email address, information about my dependents may also be sent by email or electronically. I know I (or my enrolled dependents) can change our minds at any time and request a free copy of specific materials by mail. To do either, I (or my enrolled dependents) will update communication preferences by going to anthem.com or calling Member Services.

Primary phone	**Secondary phone**	**Preferred written language** ☐ English (ENG) ☐ Spanish (SPA)	**Preferred spoken language** ☐ English (ENG) ☐ Spanish (SPA)

PCP (Guided Access HMO Plans only)	**PCP ID**	**Current Patient** ☐ Yes ☐ No

Tobacco use ☐ Yes ☐ No
Tobacco use is the use of tobacco products 4 or more times per week, on average, in the last 6 months (excluding religious or ceremonial reasons).

Coverage(s) selected ☐ Medical ☐ Dental ☐ Vision
To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.
If the primary applicant selects medical coverage, all family members listed on this application will be enrolled in the medical coverage.

Spouse or Domestic Partner

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security Number** - -

Relationship to applicant ☐ Spouse ☐ Domestic Partner	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of GA** ☐ Yes ☐ No

PCP (Guided Access HMO Plans only)	**PCP ID**	**Current Patient** ☐ Yes ☐ No

Tobacco use ☐ Yes ☐ No
Tobacco use is the use of tobacco products 4 or more times per week, on average, in the last 6 months (excluding religious or ceremonial reasons).

Coverage(s) selected ☐ Dental ☐ Vision
To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.
If the primary applicant selects medical coverage, all family members listed on this application will be enrolled in the medical coverage.

Child dependent Children must be under age 26.

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security Number** - -

Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of GA** ☐ Yes ☐ No

PCP (Guided Access HMO Plans only)	**PCP ID**	**Current Patient** ☐ Yes ☐ No

Tobacco use ☐ Yes ☐ No
Tobacco use is the use of tobacco products 4 or more times per week, on average, in the last 6 months (excluding religious or ceremonial reasons).

Coverage(s) selected ☐ Dental ☐ Vision
To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.
If the primary applicant selects medical coverage, all family members listed on this application will be enrolled in the medical coverage.

Child dependent

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security Number** - -

Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of GA** ☐ Yes ☐ No

PCP (Guided Access HMO Plans only)	**PCP ID**	**Current Patient** ☐ Yes ☐ No

Tobacco use ☐ Yes ☐ No
Tobacco use is the use of tobacco products 4 or more times per week, on average, in the last 6 months (excluding religious or ceremonial reasons).

Coverage(s) selected ☐ Dental ☐ Vision
To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.
If the primary applicant selects medical coverage, all family members listed on this application will be enrolled in the medical coverage.

Child dependent ☐ **Check here if you have more dependents**. Print an extra copy of this page and attach to your application.

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security Number** - -

Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**Legal resident of GA** ☐ Yes ☐ No

PCP (Guided Access HMO Plans only)	**PCP ID**	**Current Patient** ☐ Yes ☐ No

Tobacco use ☐ Yes ☐ No
Tobacco use is the use of tobacco products 4 or more times per week, on average, in the last 6 months (excluding religious or ceremonial reasons).

Coverage(s) selected ☐ Dental ☐ Vision
To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.
If the primary applicant selects medical coverage, all family members listed on this application will be enrolled in the medical coverage.

Eligibility	The answers to these questions are needed to determine your eligibility.

Are any applicants eligible for Medicare? If so, we will reduce benefits by the amount Medicare would have paid for services you receive even if not enrolled in Medicare.	☐ No	☐ Yes	**If yes, who?**
Are any applicants enrolled in Medicare?	☐ No	☐ Yes	**If yes, who?**
Are any applicants currently incarcerated (with more than 60 days left to serve before release) as a result of a conviction? (not just pending disposition of charges)	☐ No	☐ Yes	**If yes, who?**

Step 2: What coverage would you like?

Medical Plans

Please select one medical plan from the below Pathway Guided Access HMO plans only if you reside in one of the following counties: Cherokee, Cobb, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Henry, and Richmond. *These plans require the selection of a PCP.

Anthem Bronze	**Anthem Silver**	**Anthem Catastrophic**
		Only available to applicants under age 30, unless otherwise qualified.
Pathway Guided Access HMO ☐ 0% for HSA (4D8A)* ☐ 4800 (4D81)* ☐ 5200 (4D8J)* ☐ 5500 (4D8G)* ☐ 6750 (4D86)*	**Pathway Guided Access HMO** ☐ 2000 (4D8L)* ☐ 2600 (4D7Y)* ☐ 4950 (4D84)* ☐ 5500 (4D88)* ☐ 6000 (4D82)*	**Pathway Guided Access HMO** ☐ 8150 (4D8E)*

Please select one medical plan from the below Pathway HMO plans only if you reside in one of the following counties: Atkinson, Baldwin, Banks, Bartow, Berrien, Brooks, Burke, Carroll, Charlton, Chattooga, Clinch, Colquitt, Columbia, Cook, Coweta, Crawford, Dawson, Decatur, Early, Echols, Emanuel, Fannin, Floyd, Franklin, Gilmer, Glascock, Grady, Habersham, Hall, Hancock, Haralson, Hart, Heard, Jasper, Jefferson, Jenkins, Johnson, Lamar, Lanier, Laurens, Lincoln, Lowndes, Lumpkin, McDuffie, Morgan, Oglethorpe, Pickens, Pike, Polk, Rabun, Seminole, Stephens, Taliaferro, Thomas, Tift, Towns, Turner, Union, Upson, Ware, Warren, Washington, White, Wilkes and Wilkinson. Please be sure to select a PCP in Step 1.

Anthem Bronze	**Anthem Silver**	**Anthem Catastrophic**
		Only available to applicants under age 30, unless otherwise qualified.
Pathway HMO ☐ 0% for HSA (4D8B) ☐ 4800 (4D80) ☐ 5200 (4D8K) ☐ 5500 (4D8H) ☐ 6750 (4D87)	**Pathway HMO** ☐ 2000 (4D8M) ☐ 2600 (4D7Z) ☐ 4950 (4D85) ☐ 5500 (4D89) ☐ 6000 (4D83)	**Pathway HMO** ☐ 8150 (4D8F)

Health Savings Account (HSA) Enrollment	If you choose an HSA compatible plan, please select one of the options below:

☐ I request that Anthem facilitate opening my HSA with its service provider and, as a part of that transaction, I understand Anthem will disclose my name, SSN, and claims data, and that of my dependents if applicable, to its service provider to support my HSA.

☐ I request that Anthem NOT facilitate opening an HSA with its service provider for me.

Current medical coverage		☐ One or more of the applicants currently have health care coverage (Please fill out the info below.)			
Name of person covered (Last, First, M.I.)	**Coverage Type**	**Insurer name**	**Insurer phone no.**	**Policy ID no.**	**Coverage Dates (if applicable) (mm/dd/yyyy) Termination Date (if different from coverage end date)**
	☐ Group ☐ Individual				**Start:** **End:** **Termination Date:**
	☐ Group ☐ Individual				**Start:** **End:** **Termination Date:**
	☐ Group ☐ Individual				**Start:** **End:** **Termination Date:**
	☐ Group ☐ Individual				**Start:** **End:** **Termination Date:**
	☐ Group ☐ Individual				**Start:** **End:** **Termination Date:**

Dental Plans

Dental coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits).
Choose a dental plan if you want to buy coverage for more than these Pediatric Dental Essential Health Benefits.

Dental plan options

☐ Anthem Dental Family Value (3MFZ)
☐ Dental Prime A (3965)
☐ Anthem Dental Family (3MFX)
☐ Dental Prime B (3966)
☐ Anthem Dental Family Enhanced (3MFY)
☐ Dental Prime C (3968)

Prior & other dental coverage

Name of person covered (Last, First, M.I.)	Coverage (check all that apply)	Insurer name	Insurer phone no.	Policy ID no.	Dates (if applicable) (mm/dd/yyyy)
	☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Dental ☐ Orthodontia				**Start:** **End:**
	☐ Dental ☐ Orthodontia				**Start:** **End:**

Vision Plan

Vision coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits).
Choose a vision plan if you want to buy coverage for more than these Pediatric Vision Essential Health Benefits.

Vision plan options

☐ Blue View Vision Bundled (381F)
☐ Blue View Vision Value (381K)
☐ Blue View Vision Enhanced (381H)
☐ Blue View Vision Plus (381J)

Step 3: Please read and sign

Important legal information

I understand that:

- I must include my first premium payment with this application, but that does not mean coverage has been processed. I'm applying for the coverage I chose in Step 2. Anthem has the right to accept or decline this application. If my application is denied, my bank account or credit card will not be charged, and if I paid with a money order, it will be returned to me.
- I'm responsible to let Anthem know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- Check payments may be handled as Automated Clearinghouse (ACH) debit transactions. That means if I pay by check, the paper check will be destroyed and the debit payment will appear on my bank statement. My check won't be given to my financial institution or sent back to me. This does not mean I will be enrolled in an automatic debit process to pay my premium. Any resubmissions due to insufficient funds may also be electronic. All checking transactions will remain secure, and my payment by check means I agree to these terms.
- I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and me.
- I'm applying for individual health and/or dental and/or vision coverage which is not part of any employer sponsored plan and I'm responsible for all of the premium payments and making sure that all premiums are paid on time.
- I certify that each Social Security number listed on this application is correct.
- 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 at least 18 years of age; 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
- I acknowledge that I have read the Important Legal Information section, and I agree to the coverage conditions. I state 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)

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.

I hereby acknowledge that Anthem has informed me of the following prior to my enrollment in their health care coverage plan:

- Number, mix and location of participating/network health care providers;
- Limitations of choices of participation/network health care providers;
- Disclosure of contractual relationship between participation/network provider and Anthem.

By signing this application, I certify that the premium for my coverage will not be paid by a provider of health care services, hospital, non-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entity with a direct or indirect financial interest in the benefits of the contract/policy, or an employer that offers coverage under an employer health plan. I understand that if a third party is paying my premium, Anthem may decline to accept such premium payment if it is made by a person or entity from which it is not required by law to accept.

Please sign below

	Primary Applicant (or legal representative)	Date
	Spouse/Domestic Partner (or legal representative)	Date
	Dependent Child (age 18 or over)	Date
	Dependent Child (age 18 or over)	Date
	Dependent Child (age 18 or over)	Date

Did an agent or broker help you?

☐ Yes ☐ No If yes, make sure they fill out this section.

Agent (or Broker) Certification	All fields required.		
I certify to the best of my knowledge, the responses herein are accurate.			
Agent/Broker signature		**Date**	
Agent name (please print clearly)			
***(A) Writing Agent TIN/SSN** (encrypted TIN is ok)		****(B) Writing Agent/Agency/General Agency TIN** (encrypted TIN is ok)	
Agent address	**City**	**State**	**ZIP**
Agent phone no.	**Agent fax no.**	**Agent email**	

***Field (A)** - Always provide your Writing Agent TIN/SSN. ****Field (B)** - If you are a Direct Agent, with no relationship to an Agency, also enter your Agent TIN/SSN in Field (B). If this policy is sold through an Agency without a General Agency, enter the selling Agency TIN in Field (B); if this policy is sold through a General Agency, enter the General Agency TIN in Field (B).

Here's what's next.

1) Can you check a few items? When incorrect, they can cause enrollment delays.
   - Your name and address is clear and complete
   - You've included your first month's premium payment
   - Everyone 18 and older applying for coverage signed this form
   - Please make sure you submit all the pages of the application including this page, even if you don't have an agent
   - If enrolling due to a qualifying event, you've completed Appendix A: Special Enrollment

2) All good? Send this to us by mail to Anthem Blue Cross and Blue Shield, P.O. Box 659960, San Antonio, TX 78265-9146 or by fax to 1 (800) 848-2512.

3) We'll be in touch in the next few weeks (or sooner). If you have questions before then, call us at 1 (855) 837-8540.

Thank you!

Appendix A: Special Enrollment

If you're applying for coverage due to a qualifying event, please fill out this section along with your application.

Qualifying event date	
Date of qualifying event / /	For Loss of Coverage, this is the last date of existing or prior coverage. For all other events, please enter the date based on the qualifying event.

You must apply for coverage within 60 days after your qualifying event for the following events. If you have existing coverage and are adding one or more dependents due to marriage, birth, or adoption, you may add the new dependent(s) to your existing plan or apply for another plan for the dependent(s) who doesn't have current coverage.

Qualifying events	Coverage effective date
☐ **1. Marriage or Domestic Partnership** Got married or in a domestic partnership that becomes eligible for coverage (see step 3 for description of eligibility). One or both of the spouse(s)/domestic partner(s) must have had Minimum Essential Coverage for one or more days in the 60 days prior to the marriage/domestic partnership, unless one or both of the individuals has moved from a foreign country or U.S. territory within the 60 day period before the marriage/domestic partnership.	First day of the month after we receive your complete application
☐ **2. Birth or adoption** Had a baby, adoption of a child or placement of a child with you for adoption	**Select an effective date:** ☐ Same as the event date ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application* ☐ First day of month after the event date
☐ **3. Court order or guardianship** Required by a court order to provide an eligible child(ren) coverage, including a child support order or appointment of guardianship of a child	**Select an effective date:** ☐ Same as the event date ☐ Based on when we receive your complete application*
☐ **4. Death** Death of a family member enrolled under current coverage	**Select an effective date:** ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application*
☐ **5. Immigration** Immigration status changed ☐ **6. Other qualifying event** If you can't find your situation, contact your agent/broker or call us. We can only enroll based on events defined by state and/or federal law.	Based on when we receive your complete application*

* If the coverage date is based on when we receive your complete application, then if we receive it:

- Between the 1st and 15th day of the month, coverage starts the 1st day of the following month.
- Between the 16th and the last day of the month, coverage starts the 1st day of the second following month.

You must apply for coverage within 60 days before or 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
7. Loss of coverage: Lost or will lose Minimum Essential Coverage: ☐ Involuntary loss of coverage (for any reason except non-payment of premium or fraud) ☐ A legal separation or divorce ☐ Moved to a new service area. Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move.	First day of the month after we receive your complete application
8. Permanent move ☐ Moved to U.S. from a foreign country or a U.S. territory ☐ Permanent move to a new service area (within the U.S.). Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move. ☐ **9. Non-calendar renewal** Current policy does not renew on a calendar year basis (renews on a date other than January 1) ☐ **10. Jail or prison** Released from jail or prison (incarceration)	Based on when we receive your complete application*

* If the coverage date is based on when we receive your complete application, then if we receive it:

- Between the 1st and 15th day of the month, coverage starts the 1st day of the following month.
- Between the 16th and the last day of the month, coverage starts the 1st day of the second following month.

Almost there! We may need a bit more info.

We need supporting documentation for most qualifying events, such as a letter or official form from the source (employer, state or federal agency, for example) to confirm the qualifying event occurred. It should also include the date the event happened, and the names of all applicants affected. If you're applying because you've lost coverage, we need to know the reason why coverage was lost in the supporting documentation. In all cases, we might need additional documentation to confirm eligibility.

Give us or your agent a call if you have any questions.

Appendix B

Conditional Receipt

THIS RECEIPT DOES NOT PROVIDE ANY COVERAGE UNTIL ALL THE TERMS AND CONDITIONS LISTED BELOW ARE MET.

Anthem has received from the named Applicant an initial payment equal to the first month's premium together with an application for designated health insurance coverage. Such payment is accepted subject to the following conditions:

Subject to the provisions of the contract, the coverage applied for will be effective from, and the contract date as of, the day following acceptance by Anthem, unless otherwise specifically stated, provided that the payment evidenced by this receipt is the full first month's dues and provided that Anthem determines that as of the date of the application all proposed covered persons were acceptable for coverage and for the benefits applied for. If the application is not approved by Anthem said Plan shall incur no liability and the payment evidenced by this receipt will be refunded to the applicant. No one has the authority to waive or modify any of the terms or conditions of this receipt.

If you do not receive a contract within 60 days, please contact Anthem Member Services at 1 (855) 402-9635 or P.O. Box 105370, Atlanta, GA 30348-5370.

Abbreviated Notice Of Insurance Information Practices

PRIVACY ACT. Georgia state law establishes standards for the collection, use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. We need your answers to decide if you qualify for coverage. We are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals.

ALL DATA CONFIDENTIAL. Official Code of Georgia, Code Section 33-39-5, subsection (c) (1 through 4) requires that:

1. Personal information may be collected from persons other than the individual or individuals proposed for coverage;
2. Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be disclosed to third parties without authorization;
3. A right of access and correction exists with respect to all personal information collected; and
4. The notice prescribed in subsection (c) of the above referenced Code Section will be furnished to the applicant or policyholder upon request.

ACCESS TO YOUR DATA. You have the right to see or obtain a photocopy of your personal information which we have. You also have the right to send us a written request if you want any of your personal information to be amended, corrected or deleted. If you wish to have a more detailed explanation of our information practices, please contact Anthem Member Services at 1 (855) 402-9635 or P.O. Box 105370, Atlanta, GA 30348-5370.

Payment Methods for Individual Applications

Anthem

Applicant/Member name	Primary applicant's Social Security number

Anthem Blue Cross and Blue Shield (Anthem) will accept monthly payments on behalf of applicants/members **if the payment is made by the following persons or entities:** The Ryan White HIV/AIDS Program; other federal and state government programs that provide monthly payments and cost-sharing support for specific individuals; Indian tribes, tribal organizations and urban Indian organizations; or a relative or legal guardian on behalf of an applicant/member.

Unless required by law, Anthem does not accept monthly payments from third parties that are not listed above. Examples of third parties from whom Anthem will not accept monthly payments include, but are not limited to, insurance brokers and/or agents, doctors, hospitals, not-for-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/policy, commercial entities with a direct or indirect financial interest in the benefits of the contract/policy and employers that offer coverage under an employer health plan. Note: As allowed by law, Anthem reserves the right to decline monthly payments from third parties.

I authorize Anthem to debit the bank account listed or charge the credit/debit card listed for my first monthly payment on or after the day that my coverage is approved. By signing this form, I understand that the amount of the first payment may change from what I was told because my coverage has not been approved yet. In addition if I select Option 1 or Option 2 below, I understand that my future payments may vary as a result of changes(s) I make once enrolled, including but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified according to my plan/policy. In addition, I understand if changes I make are close to the auto withdrawal date, Anthem may not be able to notify me before the withdrawal is made. **I agree to pay any service charge that Anthem may bill me because the debit/charge was not honored.** I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Please choose how you want to pay your monthly payments for all of your plans. Put a check in the box for either Option 1, Option 2 or Option 3.

☐ **Option 1 Bank Account Authorization: Have your first and future monthly payments automatically deducted from your bank account.**

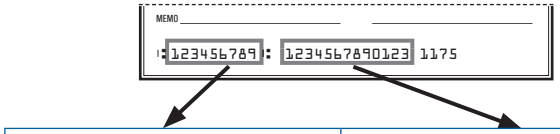
All of your monthly payments will be taken out of the **bank account** you check below.

Checking account: ☐ Business ☐ Personal

Savings account: ☐ Business ☐ Personal

Enter the requested debit date from your bank account ___ (1st to 6th of each month). If no date is requested your monthly payments will be debited on the first of each month.

Write the routing and account numbers that are on your check here: →



9-digit bank routing number	Bank account number

I authorize Anthem to automatically debit the **bank account** listed above each month to make my monthly payments. I agree that **Anthem's rights with each debit are the same as if the debit was a check that I signed**. I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem to automatically debit my account (and to make corrections to previous debits). This authority stays in effect until I let Anthem know that I no longer want them to debit my account by giving them a 30-day advance written notice. I understand that if my bank does not allow Anthem to debit my account for any reason, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Authorized signature (as it appears on bank's records) X	Printed bank account holder's name (as it appears on account)	Date (MM/DD/YY)

☐ **Option 2 Credit/Debit Card Authorization: Have your first and future monthly payments automatically charged to your credit/debit card.**

Complete the information below

Enter the requested charge date for your credit/debit card ___ (1st to 6th of each month).

I authorize Anthem to automatically charge my **credit/debit card** listed below each month to make my monthly payments. I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem to charge my credit/debit card until I let them know that I no longer want them to charge my credit/debit card by giving them a 30-day advance written notice. I agree that Anthem, in honoring the monthly payments charged to my credit/debit card, is not responsible for any fees charged by my bank. I understand if that if any Anthem credit/debit transaction is not honored, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Anthem accepts ☐ **Visa or** ☐ **Mastercard (Note to applicant: Please check one.)**

Card number	Expiration date ___ (MM/YY)	
Billing address for this credit/debit card	**City**	**Zip code**
Authorized signature (as it appears on card) X	**Printed card holder's name (as it appears on card)**	**Date (MM/DD/YY)**

See page two for *Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.*

Payment Methods for Individual Applications

Applicant/Member name	Primary applicant's Social Security number

☐ **Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.**

Choose one of the ways below that you would like to pay only your first monthly payment.

☐ Check (enclose your paper check with application) ☐ Electronic check (fill out section A below) ☐ Credit/Debit card (fill out section B below)

A. **Electronic check:** Instead of sending us a paper check, you can use an electronic check that allows Anthem to take the money right from your bank account to make your first payment on the day that your coverage is approved. You will not get the check back from your bank. (We will not keep this information on file or use it for any future payments.) Please fill out this information.

Printed account holder name	Routing number	Account Number	Amount of first payment
			$

B. **Credit/Debit card:** I allow Anthem to charge the credit or debit card I listed below one time for my first monthly payment. This payment will cover the first monthly payment for all of the plans I have with Anthem.

Anthem accepts ☐ Visa or ☐ Mastercard (Note to applicant: Please check one.)

Card number	Expiration date (MM/YY)

Billing address for this credit/debit card	City	Zip code

I authorize Anthem to debit/charge the bank account or credit/debit card listed above **to make my first monthly payment only.**

I agree that Anthem will not have to pay any fees that my bank may charge because my electronic check or credit/debit card was rejected even if I can no longer continue coverage. I understand that **this is a one-time payment and that I am responsible for making sure Anthem receives my future monthly payments after this first payment.**

Authorized signature (as it appears on bank account/card)	Printed bank account/card holder's name (as it appears on account/card)	Date (MM/DD/YY)
X		

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a recibir ayuda en su idioma en forma gratuita. Simplemente llame al número de Servicios para Miembros que figura en su tarjeta de identificación.

Chinese
您有權免費獲得透過您使用的語言提供的幫助。請撥打您的 ID 卡片上的會員服務電話號碼。若您是視障人士，還可索取本文件的其他格式版本。

Vietnamese
Quý vị có quyền nhận miễn phí trợ giúp bằng ngôn ngữ của mình. Chỉ cần gọi số Dịch vụ dành cho thành viên trên thẻ ID của quý vị. Bị khiếm thị? Quý vị cũng có thể hỏi xin định dạng khác của tài liệu này."

Korean
귀하는 자국어로 무료지원을 받을 권리가 있습니다. ID 카드에 있는 멤버 서비스번호로 연락하십시오.

Tagalog
May karapatan ka na makakuha ng tulong sa iyong wika nang libre. Tawagan lamang ang numero ng Member Services sa iyong ID card. May kapansanan ka ba sa paningin? Maaari ka ring humiling ng iba pang format ng dokumentong ito.

Russian
Вы имеете право на получение бесплатной помощи на вашем языке. Просто позвоните по номеру обслуживания клиентов, указанному на вашей идентификационной карте. Пациенты с нарушением зрения могут заказать документ в другом формате.

Armenian
Դուք իրավունք ունեք ստանալ անվճար օգնություն ձեր լեզվով: Պարզապես զանգահարեք Անդամների սպասարկման կենտրոն, որի հեռախոսահամարը նշված է ձեր ID քարտի վրա:

Farsi
"شما این حق را دارید تا به صورت رایگان به زبان مادری تان کمک دریافت کنید. کافی است با شماره خدمات اعضا (Member Services) درج شده روی کارت شناسایی خود تماس بگیرید." دچار اختلال بینایی هستید؟ می توانید این سند را به فرمت های دیگری نیز درخواست دهید.

French
Vous pouvez obtenir gratuitement de l'aide dans votre langue. Il vous suffit d'appeler le numéro réservé aux membres qui figure sur votre carte d'identification. Si vous êtes malvoyant, vous pouvez également demander à obtenir ce document sous d'autres formats.

Arabic
لك الحق في الحصول على مساعدة بلغتك مجانًا. ما عليك سوى الاتصال برقم خدمة الأعضاء الموجود على بطاقة الهوية. هل أنت ضعيف البصر؟ يمكنك طلب أشكال أخرى من هذا المستند.

Japanese
お客様の言語で無償サポートを受けることができます。IDカードに記載されているメンバーサービス番号までご連絡ください。

Haitian
Se dwa ou pou w jwenn èd nan lang ou gratis. Annik rele nimewo Sèvis Manm ki sou kat ID ou a. Èske ou gen pwoblèm pou wè? Ou ka mande dokiman sa a nan lòt fòma tou.

Italian
Ricevere assistenza nella tua lingua è un tuo diritto. Chiama il numero dei Servizi per i membri riportato sul tuo tesserino. Sei ipovedente? È possibile richiedere questo documento anche in formati diversi

Polish
Masz prawo do uzyskania darmowej pomocy udzielonej w Twoim języku. Wystarczy zadzwonić na numer działu pomocy znajdujący się na Twojej karcie identyfikacyjnej.

Punjabi
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮੁਫ਼ਤ ਵਿੱਚ ਮਦਦ ਹਾਸਲ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਬਸ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਤੇ ਦਿੱਤੇ ਸਿਰਵਸ ਨੰਬਰ ਤੇ ਕਾਲ ਕਰੋ। ਨਜ਼ਰ ਕਮਜ਼ੋਰ ਹੈ? ਤੁਸ ਇਸ ਦਸਤਾਵੇਜ਼ ਦੇ ਹੋਰ ਰੂਪਾਂਤਰ ਮੰਗ ਸਕਦੇ ਹੋ।

TTY/TTD:711

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. By calling Member Services, our members can get free in-language support, and free aids and services if you have a disability. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed in any of these areas, you can mail a complaint to: Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf