IN THE DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS & PROFESSIONAL REGISTRATION
STATE OF MISSOURI

In Re:	)	
	)	
HEALTHY ALLIANCE LIFE INSURANCE COMPANY,	)	**Case No. C121106581**
	)	
and	)	
	)	
HMO MISSOURI, INC.	)	

SUMMARY CEASE AND DESIST ORDER

TO: HEALTHY ALLIANCE LIFE INSURANCE COMPANY and HMO MISSOURI, INC.

BEFORE me, John M. Huff, Director of the Missouri Department of Insurance, Financial Institutions ("Director"), is the Division of Insurance Market Regulation's Verified Statement of Charges and Request for Orders ("Verified Petition"). One of the requested orders is a Summary Cease and Desist Order. Based on the allegations contained in the Verified Petition and the Exhibits attached thereto, which constitute substantial and competent evidence, I hereby enter the following Summary Cease and Desist Order directed to Healthy Alliance Life Insurance Company and HMO Missouri, Inc., pursuant to §374.046, RSMo Supp. 2012, which is effective this day:

1. Section 376.1199, as recently amended, outlines specific requirements for health carriers or health benefit plans that provide obstetrical/gynecological benefits and prescription drug benefits (hereafter referred to as "OBGRx" plans). The Verified

Petition and its attachments, which constitutes substantial and competent evidence, alleges that Healthy Alliance Life Insurance Company ("Healthy Alliance") and HMO Missouri, Inc. (HMO-MO), (hereafter collectively referred to as "Anthem" where appropriate), both health carriers offering OBGRx plans, have committed violations of §376.1199, which provides in relevant part:

> 1. Each health carrier or health benefit plan that offers or issues health benefit plans providing obstetrical/gynecological benefits and pharmaceutical coverage, which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 2002, shall:
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> * * *
>
> (4) If the health benefit plan also provides coverage for pharmaceutical benefits, provide coverage for contraceptives either at no charge or at the same level of deductible, coinsurance or co-payment as any other covered drug.
> No such deductible, coinsurance or co-payment shall be greater than any drug on the health benefit plan's formulary. As used in this section, "contraceptive" shall include all prescription drugs and devices approved by the federal Food and Drug Administration for use as a contraceptive, but shall exclude all drugs and devices that are intended to induce an abortion, as defined in section 188.015, which shall be subject to section 376.805. Nothing in this subdivision shall be construed to exclude coverage for prescription contraceptive drugs or devices ordered by a health care provider with prescriptive authority for reasons other than contraceptive or abortion purposes.
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> * * *
>
> 4. Notwithstanding the provisions of subdivision (4) of subsection 1 of this section to the contrary:
> (1) Any health carrier shall offer and issue to any person or entity purchasing a health benefit plan, a health benefit plan that excludes coverage for contraceptives if the use or provision of such contraceptives is contrary to the moral, ethical or religious beliefs or tenets of such person or entity;
> (2) Upon request of an enrollee who is a member of a group health benefit plan and who states that the use or provision of contraceptives is contrary to his or her moral, ethical or religious beliefs, any health carrier shall issue to or on behalf of such enrollee a policy form that excludes coverage for contraceptives. Any administrative costs to a group health benefit plan associated with such exclusion of coverage

not offset by the decreased costs of providing coverage shall be borne by the group policyholder or group plan holder;

(3) Any health carrier which is owned, operated or controlled in substantial part by an entity that is operated pursuant to moral, ethical or religious tenets that are contrary to the use or provision of contraceptives shall be exempt from the provisions of subdivision (4) of subsection 1 of this section. For purposes of this subsection, if new premiums are charged for a contract, plan or policy, it shall be determined to be a new contract, plan or policy.

* * *

6. Any health benefit plan issued pursuant to subsection 1 of this section shall provide clear and conspicuous written notice on the enrollment form or any accompanying materials to the enrollment form and the group health benefit plan application and contract:

(1) Whether coverage for contraceptives is or is not included;

(2) That an enrollee who is a member of a group health benefit plan with coverage for contraceptives has the right to exclude coverage for contraceptives if such coverage is contrary to his or her moral, ethical or religious beliefs;

(3) That an enrollee who is a member of a group health benefit plan without coverage for contraceptives has the right to purchase coverage for contraceptives;

(4) Whether an optional rider for elective abortions has been purchased by the group contract holder pursuant to section 376.805; and

(5) That an enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical, or religious beliefs.

For purposes of this subsection, if new premiums are charged for a contract, plan, or policy, it shall be determined to be a new contract, plan, or policy.

2. The Director has jurisdiction over this proceeding pursuant to §374.046, which provides in relevant part:

1. If the director determines based upon substantial and competent evidence that a person has engaged, is engaging in or has taken a substantial step toward engaging in an act, practice, omission, or course of business constituting a violation of the laws of this state relating to insurance in this chapter, chapter 354, and chapters 375 to 385, . . . or course of business constituting a violation of the laws of this state relating

to insurance in this chapter, chapter 354, and chapters 375 to 385, . . . the director may order the following relief:

(1) An order directing the person to cease and desist from engaging in the act, practice, omission, or course of business;

(2) A curative order or order directing the person to take other action necessary or appropriate to comply with the insurance laws of this state;

(3) Order a civil penalty or forfeiture as provided in section 374.049; and

(4) Award reasonable costs of the investigation.

* * *

3. Unless the director determines that a summary order is appropriate under subsection 4 of this section, the director shall provide notice of the intent to initiate administrative enforcement by serving a statement of the reasons for the action upon any person subject to the proceedings. A statement of reasons, together with an order to show cause why a cease and desist order and other relief should not be issued, shall be served either personally or by certified mail on any person named therein. The director shall schedule a time and place at least ten days thereafter for hearing, and after notice of and opportunity for hearing to each person subject to the order, the director may issue a final order under subsection 6 of this section.

4. If the director determines that sections 375.014, 375.144, or 375.310 are being violated and consumers are being aggrieved by the violations, the order issued under subdivision (1) of subsection 1 of this section may be summary and be effective on the date of issuance. Upon issuance of the order, the director shall promptly serve each person subject to the order with a copy of the order and a notice that the order has been entered.

5. A summary order issued under subsection 4 of this section must include a statement of the reasons for the order, notice within five days after receipt of a request in a record from the person that the matter will be scheduled for a hearing, and a statement whether the department is seeking a civil penalty or costs of the investigation. If a person subject to the order does not request a hearing and none is ordered by the director within thirty days after the date of service of the order, the order becomes final as to that person by operation of law. If a hearing is requested or ordered, the director, after notice of and opportunity for hearing to each person subject to the order, may modify or vacate the order or extend it until final determination.

3. The Verified Petition alleges that Anthem has committed violations of §375.144, which provides in relevant part:

> It is unlawful for any person, in connection with the offer, sale, solicitation or negotiation of insurance, directly or indirectly, to:
> * * *
>
> (2) As to any material fact, make or use any misrepresentation, concealment, or suppression.

4. Section 375.145.1 authorizes the Director to issue such administrative orders as are authorized under §374.046 if he determines "that a person has engaged, is engaged in, or has taken a substantial step toward engaging in an act, practice or course of business constituting a violation of section 375.012 to 375.144."

STATEMENT OF REASONS FOR THE ORDER

5. Based on the Verified Petition and its attachments, Anthem has violated and is violating §375.144(2) by making or using misrepresentation, concealment, or suppression as to material facts in connection with the offer, sale, solicitation, or negotiation of group health insurance directly or indirectly by engaging in the following acts, practices omissions, or a course of business relating to insurance, in that:

> a. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders and applicants, specifically, applicants' and policyholders' right under Missouri law to purchase an OBGRx plan that excludes coverage for contraceptives, if coverage for contraceptives is contrary to the policyholder's or applicant's moral, ethical, or religious beliefs or tenets, by failing to offer an individual health benefit plan that excludes coverage for contraceptives;
>
> b. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders and applicants, specifically, applicants' and policyholders' right under Missouri law to purchase an OBGRx plan that excludes coverage for contraceptives, if coverage for contraceptives is contrary to the policyholder's or applicant's moral,

ethical, or religious beliefs or tenets, by failing to offer a group health benefit plan that excludes coverage for contraceptives;

c. Anthem has and continues to misrepresent, conceal and suppress material facts from its enrollees about the coverage of contraceptives under Anthem's group OBGRx plans by failing to provide notice to said enrollees whether or not the plan includes coverage for contraceptives on the enrollment form or accompanying materials;

d. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders and applicants about the coverage of contraceptives under Anthem's group OBGRx plans by failing to provide notice to said policyholders and applicants on the group application form whether or not the plan includes coverage for contraceptives;

e. Anthem has and continues to misrepresent, conceal and suppress material facts from its enrollees about the coverage of contraceptives under Anthem's group OBGRx plans by failing to provide notice on the enrollment form or accompanying materials of the enrollee's right to exclude coverage for contraceptives;

f. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders and applicants about the coverage of contraceptives under Anthem's group OBGRx Plans by failing to provide notice on the group application of an enrollee's right to exclude coverage for contraceptives;

g. When a group policy holder of an Anthem OBGRx plan has excluded coverage for contraceptives, Anthem has and continues to misrepresent, conceal and suppress that material fact from its enrollees by failing to provide notice to the enrollee on the enrollment form or accompanying materials of an enrollee's right to purchase contraceptive coverage;

h. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders and applicants, about the coverage of contraceptives under Anthem's group OBGRx plans by failing to provide notice on the group application of an enrollee's right to purchase coverage for contraceptives;

i. Anthem has and continues to misrepresent, conceal and suppress material facts from its enrollees about the coverage of elective

abortion under Anthem's group OBGRx plans by failing to provide notice on the enrollment form or accompanying materials whether the optional abortion rider has been purchased;

j. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders and applicants about the coverage of elective abortion under Anthem's group OBGRx plans by failing to provide notice on the group application whether the optional abortion rider has been purchased;

k. Anthem has and continues to misrepresent, conceal and suppress material facts from its enrollees about the coverage of elective abortion under Anthem's group OBGRx plans by failing to provide notice on the enrollment form or accompanying materials of the enrollee's right to exclude coverage for abortion, if the optional rider has been purchased;

l. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders and applicants about the coverage of elective abortion under Anthem's group OBGRx plans, by failing to provide notice on the group application of the enrollee's right to exclude coverage for abortion, if the optional rider has been purchased.

6. Consumers are being aggrieved by the violations listed in paragraph 5 in that they are not being provided with facts and options regarding coverage for contraceptives and elective abortions that the Missouri Legislature has required and deemed material through its passage of §376.1199.

NOTICE REGARDING HEARING

7. Pursuant to §374.046.5, Respondents are hereby notified that they may request a hearing on this Summary Cease and Desist Order before the Director of the Department of Insurance, Financial Institutions and Professional Registration or his designee and such hearing will be scheduled within five days after receipt of a request in a record.

STATEMENT REGARDING SEEKING OF CIVIL PENALTIES OR COSTS

8. The Department of Insurance, Financial Institutions and Professional Registration is seeking civil penalties and/or costs of the investigation in this matter pursuant to §374.046, §374.049, §374.280, and §375.145.

ORDER

Based upon the foregoing and §374.046, RSMo, Healthy Alliance and HMO-MO. are hereby ORDERED to cease and desist the continuation of its unlawful acts, practices, omissions and courses of business and shall immediately cease and desist offering, selling, soliciting, or negotiating, directly or indirectly, all OBGRx Plans, that are in violation of §375.144, in any of the manners set forth in Paragraph 5 of this Summary Cease and Desist Order.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of my office in Jefferson City, Missouri, this 16th day of November, 2012.

John M. Huff, Director
Department of Insurance, Financial
Institutions and Professional Registration
State of Missouri

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and correct copy of the foregoing was served by certified mail, postage prepaid, on this 16 day of November, 2012 to:

HEALTHY ALLIANCE LIFE
INSURANCE COMPANY
CT Corporation, Registered Agent
120 South Central Ave.
St. Louis, Missouri 63105

HMO MISSOURI, INC.
CT Corporation, Registered Agent
120 South Central Ave.
St. Louis, Missouri 63105

[signature]

IN THE DEPARTMENT OF INSURANCE, FINANCIAL INSTITUTIONS &
PROFESSIONAL REGISTRATION
STATE OF MISSOURI

In Re:	)	
	)	
HEALTHY ALLIANCE LIFE	)	
INSURANCE COMPANY,	)	**Case No. C121106581**
	)	
and	)	
	)	
HMO MISSOURI, INC.	)	

ORDER TO SHOW CAUSE

TO: HEALTHY ALLIANCE LIFE INSURANCE COMPANY and HMO MISSOURI, INC.

BEFORE me, John M. Huff, Director of the Missouri Department of Insurance, Financial Institutions ("Director"), is the Division of Insurance Market Regulation's Verified Statement of Charges and Request for Orders ("Verified Petition"). One of the requested orders is an Order to Show Cause why the relief requested in the Verified Petition shoul d not be granted. Based on the allegations contained in the Verified Petition and the Exhibits attached thereto, which constitute substantial and competent evidence, I hereby enter the following Order to Show Cause directed to Healthy Alliance Life Insurance Company and HMO Missouri, Inc., pursuant to §374.046, RSMo Supp. 2012:

You are hereby notified that a public hearing will be held on the Verified Statement of Charges filed by the Division of Market Regulation accompanying this

Order before me or my designee on February 4, 2013, at 9:00 a.m., in Room 530 of the Harry S. Truman State Office Building, 301 West High Street, Jefferson City, Missouri, at which time you are ordered to show cause why the Director should not:

A. Issue a final order finding that Healthy Alliance Life Insurance Company and HMO Missouri, Inc. (hereinafter collectively referred to as "Anthem") have engaged in acts, practices, omissions or courses of business constituting a violation of the laws of this state relating to insurance in Chapters 354 or 374 to 385, including violations of §§375.144, 375.934, 376.1199;

B. Issue a final order requiring Anthem to cease and desist offering, selling, soliciting, or negotiating, directly or indirectly, all non-compliant health benefit plans that provide obstetrical/gynecological benefits and prescription drug benefits (hereinafter referred to as "OBGRx Plans");

C. Issue a final order requiring Anthem to cease and desist using application forms, application processes, enrollment forms or accompanying materials to the enrollment forms and all other forms or processes that are not in compliance with §376.1199;

D. Issue a final curative order requiring Anthem to:

i. Offer and issue OBGRx Plans that exclude coverage for contraceptives if such coverage is contrary to the moral, ethical or religious beliefs or tenets of the person or entity;

ii. For policies purchased since October 12, 2012, to take the following actions:

1. Provide notice to all enrollees as to whether coverage for contraceptives is included or not;
2. For enrollees whose OBGRx health benefit plan includes coverage for contraceptives, allow enrollees to opt out of such coverage if it is contrary to the enrollee's moral, ethical, or religious beliefs;
3. For enrollees whose OBGRx group health benefit plan does not include coverage for contraceptives, allow enrollees to purchase coverage for contraceptives;
4. Provide notice to enrollees in an OBGRx group health benefit plan as to whether an optional rider for elective abortion has been purchased by the group policyholder; and
5. For enrollees whose OBGRx group health benefit plan includes coverage for elective abortion, allow enrollees to exclude and not pay for coverage for elective abortion if it is contrary to the enrollee's moral, ethical, or religious beliefs.

iii. For policies intended to be marketed, issued, or sold in the State of Missouri, submit to the Director for review and approval policies, enrollment forms or accompanying materials to the enrollment forms and group health benefit plan application forms, contracts or any

accompanying materials to the enrollment form that meet the following statutory requirements:

1. Provide notice to all enrollees as to whether or not their health benefit plan includes coverage for contraceptives;
2. For enrollees whose health benefit plan includes coverage for contraceptives, allow enrollees to opt out of such coverage if it is contrary to the enrollee's moral, ethical, or religious beliefs;
3. For enrollees whose group health benefit plan does not include coverage for contraceptives, allow enrollees to purchase coverage for contraceptives;
4. Provide notice to enrollees in a group health benefit plan as to whether an optional rider for elective abortion has been purchased by the group policyholder; and
5. For enrollees whose group health benefit plan includes coverage for elective abortion, allow enrollees to exclude and not pay for coverage for elective abortion if it is contrary to the enrollee's moral, ethical, or religious beliefs.

E. Issue a final order imposing monetary penalties or forfeitures pursuant to §374.046, §374.049, §374.280 and §375.145, RSMo 2000.

F. Issue a final order requiring the payment of the actual costs of the investigation and the actual costs of this proceeding pursuant to §374.046.8 and the reasonable costs of the investigation pursuant to §374.046.1(4).

G. Such other relief as the Director deems just and appropriate.

Pursuant to 20 CSR 800-1.060 (1) (A), you are hereby notified of your obligation to file an Answer to the Division's Verified Statement of Charges within thirty days of receipt of this Order unless a request for additional time is granted. Pursuant to 20 CSR 800-1.030 (4), a prehearing conference may be ordered. If either party wishes a prehearing conference, a request for the same shall be filed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of my office in Jefferson City, Missouri, this 16th day of November 2012.

John M. Huff, Director
Department of Insurance, Financial
Institutions and Professional Registration
State of Missouri

CERTIFICATE OF SERVICE

The undersigned hereby certifies that a true and accurate copy of the following Order to Show Cause was served by certified mail, post prepaid, this 16 day of November, 2012, to:

HEALTHY ALLIANCE LIFE
INSURANCE COMPANY
CT Corporation, Registered Agent
120 South Central Ave.
St. Louis, Missouri 63105

HMO MISSOURI, INC.
CT Corporation, Registered Agent
120 South Central Ave.
St. Louis, Missouri 63105

Stewart Freilich

IN THE DEPARTMENT OF INSURANCE, FINANCIAL
INSTITUTIONS AND PROFESSIONAL REGISTRATION
STATE OF MISSOURI

In Re:	)	**FILED**
	)	
HEALTHY ALLIANCE LIFE INSURANCE COMPANY	)	NOV 06 2012
	)	
Serve: CT Corporation, 120 South Central Ave., St. Louis, Missouri 63105	)	DIRECTORS OFFICE MO. DEPT OF INSURANCE, FINANCIAL INSTITUTIONS & PROFESSIONAL REGISTRATION
	)	
and	)	Case No. C121106581
	)	
HMO MISSOURI, INC.	)	HEARING REQUESTED
	)	
Serve: CT Corporation, 120 South Central Ave., St. Louis, Missouri 63105	)	

VERIFIED STATEMENT OF CHARGES AND REQUEST FOR ORDERS

The Insurance Market Regulation Division (hereinafter "Division") of the Missouri Department of Insurance, Financial Institutions and Professional Registration (hereinafter "Department"), by and through counsel, requests that John M. Huff, the Director of the aforementioned Department (hereinafter the "Director"), find that Healthy Alliance Life Insurance Company and HMO Missouri, Inc. (hereinafter collectively referred to as "Anthem") have violated and are continuing to violate Missouri law relating to elective abortion and contraceptive coverage, and, pursuant to §374.046 RSMo (Supp. 2012),[1] issue an order: 1) to cease and desist violations of Missouri law; 2) directing Anthem to take curative action or other necessary or appropriate action to comply with Missouri law; 3) requiring Anthem to pay a civil penalty or forfeiture; 4) awarding the Division the actual or reasonable costs of the

[1] All statutory references are to RSMo (Supp. 2012) unless otherwise indicated.

investigation and prosecution of this matter; and 5) providing such other relief, preliminary or final, as is warranted against Anthem, including a) a Summary Cease and Desist Order, b) an Order to show cause why the relief requested in this Verified Statement of Charges should not be granted and, c) an Order appointing a hearing officer, all based on the violations contained in the following Statement of Charges or as the same may be later amended.

JURISDICTION AND RELEVANT STATUTES

1. The jurisdiction of the Director to initiate and administer this proceeding is found in §374.046 which provides, in part:

> 1. If the director determines based upon substantial and competent evidence that a person has engaged, is engaging in or has taken a substantial step toward engaging in an act, practice, omission, or course of business constituting a violation of the laws of this state relating to insurance in this chapter, chapter 354, and chapters 375 to 385, or a rule adopted or order issued pursuant thereto or that a person has materially aided or is materially aiding an act, practice, omission, or course of business constituting a violation of the laws of this state relating to insurance in this chapter, chapter 354, and chapters 375 to 385 or a rule adopted or order issued pursuant thereto, the director may order the following relief:
>
> (1) An order directing the person to cease and desist from engaging in the act, practice, omission, or course of business;
>
> (2) A curative order or order directing the person to take other action necessary or appropriate to comply with the insurance laws of this state;
>
> (3) Order a civil penalty or forfeiture as provided in section 374.049; and
>
> (4) Award reasonable costs of the investigation.
>
> * * *
>
> 3. Unless the director determines that a summary order is appropriate under subsection 4 of this section, the director shall provide notice of the intent to initiate administrative enforcement by serving a statement of the reasons for the action upon any person subject to the proceedings. A statement of reasons, together with an order to show cause why a cease and desist order and other relief should not be issued, shall be served

> either personally or by certified mail on any person named therein. The director shall schedule a time and place at least ten days thereafter for hearing, and after notice of and opportunity for hearing to each person subject to the order, the director may issue a final order under subsection 6 of this section.
>
> 4. If the director determines that sections 375.014, 375.144, or 375.310, RSMo are being violated and consumers are being aggrieved by the violations, the order issued under subdivision (1) of subsection 1 of this section may be summary and be effective on the date of issuance. Upon issuance of the order, the director shall promptly serve each person subject to the order with a copy of the order and a notice that the order has been entered.

2. Pursuant to §374.280, the Director, after a hearing under §374.046, may order a civil penalty or forfeiture payable to the state of Missouri authorized by §374.049.

3. Section 374.049 authorizes the Director to impose a monetary penalty or forfeiture depending on the level of the violation for violations committed after August 28, 2006, and states in relevant part:

> 2. An order to impose a civil penalty or forfeiture, when imposed by the director in an administrative proceeding under section 374.046 on a person for any violation of the laws of this state relating to insurance in this chapter, chapter 354 and chapters 375 to 385, RSMo or a rule adopted or order issued by the director, shall be an order to pay an amount not exceeding the following:
>
> (1) No civil penalty or forfeiture for a level one violation;
>
> (2) One thousand dollars per each level two violation, up to an aggregate civil penalty or forfeiture of fifty thousand dollars per annum for multiple violations;
>
> (3) Five thousand dollars per each level three violation, up to an aggregate civil penalty or forfeiture of one hundred thousand dollars per annum for multiple violations;
>
> (4) Ten thousand dollars per each level four violation, up to an aggregate civil penalty or forfeiture of two hundred fifty thousand dollars per annum for multiple violations;
>
> (5) Fifty thousand dollars per each level five violation, up to an aggregate civil penalty or forfeiture of two hundred fifty thousand dollars per annum for multiple violations.

* * *

5. Any violation of the laws of this state relating to insurance in this chapter, chapter 354 and chapters 375 to 385, which is not classified or does not authorize a specific range for a civil penalty or forfeiture for violations, shall be classified as a level one violation.

* * *

7. In any enforcement proceeding, the court, or director in administrative enforcement, may enhance the civil penalty or forfeiture with a one-classification step increase under this section, if the violation was knowing. The court, or director in administrative enforcement, may enhance the civil penalty or forfeiture with a two-level increase if the violation was knowingly committed in conscious disregard of the law.

4. Section 375.144 provides:

> It is unlawful for any person, in connection with the offer, sale, solicitation or negotiation of insurance, directly or indirectly, to:
>
> (1) Employ any deception, device, scheme, or artifice to defraud;
>
> (2) As to any material fact, make or use any misrepresentation, concealment, or suppression;
>
> (3) Engage in any pattern or practice of making any false statement of material fact; or
>
> (4) Engage in any act, practice, or course of business which operates as a fraud or deceit upon any person.

5. Under §375.145, the Director may issue such administrative orders as authorized under §374.046 if he determines "that a person has engaged, is engaging in, or has taken a substantial step toward engaging in an act, practice or course of business constituting a violation of section 375.012 to 375.144." Pursuant to §375.145.1, violations of §375.144 are level four violations under §374.049. Furthermore, §374.049.7, provides:

> In any enforcement proceeding, the court, or director in administrative enforcement, may enhance the civil penalty or forfeiture with a one-classification step increase under this section, if the violation was knowing. The court, or director in administrative enforcement, may

> enhance the civil penalty or forfeiture with a two-level increase if the violation was knowingly committed in conscious disregard of the law.

6. Missouri law defines actions which constitute unfair trade practices in the business of insurance. Specifically, §375.936, RSMo (2000) defines "misrepresentations and false advertising of insurance policies" as "making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustrations, circular or statement, sales presentation, omission or comparison which: (a) Misrepresents the benefits, advantages, conditions, or terms of any policy". An insurer commits an unfair trade practice if it commits a practice defined in §375.936 and it is committed in conscious disregard of §§375.930 to 375.948 or regulations promulgated thereunder, or is "committed with such frequency to indicate a general business practice to engage in that type of conduct."

7. Each unfair trade practice in violation of §375.934 is a level two violation, pursuant to §375.942.

8. Section 376.777, RSMo (2000) specifies that individual health insurance policies must be approved or deemed approved before sold in Missouri. It provides in part:

> 7. Approval of policies.
>
> (1) No policy subject to sections 376.770 to 376.800 shall be delivered or issued for delivery to any person in this state unless such policy, including any rider, endorsement or other provisions, supplementary thereto, shall have been approved by the director of the department of insurance, financial institutions and professional registration.
>
> * * *
>
> (3) The director of the department of insurance, financial institutions and professional registration shall approve only those policies which are in compliance with the insurance laws of this state.

9. Section 376.405, RSMo (2000), specifies that group health insurance policies must be approved or deemed approved before sold in Missouri. In pertinent part it provides:

> 1. No insurance company licensed to transact business in this state shall deliver or issue for delivery in this state any policy of group accident or group health insurance, or group accident and health insurance, including insurance against hospital, medical or surgical expenses, covering a group in this state, unless such policy form shall have been approved by the director of the department of insurance, financial institutions and professional registration of the state of Missouri.
>
> * * *
>
> 3. The director of the department of insurance, financial institutions and professional registration shall approve only those policy forms which are in compliance with the insurance laws of this state….

10. Section 354.405 outlines requirements related to the filing and approval of forms by the Director for Health Maintenance Organizations:

> 4. Every health maintenance organization shall file with the director notice of its intention to modify any of the procedures or information described in and required to be filed by this section. Such changes shall be filed with the director prior to the actual modification. If the director does not disapprove the modification within forty-five days of filing, citing specific reasons for noncompliance, such modification shall be deemed approved. If a filing that is deemed approved is a document described in subdivision (4), (5) or (6) of subsection 3 of this section, the director shall not disapprove the deemed filing for a period of twelve months thereafter. If at any time during that twelve-month period the director determines that any provision of the deemed filing is contrary to state law, the director shall notify the health maintenance organization of the specific provision that is contrary to state law, and any specific statute to which the provision is contrary to, and request that the health maintenance organization file, within thirty days of receipt of the request, an amendment form that modifies the provision to conform to the state law. Upon approval of the amendment form by the director, the health maintenance organization shall issue a copy of the amendment to each individual and entity to which the deemed filing was previously issued and shall attach a copy of the amendment to the deemed filing when it is subsequently issued. Such amendment shall have the force and effect as if the amendment was in the original filing or policy.

11. Section 376.1199 outlines specific requirements for health carriers or health benefit plans that provide obstetrical/gynecological benefits and prescription drug benefits (hereinafter referred to as "OBGRx Plan"). Specifically, §376.1199 provides:

> Each health carrier or health benefit plan that offers or issues health benefit plans providing obstetrical/gynecological benefits and pharmaceutical coverage, which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 2002, shall:
>
> * * *
>
> (4) If the health benefit plan also provides coverage for pharmaceutical benefits, provide coverage for contraceptives either at no charge or at the same level of deductible, coinsurance or co-payment as any other covered drug.
>
> * * *
>
> 6. Any health benefit plan issued pursuant to subsection 1 of this section shall provide clear and conspicuous written notice on the enrollment form or any accompanying materials to the enrollment form and the group health benefit plan application and contract:
>
> (1) Whether coverage for contraceptives is or is not included;
>
> (2) That an enrollee who is a member of a group health benefit plan with coverage for contraceptives has the right to exclude coverage for contraceptives if such coverage is contrary to his or her moral, ethical or religious beliefs;
>
> (3) That an enrollee who is a member of a group health benefit plan without coverage for contraceptives has the right to purchase coverage for contraceptives;
>
> (4) Whether an optional rider for elective abortions has been purchased by the group contract holder pursuant to section 376.805; and
>
> (5) That an enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical, or religious beliefs.
>
> For purposes of this subsection, if new premiums are charged for a contract, plan, or policy, it shall be determined to be a new contract, plan, or policy.

12. Section 376.1199 does not assign a level for violations and therefore, a violation of §376.1199 is a Level I violation pursuant to §374.049.5, subject to enhancement pursuant to §374.049.7.

FACTS RELEVANT TO ALL COUNTS

13. John M. Huff is the duly appointed Director of the Missouri Department of Insurance, Financial Institutions and Professional Registration whose duties pursuant to Chapters 354, 374, 375, 376, and 379 include supervision, regulation, and discipline of health insurance carriers.

14. The Insurance Market Regulation Division is a division of the Department of Insurance, Financial Institutions and Professional Registration whose duties include review of policy forms for compliance with Missouri law as well as market conduct examinations and investigation of insurance company practices.

15. Healthy Alliance Life Insurance Company (hereinafter "Healthy Alliance") is a domestic life and health insurance company organized pursuant to the laws of the state of Missouri and transacting insurance business in the state of Missouri pursuant to a Certificate of Authority issued by the Director.

16. HMO Missouri, Inc. (hereinafter "HMO-MO"), is a domestic health maintenance organization organized pursuant to the laws of the state of Missouri and transacting insurance business in the state of Missouri pursuant to a Certificate of Authority issued by the Director.

17. Healthy Alliance and HMO-MO are health carriers that offer and issue OBGRx plans in the state of Missouri.

18. The Missouri General Assembly voted to override the Governor's veto of CCS HCS SS SB 749 on September 12, 2012 and thereby imposed regulatory burdens on some insurance companies in the form of new requirements for health insurance policies and forms.

19. The provisions of §376.1199, as amended in CCS HCS SS SB 749, became effective on October 12, 2012, pursuant to §21.250, RSMo.

20. CCS HCS SS SB 749 revised §376.1199.4 to specify that any health carrier shall offer and issue an OBGRx health benefit plan excluding contraceptives, when coverage for contraceptives is contrary to the moral, ethical, or religious beliefs or tenets of the individual or entity purchasing the OBGRx Plan, if requested after proper notice.

21. CCS HCS SS SB 749 revised §376.1199.6 to specify additional notice requirements on the group health plan application forms, in addition to the group health plan enrollment forms, accompanying materials, and contracts related to coverage for contraceptives.

22. CCS HCS SS SB 749 revised §376.1199.6 to specify additional requirements for health carriers to notify enrollees if the group policyholder purchased an optional elective abortion rider. If the optional elective abortion rider was purchased, then the health carrier is additionally required to provide the enrollee notice as to their right to exclude and not pay for this coverage if such coverage is contrary to the enrollee's moral, ethical, or religious beliefs.

23. The Department issued Insurance Bulletin 12-02 on September 14, 2012, notifying insurers that the General Assembly voted to override the Governor's veto of CCS HCS SS SB 749. A true and correct copy of Bulletin 12-02 is attached hereto as Exhibit A

24. The Department issued Insurance Bulletin 12-03 on October 12, 2012, notifying insurers of the requirements of §376.1199, as amended, and reminding insurers of the October

12, 2012 effective date of those amendments. A true and correct copy of Insurance Bulletin 12-03 is attached hereto as Exhibit B.

25. Upon information and belief of possible non-compliance with the newly revised provision of §376.1199, the Division accessed Anthem's web site on October 15, 16, 17, 18, 19, 24, 25, and 31, 2012.

26. On October 17, 2012, the Division accessed the "Agent Home" portion of Anthem's web site, and was able to download application and enrollment forms and accompanying materials to the enrollment form for large and small group employers. The forms downloaded include: "Enrollment Application," "Employee Change Form Application," and "Employer Application" for both large and small employer groups. A true and correct copy of the forms accessed is attached hereto as Exhibit C.

27. The application and enrollment forms contained within Exhibit C are used for group OBGRx Plans, including plans underwritten by both Healthy Alliance and HMO-MO

28. Upon information and belief, the forms contained within Exhibit C are for large and small group health benefit plans for which Anthem proposes to provide coverage for obstetrical/gynecological services as well as pharmaceuticals.

29. The group enrollment and application forms contained within Exhibit C are currently available on Anthem's web site for producers to access in order to sell such products to employers.

30. The group enrollment and application forms contained within Exhibit C did not reflect an offer of coverage excluding contraceptives.

31. On October 31, 2012, the Division accessed the Employer self-service portal on Anthem's website and downloaded a form entitled "Contraceptive Benefits Option Form,"

Form Number 23330MOMENABS 8/11. A true and correct copy of the form accessed is attached as Exhibit D.

32. The Contraceptive Benefits Option Form allows individual enrollees to change their contraceptive benefit coverage by choosing to exclude contraceptives if their health benefit plan includes benefits for contraceptive drugs and devices, or to include contraceptive drugs and devices if their health benefit plan excludes such coverage. The form specifies that it is to be returned directly to Anthem.

33. The Contraceptive Benefits Option Form fails to notify the enrollees whether contraceptives are included or not in their health benefit plan.

34. Upon information and belief, the Contraceptive Benefits Option Form appears to be the only document or material which may constitute "accompanying materials to the enrollment form" under §376.1199.6.

35. On October 31, 2012, the Division accessed Anthem's website and downloaded an application for Individual Health Insurance Coverage. A true and correct copy of the application is attached hereto as Exhibit E.

36. The application form contained within Exhibit E is for an individual health benefit plan for which Anthem proposes to provide coverage for obstetrical/gynecological services as well as pharmaceuticals.

37. The application form contained within Exhibit E is used for individual OBGRx Plans, including plans underwritten by both Healthy Alliance and HMO-MO.

38. Through the application form, Anthem presented coverage options to the Division, including cost-sharing options, dental coverage, vision coverage, a maternity rider, an autism rider, and life insurance.

39. Anthem did not offer a Plan excluding coverage for contraceptives through its application form.

40. Missouri law requires health carriers to issue to any person or entity purchasing an OBGRx Plan, a Plan that excludes coverage for contraceptives if the use of contraceptives is contrary to the moral, ethical or religious beliefs or tenets of the person or entity pursuant to §376.1199.

41. Missouri law, pursuant to §376.1199.6, requires OBGRx Plans to provide "clear and conspicuous written notice" on the enrollment form or accompanying materials, the group health benefit plan application, and the group health benefit plan contract related to coverage for contraceptives

42. The OBGRx Plans offered for sale by Healthy Alliance and HMO-MO do not comply with §376.1199.

43. The Division has reviewed form filing submissions made via the System for Electronic Rate and Form Filing (hereinafter "SERFF") system. The Division has been unable to locate any application or enrollment form, or accompanying materials to an enrollment form submitted by Anthem for the Department's review and approval that complies with the amendments to §376.1199.

44. This proceeding is in the public interest.

COUNT I

Anthem has failed to offer individual health benefit plans excluding coverage for contraceptives, as required by §376.1199.

45. The Division incorporates and re-alleges paragraphs 1 through 44 of this Verified Statement of Charges.

46. As reflected in Exhibit E, Anthem has violated §376.1199.4 by not offering individual OBGRx Plans that exclude coverage for contraceptives, if the use or provision of contraceptives is contrary to the moral, ethical, or religious beliefs or tenets of the individual.

47. Each of Anthem's failures to offer an applicant an individual OBGRx Plan excluding coverage for contraceptives is a separate violation of §376.1199.4.

48. Each violation of §376.1199.4 is a Level I violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7 to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT II

Anthem has made or used misrepresentations, concealment, or suppression as to a material fact or facts relating to the coverage of contraceptives in connection with the offer or solicitation of individual health benefit plans in violation of §375.144(2).

49. The Division incorporates and re-alleges Paragraphs 1 through 48 of this Verified Statement of Charges.

50. Anthem has violated §375.144(2), RSMo (2000) by making or using misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of individual health benefit plans directly or indirectly, by engaging in the acts, practices, omissions or course of business relating to insurance described herein.

51. The requirements of §376.1199.4 establish that making an offer of coverage of an OBGRx plan that excludes coverage for contraceptives is a fact which is material to the purchase of individual OBGRx Plans.

52. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders and applicants, to wit, applicants' and policyholders' right under Missouri law to purchase an OBGRx Plan that excludes coverage for contraceptives, if the coverage of contraceptives is contrary to the policyholder or applicant's moral, ethical, or religious beliefs or tenets.

53. Each instance in which Anthem made or used misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of individual health benefit plans is a separate violation of §375.144(2).

54. Each violation of §375.144(2) committed on or after August 28, 2006 is a Level 4 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT III

Anthem has failed to offer group health benefit plans excluding coverage for contraceptives, as required by §376.1199.

55. The Division incorporates and re-alleges paragraphs 1 through 54 of this Verified Statement of Charges.

56. As reflected in Exhibit C, Anthem has violated §376.1199.4 by failing to offer group OBGRx Plans that exclude coverage for contraceptives, if the use or provision of contraceptives is contrary to the moral, ethical, or religious beliefs or tenets of the group policyholder.

57. Anthem's application forms for large and small group health insurance are not in compliance with §376.1199.4 in that they do not include an option that would allow small or large group employers the ability to choose to exclude coverage for contraceptives.

58. Each instance where Anthem failed to offer group applicants an OBGRx Plan excluding coverage for contraceptives is a separate violation of §376.1199.4.

59. Each violation of §376.1199.4 is a Level 1 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7 to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT IV

Anthem has made or used misrepresentations, concealment, or suppression as to a material fact or facts relating to the coverage of contraceptives in connection with the offer or solicitation of group health benefit plans in violation of §375.144(2).

60. The Division incorporates and re-alleges Paragraphs 1 through 59 of this Verified Statement of Charges.

61. As reflected in Exhibit C, Anthem has violated §375.144(2) by making or using misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of group health benefit plans directly or indirectly, by engaging in the acts, practices, omissions or course of business relating to insurance described herein

62. The requirements of §376.1199.4 establish that making an offer of coverage of an OBGRx plan that excludes coverage for contraceptives is a fact which is material to the purchase of group OBGRx Plans.

63. As reflected in Exhibit C, Anthem's application forms for large and small group health insurance are not in compliance with §376.1199.4 in that they do not include an option that would allow small or large group employers the ability to choose to exclude coverage for contraceptives.

64. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders and applicants, to wit, applicants and policyholders have a right under Missouri law to purchase an OBGRx Plan that excludes coverage for contraceptives, if the coverage of contraceptives is contrary to the policyholder or applicant's moral, ethical, or religious beliefs or tenets.

65. Each instance in which Anthem made or used misrepresentation, concealment or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of group health benefit plans is a separate violation of §375.144(2).

66. Each violation of §375.144(2) is subject to the imposition of a forfeiture and, if committed on or after August 28, 2006 is a Level 4 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT V

Anthem has failed to provide clear and conspicuous written notice regarding coverage for contraceptives on enrollment forms or accompanying materials to the enrollment form, as required by §376.1199.6(1).

67. The Division incorporates and re-alleges paragraphs 1 through 66 of this Verified Statement of Charges.

68. As reflected in Exhibits C and D, Anthem has violated §376.1199.6(1) regarding OBGRx Plans by failing to provide clear and conspicuous written notice on the enrollment form or accompanying materials to the enrollment form "whether coverage for contraceptives is or is not included."

69. As reflected in Exhibits C and D, neither the small group nor the large group plan enrollment form or accompanying materials to the enrollment form include clear and conspicuous notice to the enrollee as to whether or not coverage for contraceptives is included.

70. Each of Anthem's failures to inform enrollees of the coverage for contraceptives under a group OBGRx Plan is a separate violation of § 376.1199.6(1).

71. Each violation of §376.1199.6(1) is a Level 1 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7 to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT VI

Anthem has made or used misrepresentations, concealment, or suppression as to a material fact or facts relating to written notice regarding coverage of contraceptives on enrollment forms or accompanying materials to the enrollment form in connection with the offer or solicitation of group health benefit plans in violation of §375.144(2).

72. The Division incorporates and re-alleges Paragraphs 1 through 71 of this Verified Statement of Charges.

73. Anthem has violated §375.144(2) by making or using misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of group health insurance directly or indirectly, by engaging in the acts, practices, omissions or course of business relating to insurance described herein.

74. The requirements of §376.1199.6 have established that notice of the existence of coverage for contraceptives under group OBGRx Plans and each enrollee's right to exclude coverage, is a fact that is material to those seeking to be covered under group health benefit plans.

75. As demonstrated by Exhibits C and D, Anthem's enrollment form and accompanying materials to the enrollment form for large and small group health insurance are not in compliance with §376.1199.6(1) in that they fail to provide clear and conspicuous notice of whether or not coverage for contraceptives is included under the group OBGRx Plan.

76. Anthem has and continues to misrepresent, conceal and suppress material facts from its enrollees about the coverage of contraceptives under Anthem's group OBGRx Plans.

77. Each instance in which Anthem made or used misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation, or negotiation of group health benefit plans is a separate violation of §375.144(2).

78. Each violation of §375.144(2) is subject to the imposition of a forfeiture, and, if committed on or after August 28, 2006 is a Level 4 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT VII

Anthem has violated §375.934, engaging in unfair trade practices defined in §375.936(6)(a) by misrepresenting insurance policies through an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan with regard to coverage for contraceptives, in violation of §375.936(6)(a)

79. The Division incorporates and re-alleges paragraphs 1 through 78 of this Verified Statement of Charges.

80. The failure to provide clear and conspicuous written notice regarding the coverage for contraceptives on the enrollment form or accompanying materials to the enrollment form also constitutes a violation of §375.934 in that it is an unfair trade practice,

which is defined in §375.936(6)(a) to include an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan.

81. Each instance in which Anthem made misrepresentations of insurance policies by making an omission that misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan is a separate violation of §375.934.

82. Each violation of §375.934 is a Level 2 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT VIII

Anthem has failed to provide clear and conspicuous written notice regarding for coverage for contraceptives on applications for group health benefit plans, as required by §376.1199.6(1)

83. The Division incorporates and re-alleges paragraphs 1 through 82 of this Verified Statement of Charges.

84. As reflected in Exhibit C, Anthem has violated §376.1199.6(1) regarding OBGRx Plans by failing to provide clear and conspicuous written notice on the group health benefit application "whether coverage for contraceptives is or is not included."

85. Each of Anthem's failures to inform applicants and policyholders whether or not coverage for contraceptives is included in a group OBGRx Plan is a separate violation of §376.1199.6(1).

86. Each violation of §376.1199.6(1) is a Level 1 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7 to the extent such violations were knowing,

and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT IX

Anthem has made or used misrepresentations, concealment, or suppression as to a material fact or facts relating to written notice regarding coverage of contraceptives on application forms in connection with the offer or solicitation of group health benefit plans in violation of §375.144(2).

87. The Division incorporates and re-alleges Paragraphs 1 through 86 of this Verified Statement of Charges.

88. As demonstrated by Exhibit C, Anthem has violated §375.144(2) by making or using misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of group health insurance directly or indirectly, by engaging in the acts, practices, omissions or course of business relating to insurance described herein.

89. The requirements of §376.1199.6 establish that the existence of coverage for contraceptives under group OBGRx Plans is a fact that is material to those seeking to purchase group health benefit plans.

90. As demonstrated by Exhibit C, Anthem's application forms for large and small group health insurance are not in compliance with §376.1199 in that they fail to provide clear and conspicuous notice of whether or not coverage for contraceptives is included under the group OBGRx Plan.

91. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders and applicants about the coverage of contraceptives under Anthem's group OBGRx Plans.

92. Each instance in which Anthem made or used misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of group health benefit plans is a separate violation of §375.144(2).

93. Each violation of §375.144(2) is subject to the imposition of a forfeiture and, if committed on or after August 28, 2006 is a Level 4 violation pursuant to § 374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT X

Anthem has violated §375.934, engaging in unfair trade practices defined in §375.936(6)(a) by misrepresenting insurance policies through an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan with regard to coverage for contraceptives.

94. The Division incorporates and re-alleges paragraphs 1 through 93 of this Verified Statement of Charges.

95. The failure to provide clear and conspicuous notice regarding coverage for contraceptives on applications for group health benefit plans also constitutes a violation of §375.934 in that it is an unfair trade practice, which is defined in §375.936(6)(a) to include an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan.

96. Each instance in which Anthem made misrepresentations of insurance policies by making an omission that misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan is a separate violation of §375.934.

97. Each violation of §375.934 is a Level 2 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and

subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XI

Anthem has failed to provide clear and conspicuous notice on the enrollment form or accompanying materials to the enrollment form regarding an enrollee's right to reject coverage for contraceptives if such coverage is included in the group health benefit plan, as required by §376.1199.6(2)

98. The Division incorporates and re-alleges paragraphs 1 through 97 of this Verified Statement of Charges.

99. As demonstrated by Exhibit C, Anthem has violated §376.1199.6(2) regarding OBGRx Plans by failing to provide clear and conspicuous written notice on the enrollment form or accompanying materials to the enrollment form of the enrollee's right to reject coverage for contraceptives, if such coverage is included in the group OBGRx Plan.

100. Each of Anthem's failures to inform enrollees of their right to reject the coverage for contraceptives under a group OBGRx Plan is a separate violation of §376.1199.6(2).

101. Each violation of §376.1199.6(2) is a Level 1 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7 to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XII

Anthem has made or used misrepresentations, concealment, or suppression as to a material fact or facts relating to the enrollee's right to reject coverage for contraceptives if such coverage is included in the group health benefit plan in violation of §375.144(2).

102. The Division incorporates and re-alleges Paragraphs 1 through 101 of this Verified Statement of Charges.

103. As demonstrated by Exhibit C, Anthem has violated §375.144(2) by making or using misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of group health insurance directly or indirectly, by engaging in the acts, practices, omissions or course of business relating to insurance described herein.

104. The requirements of §376.1199.6 have established that the existence of coverage for contraceptives and elective abortions under group OBGRx Plans is a fact which is material to those seeking to be covered under group health benefit plans.

105. As demonstrated by Exhibit C, Anthem's enrollment forms or accompanying materials to the enrollment forms for large and small group health insurance are not in compliance with §376.1199.6 in that they fail provide clear and conspicuous notice that enrollees have the option to reject coverage for contraceptives, if such coverage is purchased by their employer.

106. Anthem has and continues to misrepresent, conceal and suppress material facts from its enrollees about the coverage of contraceptives under Anthem's group OBGRx Plans.

107. Each of Anthem's failures to inform enrollees of their right to reject coverage for contraceptives, if provided under a group OBGRx Plan is a separate violation of §375.144(2).

108. Each violation of §375.144(2) is subject to the imposition of a forfeiture and, if committed on or after August 28, 2006 is a Level 4 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XIII

Anthem has violated §375.934, engaging in unfair trade practices defined in §376.936(6)(a) by misrepresenting insurance policies through an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan with regard to coverage for contraceptives.

109. The Division incorporates and re-alleges paragraphs 1 through 108 of this Verified Statement of Charges.

110. The failure to provide clear and conspicuous notice on the enrollment forms or accompanying materials to the enrollment forms of the enrollee's right to reject contraceptive coverage also constitutes a violation of §375.934 in that it is an unfair trade practice, which is defined in §375.936(6)(a) to include an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan..

111. Each instance in which Anthem made misrepresentations of insurance policies through an omission that misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan is a separate violation of §375.934.

112. Each violation of §375.934 is a Level 2 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XIV

Anthem has failed to provide clear and conspicuous notice on application forms regarding an enrollee's right to reject coverage for contraceptives if such coverage is included in the group health benefit plan, as required by §376.1199.6(2)

113. The Division incorporates and re-alleges paragraphs 1 through 112 of this Verified Statement of Charges.

114. As demonstrated by Exhibit C, Anthem has violated §376.1199.6(2) regarding OBGRx Plans by failing to provide clear and conspicuous written notice on the group health benefit application of the enrollee's right to reject coverage for contraceptives, if such coverage is included in the group health benefit plan.

115. Each of Anthem's failures to inform applicants and policyholders of the enrollee's right to coverage for contraceptives under a group OBGRx Plan is a separate violation of § 376.1199.

116. Each violation of §376.1199 is a Level 1 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7 to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XV

Anthem has made or used misrepresentations, concealment, or suppression as to a material fact or facts relating to the enrollee's right to reject coverage for contraceptives if such coverage is included in the group health benefit plan in violation of §375.144(2).

117. The Division incorporates and re-alleges Paragraphs 1 through 116 of this Verified Statement of Charges.

118. As demonstrated by Exhibit C, Anthem has violated §375.144(2) by making or using misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of group health insurance directly or indirectly, by engaging in the acts, practices, omissions or course of business relating to insurance described herein.

119. The requirements of §376.1199.6 have established that the existence of coverage for contraceptives and elective abortions under group OBGRx Plans is a fact which is material to those seeking to purchase group health benefit plans.

120. As demonstrated by Exhibit C, Anthem's application forms for large and small group health insurance are not in compliance with §376.1199.6(2) in that they fail to provide clear and conspicuous notice that enrollees have the option to reject coverage for contraceptives, if such coverage is purchased by their employer.

121. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders and applicants about the coverage of contraceptives under Anthem's group OBGRx Plans.

122. Each of Anthem's failures to inform applicants and policyholders of the right of an enrollee to reject coverage for contraceptives, if provided under a group OBGRx Plan is a separate violation of §375.144(2).

123. Each violation of §375.144(2) is subject to the imposition of a forfeiture and, if committed on or after August 28, 2006 is a Level 4 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XVI

Anthem has violated §375.934, engaging in unfair trade practices defined in §376.936(6)(a) by misrepresenting insurance policies through an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan with regard to coverage for contraceptives.

124. The Division incorporates and re-alleges paragraphs 1 through 123 of this Verified Statement of Charges.

125. The failure to provide clear and conspicuous notice on application forms of an enrollee's right to reject contraceptive coverage also constitutes a violation of §375.934 in that it is an unfair trade practice, which is defined in §375.936(6)(a) to include an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan.

126. Each instance in which Anthem made misrepresentations of insurance policies through an omission that misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan is a separate violation of §375.934.

127. Each violation of §375.934 is a Level 2 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XVII

Anthem has failed to provide clear and conspicuous notice on enrollment forms or accompanying materials to the enrollment form regarding an enrollee's right to purchase coverage for contraceptives if such coverage is not included in the group health benefit plan as required by §376.1199.

128. The Division incorporates and re-alleges paragraphs 1 through 127 of this Verified Statement of Charges.

129. As demonstrated by Exhibit C, Anthem has violated §376.1199.6(3) regarding large and small group OBGRx Plans by failing to provide clear and conspicuous written notice on the enrollment form or accompanying materials to the enrollment form "that an enrollee who is a member of a group health benefit plan without coverage for contraceptives has the right to purchase coverage for contraceptives."

130. Each of Anthem's failures to inform enrollees of the right to purchase otherwise excluded coverage for contraceptives under a group OBGRx Plan is a separate violation of §376.1199.

131. Each violation of §376.1199 is a Level 1 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7 to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XVIII

Anthem has made or used misrepresentations, concealment, or suppression as to a material fact or facts relating to providing notice on the enrollment form or accompanying materials to the enrollment form of an enrollee's right to purchase coverage for contraceptives if such coverage is not included in the group health benefit plan in violation of §375.144(2).

132. The Division incorporates and re-alleges Paragraphs 1 through 131 of this Verified Statement of Charges.

133. As demonstrated by Exhibit C, Anthem has violated §375.144(2) by making or using misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of group health insurance directly or indirectly, by engaging in the acts, practices, omissions or course of business relating to insurance described herein.

134. The requirements of §376.1199.6 have established that the existence of coverage of contraceptives under group OBGRx Plans is a fact which is material to those seeking to be covered under said Plan.

135. As demonstrated by Exhibit C, Anthem's enrollment form or accompanying materials to the enrollment form for large and small group health insurance are not in compliance with §376.1199.6(3) in that they fail to provide clear and conspicuous notice that enrollees have the option to purchase coverage for contraceptives, if such contraceptive coverage is excluded by their employer.

136. Anthem has and continues to misrepresent, conceal and suppress material facts from its enrollees about the coverage of contraceptives under Anthem's group OBGRx Plans.

137. Each instance in which Anthem made or used misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of individual health benefit plans is a separate violation of § 375.144(2).

138. Each violation of §375.144(2) is subject to the imposition of a forfeiture and, if committed on or after August 28, 2006 is a Level 4 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XIX

Anthem has violated §375.934, engaging in unfair trade practices defined in §375.936(6)(a) by misrepresenting insurance policies through an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan with regard to coverage for contraceptives.

139. The Division incorporates and re-alleges paragraphs 1 through 138 of this Verified Statement of Charges.

140. The failure to provide clear and conspicuous notice on the enrollment form or accompanying materials to the enrollment form of enrollees' right to purchase otherwise excluded contraceptive coverage also constitutes a violation of §375.934 in that it is an unfair trade practice, which is defined in §375.936(6)(a) to include an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan.

141. Each instance in which Anthem made misrepresentations of insurance policies through an omission that misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan is a separate violation of §375.934.

142. Each violation of §375.934 is a Level 2 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XX

Anthem has failed to provide clear and conspicuous notice on application forms regarding an enrollee's right to purchase coverage for contraceptives if such coverage is not included in the group health benefit plan as required by §376.1199.

143. The Division incorporates and re-alleges paragraphs 1 through 142 of this Verified Statement of Charges.

144. As demonstrated by Exhibit C, Anthem has violated §376.1199.6(3) regarding OBGRx Plans by failing to provide clear and conspicuous written notice on the group health benefit application "that an enrollee who is a member of a group health benefit plan without coverage for contraceptives has the right to purchase coverage for contraceptives."

145. Each of Anthem's failures to inform applicants and policyholders of the enrollee's right to purchase coverage for contraceptives under a group OBGRx Plan is a separate violation of §376.1199.

146. Each violation of §376.1199.6(3) is a Level 1 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7 to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXI

Anthem has made or used misrepresentations, concealment, or suppression as to a material fact or facts relating to providing notice on application forms of an enrollee's right to purchase coverage for contraceptives if such coverage is not included in the group health benefit plan in violation of §375.144(2).

147. The Division incorporates and re-alleges Paragraphs 1 through 146 of this Verified Statement of Charges.

148. As demonstrated by Exhibit C, Anthem has violated §375.144(2) by making or using misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of group health insurance directly or indirectly, by engaging in the acts, practices, omissions or course of business relating to insurance described herein.

149. The requirements of §376.1199.6 have established that the existence of coverage of contraceptives under group OBGRx Plans is a fact which is material to those seeking purchase said Plan.

150. As demonstrated by Exhibit C, Anthem's application forms for large and small group health insurance are not in compliance with §376.1199.6(3) in that they fail to provide

clear and conspicuous notice that enrollees have the option to purchase coverage for contraceptives, if such contraceptive coverage is not purchased by their employer.

151. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders, and applicants, about the coverage of contraceptives under Anthem's group OBGRx Plans.

152. Each of Anthem's failures to inform applicants and policyholders of the enrollee's right to purchase coverage for contraceptives, if coverage for contraceptives is not included under a group OBGRx Plan is a separate violation of §375.144(2).

153. Each violation of § 375.144(2) is subject to the imposition of a forfeiture and, if committed on or after August 28, 2006 is a Level 4 violation pursuant to § 374.049 and is subject to enhancement pursuant to § 374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXII

Anthem has violated §375.934, engaging in unfair trade practices defined in §375.936(6)(a) by misrepresenting insurance policies through an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan with regard to coverage for contraceptives.

154. The Division incorporates and re-alleges paragraphs 1 through 153 of this Verified Statement of Charges.

155. The failure to provide clear and conspicuous notice on application forms regarding otherwise excluded coverage for contraceptives also constitutes a violation of §375.934 in that it is an unfair trade practice, which is defined in §375.936(6)(a) to include an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan.

156. Each instance in which Anthem made misrepresentations of insurance policies through an omission that misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan is a separate violation of §375.934.

157. Each violation of §375.934 is a Level 2 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXIII

Anthem has failed to provide clear and conspicuous written notice that the optional rider for elective abortions has been purchased by the group contract holder on the enrollment form or accompanying materials to the enrollment form or accompanying materials, as required by §376.1199.6(4)

158. The Division incorporates and re-alleges paragraphs 1 through 157 of this Verified Statement of Charges.

159. As demonstrated by Exhibits C and D, Anthem has violated §376.1199.6(4) related to OBGRx Plans by failing to provide clear and conspicuous written notice on the enrollment form or accompanying materials "whether an optional rider for elective abortions has been purchased by the group contract holder pursuant to section 376.805."

160. Each of Anthem's failures to inform enrollees of the coverage for elective abortion under a group OBGRx Plan is a separate violation of §376.1199.6(4).

161. Each violation of §376.1199 is a Level 1 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7 to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXIV

Anthem has made or used misrepresentations, concealment, or suppression as to a material fact or facts relating to the purchase by the employer of an optional rider covering elective abortion in connection with the offer or solicitation of group health benefit plans in violation of §375.144(2).

162. The Division incorporates and re-alleges Paragraphs 1 through 161 of this Verified Statement of Charges.

163. As demonstrated by Exhibits C and D, Anthem has violated §375.144(2) by making or using misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of group health insurance directly or indirectly, by engaging in the acts, practices, omissions or course of business relating to insurance described herein.

164. The requirements of §376.1199.6 have established that the existence of coverage for elective abortions under group OBGRx Plans is a fact which is material to those seeking to be covered under group health benefit plans.

165. As demonstrated by Exhibits C and D, Anthem's enrollment form or accompanying materials to the enrollment form for large and small group health insurance are not in compliance with §376.1199.6(4) in that they fail to provide clear and conspicuous notice to enrollees whether coverage for elective abortion is to be provided under the OBGRx Plan, through the separate elective abortion rider purchased by their employer.

166. Anthem has and continues to misrepresent, conceal and suppress material facts from its enrollees about the coverage of elective abortion under Anthem's group OBGRx Plans.

167. Each of Anthem's failures to inform enrollees of the coverage for elective abortion under a group OBGRx Plan is a separate violation of §375.144(2).

168. Each violation of §375.144(2) is subject to the imposition of a forfeiture and, if committed on or after August 28, 2006 is a Level 4 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXV

Anthem has violated §375.934, engaging in unfair trade practices defined in §375.936(6)(a) by misrepresenting insurance policies through an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan with regard to coverage for contraceptives.

169. The Division incorporates and re-alleges paragraphs 1 through 168 of this Verified Statement of Charges.

170. The failure to provide required notice to enrollees on the enrollment form or accompanying materials to the enrollment form also constitutes a violation of §375.934 in that it is an unfair trade practice, which is defined in §375.936(6)(a) to include an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan.

171. Each instance in which Anthem made misrepresentations of insurance policies through an omission that misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan is a separate violation of §375.934.

172. Each violation of §375.934 is a Level 2 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXVI

Anthem has failed to provide clear and conspicuous written notice that the optional rider for elective abortions has been purchased by the group contract holder on application forms, as required by §376.1199.6(4)

173. The Division incorporates and re-alleges paragraphs 1 through 172 of this Verified Statement of Charges.

174. Anthem has violated §376.1199.6(4) related to OBGRx Plans by failing to provide clear and conspicuous written notice on the application form "whether an optional rider for elective abortions has been purchased by the group contract holder pursuant to section 376.805."

175. Anthem's application forms do not include clear and conspicuous notice as to whether the group contract holder has purchased an optional rider for elective abortions.

176. Each of Anthem's failures to inform applicants and policyholders of the coverage for elective abortion under a group OBGRx Plan is a separate violation of §376.1199.6(4).

177. Each violation of §376.1199.6(4) is a Level 1 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7 to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXVII

Anthem has made or used misrepresentations, concealment, or suppression as to a material fact or facts relating to the coverage of elective abortion in connection with the offer or solicitation of group health benefit plans in violation of §375.144(2).

178. The Division incorporates and re-alleges Paragraphs 1 through 177 of this Verified Statement of Charges.

179. As demonstrated by Exhibit C, Anthem has violated §375.144(2) by making or using misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of group health insurance directly or indirectly, by engaging in the acts, practices, omissions or course of business relating to insurance described herein.

180. The requirements of §376.1199.6 have established that the existence of coverage for elective abortions under group OBGRx Plans is a fact which is material to those seeking to purchase group health benefit plans.

181. As demonstrated by Exhibit C, Anthem's applications for large and small group health insurance are not in compliance with §376.1199.6(4) in that they fail to provide clear and conspicuous notice to applicants and policyholders if coverage for elective abortion is to be provided under the OBGRx Plan, through the purchase of a separate elective abortion rider.

182. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders and applicants about the coverage of elective abortion under Anthem's group OBGRx Plans.

183. Each of Anthem's failures to inform applicants and policyholders of the coverage for elective abortion under a group OBGRx Plan is a separate violation of §375.144(2).

184. Each violation of §375.144(2) is subject to the imposition of a forfeiture and, if committed on or after August 28, 2006 is a Level 4 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXVIII

Anthem has violated §375.934, engaging in unfair trade practices defined in §375.936(6)(a) by misrepresenting insurance policies through an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan relating to the coverage of elective abortion.

185. The Division incorporates and re-alleges paragraphs 1 through 184 of this Verified Statement of Charges.

186. The failure to provide clear and conspicuous written notice that the optional rider for elective abortions has been purchased by the group contract holder on application forms, also constitutes a violation of §375.934 in that it is an unfair trade practice, which is defined in §375.936(6)(a) to include an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan.

187. Each instance in which Anthem made misrepresentations of insurance policies through an omission that misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan is a separate violation of §375.934.

188. Each violation of §375.934 is a Level 2 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXIX

Anthem has failed to provide clear and conspicuous written notice on the enrollment form or accompanying materials to the enrollment form of an enrollee's right to exclude and not pay for coverage of elective abortions when the optional rider has been purchased by the group policyholder, as required by §376.1199.

189. The Division incorporates and re-alleges paragraphs 1 through 188 of this Verified Statement of Charges.

190. As demonstrated by Exhibit C, Anthem has violated §376.1199.6(5) related to OBGRx Plans by failing to provide clear and conspicuous written notice on the enrollment form or accompanying materials:

> (5) That an enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical, or religious beliefs. For purposes of this subsection, if new premiums are charged for a contract, plan, or policy, it shall be determined to be a new contract, plan, or policy.

191. Each of Anthem's failures to inform enrollees of their right to exclude and not pay for coverage of elective abortion under a group OBGRx Plan is a separate violation of §376.1199.6(5).

192. Each violation of §376.1199.6(5) is a Level 1 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7 to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXX

Anthem has made or used misrepresentations, concealment, or suppression as to a material fact or facts relating to enrollee's right to reject coverage of elective abortion in connection with the offer or solicitation of group health benefit plans in violation of §375.144(2).

193. The Division incorporates and re-alleges Paragraphs 1 through 192 of this Verified Statement of Charges.

194. As demonstrated by Exhibits C and D, Anthem has violated §375.144(2) by making or using misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of group health insurance directly or

indirectly, by engaging in the acts, practices, omissions or course of business relating to insurance descried herein.

195. The requirements of §376.1199.6(5) have established that the existence of coverage for elective abortions under group OBGRx Plans is a fact which is material to those seeking to be covered under group health benefit plans.

196. As demonstrated by Exhibits C and D, Anthem's enrollment form or accompanying materials to the enrollment form for large and small group health insurance are not in compliance with §376.1199.6(5) in that they fail to provide clear and conspicuous notice to enrollees of their right to exclude coverage for elective abortion under a group OBGRx Plan.

197. Anthem has and continues to misrepresent, conceal and suppress material facts from its enrollees about the coverage of elective abortion under Anthem's group OBGRx Plans.

198. Each of Anthem's failures to inform enrollees of their right to exclude coverage for elective abortion under a group OBGRx Plan is a separate violation of §375.144(2).

199. Each violation of §375.144(2) is subject to the imposition of a forfeiture and, if committed on or after August 28, 2006 is a Level 4 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXXI

Anthem has violated §375.934, engaging in unfair trade practices defined in §375.936(6)(a) by misrepresenting insurance policies through an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan relating to the coverage of elective abortion.

200. The Division incorporates and re-alleges paragraphs 1 through 199 of this Verified Statement of Charges.

201. The failure to provide clear and conspicuous written notice on the enrollment form or accompanying materials to the enrollment form of an enrollee's right to exclude and not pay for coverage of elective abortions when the optional rider has been purchased by the group policyholder also constitutes a violation of §375.934 in that it is an unfair trade practice, which is defined in §375.936(6)(a) to include an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan.

202. Each instance in which Anthem made misrepresentations of insurance policies through an omission that misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan is a separate violation of §375.934.

203. Each violation of §375.934 is a Level 2 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXXII

Anthem has failed to provide clear and conspicuous written notice on application forms of an enrollee's right to exclude and not pay for coverage for elective abortions when the optional rider has been purchased by the group policyholder, as required by §376.1199.

204. The Division incorporates and re-alleges paragraphs 1 through 203 of this Verified Statement of Charges.

205. As demonstrated by Exhibit C, Anthem has violated §376.1199.6(5) related to OBGRx Plans by failing to provide clear and conspicuous written notice on the group OBGRx Plan application and contract:

> (5) That an enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her

> moral, ethical, or religious beliefs. For purposes of this subsection, if new premiums are charged for a contract, plan, or policy, it shall be determined to be a new contract, plan, or policy.

206. Each of Anthem's failures to inform applicants and policyholders of the right of an enrollee to exclude coverage for elective abortion under a group OBGRx Plan is a separate violation of §376.1199.6(5).

207. Each violation of §376.1199.6(5) is a Level 1 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7 to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXXIII

Anthem has made or used misrepresentations, concealment, or suppression as to a material fact relating to the enrollee's right to exclude coverage of elective abortion in connection with the offer or solicitation of group health benefit plans in violation of violation of §375.144(2).

208. The Division incorporates and re-alleges Paragraphs 1 through 207 of this Verified Statement of Charges.

209. As demonstrated in Exhibit C, Anthem has violated §375.144(2) by making or using misrepresentation, concealment, or suppression as to any material fact in connection with the offer, sale, solicitation or negotiation of group health insurance directly or indirectly, by engaging in the acts, practices, omissions or course of business relating to insurance described herein.

210. The requirements of §376.1199.6 have established that the existence of coverage for elective abortions under group OBGRx Plans is a fact which is material to those seeking to purchase group health benefit plans.

211. As demonstrated by Exhibit C, Anthem's applications for large and small group health insurance are not in compliance with §376.1199 in that they fail to provide clear and conspicuous notice to applicants and policyholders of the enrollee's right to exclude coverage for elective abortion.

212. Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders and applicants about the coverage of elective abortion under Anthem's group OBGRx Plans.

213. Each of Anthem's failures to inform applicants and policyholders of the enrollee's right to exclude coverage for elective abortion under a group OBGRx Plan is a separate violation of §375.144(2).

214. Each violation of §375.144(2) is subject to the imposition of a forfeiture and, if committed on or after August 28, 2006 is a Level 4 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

COUNT XXXIV

Anthem has violated §375.934, engaging in unfair trade practices defined in §375.936(6)(a) by misrepresenting insurance policies through an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan with regard to coverage for elective abortion.

215. The Division incorporates and re-alleges paragraphs 1 through 214 of this Verified Statement of Charges.

216. The failure to provide required notice on the application form also constitutes a violation of §375.934 in that it is an unfair trade practice, which is defined in §375.936(6)(a) to

include an omission which misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan.

217. Each instance in which Anthem made misrepresentations of insurance policies through an omission that misrepresents the benefits, advantages, conditions, or terms of a group health benefit plan is a separate violation of §375.934.

218. Each violation of §375.934 is a Level 2 violation pursuant to §374.049 and is subject to enhancement pursuant to §374.049.7, to the extent such violations were knowing, and subject to further enhancement because such violations were knowingly committed in conscious disregard of the law.

VIOLATIONS ARE CONTINUING IN NATURE AND REQUEST FOR SUMMARY CEASE AND DESIST ORDER

219. The Division incorporates and re-alleges paragraphs 1 through 218 of this Verified Statement of Charges.

220. The Division has accessed Anthem's web site and reviewed the application for individual health insurance coverage on multiple occasions since the newly revised §376.1199 became effective on October 12, 2012.

221. Anthem's online application process and application form for individual health insurance are not in compliance with §376.1199 in that Anthem does not offer health benefit plans without coverage for contraceptives if such coverage is contrary to the moral, ethical or religious beliefs or tenets of the person or entity seeking coverage.

222. The Division accessed Anthem's website and reviewed Anthem's "Agent Home" and "Employer Home" portals, which allow producers and employers to access application and enrollment forms and any accompanying materials to the enrollment form for the small and large group health benefit plans sold in this state. The Division accessed these websites and

these forms on multiple occasions since the newly revised §376.1199 became effective on October 12, 2012.

223. The "Agent Home" is a self-service portal, open and accessible to any licensed producers in this state, so they may obtain the necessary forms they need to sell and solicit large and small group health benefit plans in this state.

224. The "Employer Home" is a self-service portal, open and accessible to employers seeking information about coverage options for their employees.

225. The "Agent Home" and "Employer Home" portals, and the application, enrollment forms, and accompanying materials to the enrollment forms for large and small group health benefit plans, are also open and accessible to large and small group employers, their employees, and other Missouri consumers.

226. Anthem's application, enrollment forms, and accompanying materials to the enrollment form for large and small group health insurance are not in compliance with §376.1199 in that they continue to fail to provide the required coverage notices regarding elective abortions and contraceptives under the OBGRx Plan.

227. Anthem's enrollment form and accompanying materials to the enrollment form for large and small group health insurance are not in compliance with §376.1199 in that they fail to allow enrollees the option to reject coverage for elective abortion and contraceptives, if such coverage is purchased by their employer.

228. Anthem's application forms for large and small group health insurance are not in compliance with §376.1199 in that they fail to notify employers of the enrollee's rights to purchase coverage for contraceptives, if such coverage is not provided under the OBGRx Plan.

229. Anthem's application forms for large and small group health insurance are not in compliance with §376.1199 in that they fail to notify employers of the enrollee's rights to exclude coverage for contraceptives and elective abortion, if such coverage is provided under the OBGRx Plan.

230. The requirements of §376.1199 have established that the existence of coverage for contraceptives and elective abortion under OBGRx Plans is material to persons or entities seeking to purchase, or be covered under, said OBGRx Plans.

231. Through its failure to offer OBGRx Plans without contraceptives coverage when required, Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders, applicants, and enrollees.

232. Through its failure to provide clear and conspicuous notice of whether or not coverage of contraceptives is included in its OBGRx Plans, Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders, applicants, and enrollees.

233. Through its failure to provide clear and conspicuous notice of whether coverage of elective abortions is included in its OBGRx Plans by optional rider, Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders, applicants, and enrollees.

234. Through its failure to provide clear and conspicuous notice that an enrollee who is a member of a group OBGRx Plan has the right to exclude coverage for elective abortion and contraceptives if coverage is provided under the OBGRx Plan, Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders, applicants, and enrollees.

235. Through its failure to provide clear and conspicuous notice that an enrollee who is a member of a group OBGRx Plan has the right to purchase coverage for contraceptives if coverage is not provided under the OBGRx Plan, Anthem has and continues to misrepresent, conceal and suppress material facts from its policyholders, applicants, and enrollees.

236. The Department has issued two separate bulletins to the insurance industry, to inform the industry of both the passage and effectiveness of CCS HCS SS SB 749 and the provisions contained therein.

237. The Division has reviewed form filing submissions made via the SERFF system. The Division has not been able to locate an application, enrollment form, or accompanying materials to an enrollment form submitted by Anthem on or after October 12, 2012 for the Department's review and approval which comply with §376.1199.

238. Anthem has continued to actively offer, sell, solicit and negotiate health benefit plans in this state through the Anthem website since the newly revised §376.1199 became effective on October 12, 2012.

239. Upon information and belief, Anthem has continued to actively offer, sell, solicit and negotiate health benefit plans with non-compliant policies, enrollment and application forms and accompanying materials in this state through its producer distribution channels since the newly revised §376.1199 became effective on October 12, 2012.

240. Anthem has knowingly and knowingly in conscious disregard of the law failed to make any effort to comply with §376.1199.

241. By continuing to sell products that are not in compliance with Missouri law and by not filing forms to reflect revisions to bring its products into compliance with Missouri law, Anthem has and continues to knowingly misrepresent, conceal and suppress material facts as to

coverage for elective abortion and contraceptives from its policyholders, applicants, and enrollees.

242. Because §375.144 is being violated by Anthem and consumers are being aggrieved by the violations, a summary order under §376.046.4 is necessary to stop further violations of the law and prevent further harm to consumers.

243. The Division respectfully requests that the Director issue a summary order requiring Anthem to immediately cease and desist using application forms, application processes, enrollment form or accompanying materials to the enrollment form, and all other forms or processes that are not in compliance with the requirements of §376.1199.

REQUEST FOR RELIEF

The Division respectfully requests that the Director grant the following relief:

a. Issue an order finding that Healthy Alliance and HMO-MO have engaged in acts, practices, omissions or courses of business constituting a violation of the laws of this state relating to insurance in Chapters 354 or 374 to 385, including violations of §§375.144, 375.934, and 376.1199.

b. Issue an order requiring Healthy Alliance and HMO-MO to cease and desist offering, selling, soliciting, or negotiating all non-compliant OBGRx Plans, directly or indirectly.

c. Issue an order requiring Healthy Alliance and HMO-MO to cease and desist using application forms, application processes, enrollment form or accompanying materials to the enrollment form and all other forms or processes that are not in compliance with §376.1199.

d. Issue a curative order requiring Healthy Alliance and HMO-MO to:

   i. Offer and issue OBGRx Plans that exclude coverage for contraceptives if such coverage is contrary to the moral, ethical or religious beliefs or tenets of the person or entity;

   ii. For policies purchased since October 12, 2012, to take the following actions:

      1. Provide notice to all enrollees as to whether coverage for contraceptives is included or not;

      2. For enrollees whose OBGRx health benefit plan includes coverage for contraceptives, allow enrollees to opt out of such coverage if it is contrary to the enrollee's moral, ethical, or religious beliefs;

      3. For enrollees whose OBGRx group health benefit plan does not include coverage for contraceptives, allow enrollees to purchase coverage for contraceptives;

      4. Provide notice to enrollees in an OBGRx group health benefit plan as to whether an optional rider for elective abortion has been purchased by the group policyholder; and

      5. For enrollees whose OBGRx group health benefit plan includes coverage for elective abortion, allow enrollees to exclude and not pay for coverage for elective abortion if it is contrary to the enrollee's moral, ethical, or religious beliefs.

iii. For policies intended to be marketed, issued, or sold in the State of Missouri, submit to the Director for review and approval policies, enrollment forms and group health benefit plan application forms, contracts or any accompanying materials to the enrollment form which meet the following statutory requirements:

   1. Provide notice to all enrollees as to whether or not their health benefit plan includes coverage for contraceptives;
   2. For enrollees whose health benefit plan includes coverage for contraceptives, allow enrollees to opt out of such coverage if it is contrary to the enrollee's moral, ethical, or religious beliefs;
   3. For enrollees whose group health benefit plan does not include coverage for contraceptives, allow enrollees to purchase coverage for contraceptives;
   4. Provide notice to enrollees in a group health benefit plan as to whether an optional rider for elective abortion has been purchased by the group policyholder; and
   5. For enrollees whose group health benefit plan includes coverage for elective abortion, allow enrollees to exclude and not pay for coverage for elective abortion if it is contrary to the enrollee's moral, ethical, or religious beliefs.

e. Issue an order imposing monetary penalties or forfeitures pursuant to §374.046, §374.049, §374.280 and §375.145 RSMo 2000.

f. Issue an order requiring the payment of the actual costs of the investigation and the actual costs of this proceeding pursuant to §374.046.8 and the reasonable costs of the investigation pursuant to §374.046.1(4).

REQUEST FOR A SHOW CAUSE ORDER

The Division of Insurance Market Regulation respectfully requests that the Director issue an order directing Anthem to show cause why the relief requested in this Statement of Charges should not be entered against Anthem. In such order to show cause, this matter should be set for a hearing at least ten days after service of the Statement of Charges pursuant to §374.046.3 and §374.046.6, but not more than ninety days from the date of this Statement of Charges as required by 20 CSR 800-1.030 (4).

Respectfully submitted,

AMY V. HOYT
Missouri Bar No. 49338

STEWART M. FREILICH
Missouri Bar No. 36924
Missouri Department of Insurance, Financial Institutions and Professional Registration
301 West High Street, Room 530
Jefferson City, Missouri 65101

ATTORNEYS FOR INSURANCE MARKET REGULATION DIVISION

VERIFICATION

I, Angela Nelson, Director of the Division of Insurance Market Regulation, state that the factual allegations contained in this petition are true and accurate to my best knowledge, information, and belief.

Angela Nelson
Director, Insurance Market Regulation Division
Department of Insurance, Financial
Institutions and Professional Registration

Sworn to and subscribed before me this 16th day of November, 2012

Notary (Seal)

My commission expires: March 20, 2014

NOTARY PUBLIC NOTARY SEAL STATE OF MISSOURI

JULIA K. PHELPS
My Commission Expires
March 20, 2014
Cole County
Commission #10529898

DEPARTMENT OF INSURANCE, FINANCIAL
INSTITUTIONS AND PROFESSIONAL REGISTRATION

P.O. Box 690, Jefferson City, Mo. 65102-0690

INSURANCE BULLETIN 12-02

Implementation of Senate Bill 749
Issued Sept. 14, 2012

To: All insurers authorized to conduct health insurance business in Missouri.
All insurers delivering policies covering Missouri residents.
All third-party administrators licensed to administer health insurance business for insurers and self-insured plans covering Missouri residents.

From: John M. Huff, Director

Re: Implementation of SB 749

On Sept. 12, 2012, the Missouri General Assembly voted to override Governor Nixon's veto of CCS HCS SS SB 749. The bill includes an emergency clause, making the provisions of Section 191.724, RSMo, effective upon passage and approval. The provisions of Section 376.1199, RSMo, become effective on Oct. 12, 2012.

This bulletin is for informational purposes only. Every health insurance carrier operating in this state, every health insurance carrier insuring Missouri residents, and every self-insured plan covering Missouri residents is strongly encouraged to review this law in its entirety to ensure compliance.

The Department will continue to update the market on further implementation requirements.

EXHIBIT

A

DEPARTMENT OF INSURANCE, FINANCIAL
INSTITUTIONS AND PROFESSIONAL REGISTRATION

P.O. Box 690, Jefferson City, Mo. 65102-0690

INSURANCE BULLETIN 12-03

Implementation of Senate Bill 749
Issued October 12, 2012

To: All insurers authorized to conduct health insurance business in Missouri.
All insurers delivering policies covering Missouri residents.
All producers and all other interested parties.

From: John M. Huff, Director

Re: Implementation of SB 749

On Sept. 12, 2012, the Missouri General Assembly voted to override Governor Nixon's veto of CCS HCS SS SB 749. The bill includes an emergency clause that made the provisions of Section 191.724, RSMo, effective upon passage and approval. The provisions of Section 376.1199, RSMo, became effective today.

Missouri law requires that health insurance policies, contracts, and forms be filed with the Department. These materials can only be approved by the Department if they comply with the statutory requirements contained in SB 749. Note that the bill requires, with one narrow exception, that "each carrier or health benefit plan that offers or issues health benefit plans providing obstetrical/gynecological benefits and pharmaceutical coverage, which are delivered, issued for delivery, continued or renewed in this state on or after January 1, 2002," (1) to "offer and issue to any person or entity purchasing a health benefit plan, a health benefit plan that excludes coverage for contraceptives if the use or provision of such contraceptives is contrary to the moral, ethical or religious beliefs or tenets of such person or entity;" and (2) shall "upon request of an enrollee who is a member of a group health benefit plan and who states that the use or provision of contraceptives is contrary to his or her moral, ethical or religious beliefs, any health carrier shall issue to or on behalf of such enrollee a policy form that excludes coverage for contraceptives."

EXHIBIT
B

Further note that any health benefit plan issued pursuant to 376.1199.1 "shall provide *clear and conspicuous written notice* on the enrollment form or any accompanying materials to the enrollment form and the group health benefit plan application and contract: (1) whether coverage for contraceptives is or is not included; (2) that an enrollee who is a member of a group health benefit plan with coverage for contraceptives has the right to exclude coverage for contraceptives if such coverage is contrary to his or her moral, ethical or religious beliefs; (3) that an enrollee who is a member of a group health benefit plan without coverage for contraceptives has the right to purchase coverage for contraceptives; (4) whether an optional rider for elective abortions has been purchased by the group contract holder pursuant to section 376.805; and (5) that an enrollee who is a member of a group health plan with coverage for elective abortions has the right to exclude and not pay for coverage for elective abortions if such coverage is contrary to his or her moral, ethical, or religious beliefs."

As has long been the case, the Department may only approve those filings that are in compliance with the insurance laws of this state and which contain such words, phraseology, conditions and provisions which are specific, certain and unambiguous and are reasonably adequate to protect consumers.

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Agent Home

Our websites now reflect changes brought about by health care reform. These changes will be reflected in groups' and Individual member's benefits beginning with plan years beginning on and after September 23, 2010. For general information about health care reform, visit www.anthem.com/healthcarereform.

NOTE: *For small employers with more than 50 total employees, but fewer than 50 eligible employees, please contact your Anthem sales rep for a quote with Mental Health Parity-compliant benefits.*

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Serving Missouri since 1936, we have one of the largest networks and an extensive portfolio of products. Anthem can meet all of your needs.

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- Download Forms
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- Anthem Care Comparison Demo
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- Time Well Spent[SM]
- Dental, Vision, Life and Disability Demo

Our Plans and Benefits

One size does not fit all. So, we offer freedom of choice through one of the largest provider networks in the nation, with a variety or plans built around the needs of your clients' business, whether they run a small country club or a small country.

- Group Health | Medicare Eligible Plans | Prescription | Dental | Vision | Life and Disability

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Anthem Blue Cross and Blue Shield is the trade name of: In Colorado Rocky Mountain Hospital and Medical Service, Inc. HMO products underwritten by HMO Colorado, Inc. In Connecticut: Anthem Health Plans, Inc. In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Maine: Anthem Health Plans of Maine, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Nevada: Rocky Mountain Hospital and Medical Service, Inc. HMO

products underwritten by HMO Colorado, Inc., dba HMO Nevada. In New Hampshire: Anthem Health Plans of New Hampshire, Inc. In Ohio: Community Insurance Com pany. In Virginia: Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the Town of Vienna, and the area east of State Route 123. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWi"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWi collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. Use of the Anthem Web sites constitutes your agreement with our Terms of Use

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Electronic Funds Transfer (EFT)

Wednesday, Oct 17, 2012 11:13 AM

Enrollment Application

Anthem. AnthemLife

Group size 2-99 eligible employees

Anthem Blue Cross and Blue Shield is used collectively as the trade name for RightChoice Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), HMO Missouri, Inc., and Anthem Life Insurance Company (ALIC). HALIC underwrites PPO and traditional health coverages; HMO Missouri, Inc. underwrites HMO and POS coverages; and ALIC underwrites Life, Accidental Death and Dismemberment, Short Term Disability and Long Term Disability coverages.

KS Residents only: Coverage applied for: ☐ PPO/Traditional (Healthy Alliance Life Insurance Company) ☐ Life & Disability (Anthem Life Insurance Company)

Please complete in black or blue ink for employee and all dependents enrolling with us and return to your employer. Use extra sheets of paper if necessary. Please provide complete details to avoid delay. If you have creditable coverage, we will give you credit for your prior coverage, and pre-existing condition limitations will be reduced or excluded for any conditions listed below. Please note that no one will be denied health coverage on an individual basis due to the answers provided below. *All information given should apply to this employer.*

1. TYPE OF COVERAGE REQUESTED: ☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family ☐ Life Only ☐ No coverage

2. ENROLLMENT INFORMATION ☐ Single ☐ Divorced ☐ Married

Relationship	Last Name, First Name, M.I.	Social Security No. Required	Sex	Age	Date of birth	Height/ Weight	Current tobacco user?	Disabled?
Employee			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
Spouse			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other ____			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other ____			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other ____			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other ____			☐ M ☐ F		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No

Employee Home Address: Street, City, State, ZIP Code | County

Employee Home Phone ( ) | Employee Work Phone ( ) | Employee Email Address

Dependent Home Address: Street, City, State, ZIP Code (if different from employee) | Dependent Name(s)

3. MEDICAL INFORMATION *(If yes, circle condition)*

*** Please read the Genetic Information Non-discrimination Act (GINA) information in section 11, prior to answering the below questions.**

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? ☐ Yes ☐ No
3. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, name ____________ due date ___/___/___
4. In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor/growth; disorder of the blood or immune system; stroke, aneurysm, high blood pressure, diabetes **(list age of onset below)**; mental/nervous disorder; Parkinson's disease; migraine/cluster headaches; seizures/epilepsy; depression; alcohol or drug abuse/dependency; kidney disease; kidney stones; liver or pancreas disorder; digestive/intestinal disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; muscular dystrophy; infertility/reproductive organ disorder; congenital disease or birth defect; cerebral palsy; or any other condition? ☐ Yes ☐ No
5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ Yes ☐ No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest. #	Name of Individual	Diagnosis	Treatment	Medication	Onset Date	Date(s) of Treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			

4. SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) ***Please read this section carefully before signing the application.***

I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem Blue Cross and Blue Shield in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to coverage or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being rescinded or cancelled.

READ THE TERMS SECTIONS 4 AND 11 CAREFULLY BEFORE SIGNING. PLEASE REVIEW YOUR APPLICATION FOR ERRORS OR OMISSIONS.

Applicant Signature | Please Print Name | Date / /

ANTHEM USE ONLY

Coordination of Benefits? ☐ Yes ☐ No | Pre-ex (date)

Enrollment Application

Anthem. AnthemLife

Group size 2-99 eligible employees Name: ______ SSN: ___ - ___ - ___

5. PLEASE COMPLETE ALL INFORMATION

Reason for application:
☐ New enrollment
☐ Open enrollment (N/A for Life coverage)
☐ Qualifying event
(please complete date and reason)
Event Date ___/___/___
☐ Marriage ☐ Divorce
☐ Birth of Child ☐ Adoption
☐ Termed Employment
☐ Other
☐ COBRA
Event ______
Date ___/___/___
☐ State Continuation ☐ Waiver

Group Name		Group number	Sub Group Number
Group Address			Employee Hire/Rehire Date (Full time) / /
Employee status ☐ Active ☐ Disabled ☐ Retired ☐ Other (please explain)	Hours working per Week ______ If not actively working, reason Projected Return Date ___/___/___	Occupation	Income reported by: ☐ W2 ☐ 1099 ☐ Other (please explain)

6. COVERAGE SELECTION ***(Availability dependent upon your employer's offering)***

Medical Coverage
Please check one type:
☐ Employee only
☐ Employee + spouse
☐ Employee + child(ren)
☐ Family
☐ No Coverage

Check the medical plan you are applying for:
☐ PPO
☐ Blue Preferred® Select
☐ Anthem Essential℠ PPO
☐ Anthem Essential℠ Choice PPO
☐ Anthem Essential℠ Select
☐ HMO
☐ POS
☐ Hospital Surgical
☐ HDHP*

☐ HDHP*/PPO
☐ Core
☐ Buy Up
☐ PPO/PPO
☐ Core
☐ Buy Up

☐ Lumenos® Health Savings Account
☐ Lumenos® Health Reimbursement Account
☐ Lumenos® Health Incentive Account
☐ Lumenos® Health Incentive Account Plus
☐ Blue Access® Health Savings Account
☐ Blue Access® Choice Health Savings Account

*Do you have, or are you establishing a Health Savings Account? ☐ Yes ☐ No

Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.

Dental Coverage:
Please check one type:
☐ Employee only
☐ Employee + spouse
☐ Employee + child(ren)
☐ Family
☐ No Coverage

Vision Coverage:
Please check one type:
☐ Employee Only
☐ Employee + Spouse
☐ Employee + child(ren)
☐ Family Coverage
☐ No coverage

If enrolling in an HMO product, please submit a PCP selection form. Anthem's PCP listings can be obtained at www.anthem.com.

7. WAIVER OF COVERAGE SECTION: ***(Must be completed if employee and/or dependents waive medical, vision, dental or life coverage)***

NOTE: If waiving coverage, please complete this section. Section 4 must also be signed and dated.

Medical Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)
Dental Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)
Vision Coverage declined for (check all that apply):
☐ Myself ☐ Spouse ☐ Dependent(s)
Life coverage declined for: ☐ Myself

Reason for Declining Coverage (check all that apply):
☐ Covered by spouse's group coverage - Carrier name and ID Number ______
☐ Enrolled in other Insurance provided by my employer
- Carrier name and ID Number ______
☐ Enrolled in Individual coverage - Carrier name and ID Number ______
☐ Spouse covered by employer's group medical Coverage
☐ Medicare
☐ Other (Please explain)
☐ No coverage

8. PRIOR HEALTH INSURANCE INFORMATION

Prior Health Care Coverage During the past 2 years (including Anthem):

Insurance company name(s):	Type of prior coverage	Policy number	Effective Date	Cancel Date
	☐ Employee Only ☐ Employee + child(ren) ☐ Employee + spouse ☐ Family ☐ Other		/ /	/ /

9. OTHER HEALTH INSURANCE INFORMATION

On the day your coverage begins, will you or a family member be covered by other health insurance coverage and/or Medicare? ☐ Yes ☐ No

Family Members Covered by other health coverage:	Insurance company name, address and phone number	Policy number	Effective date / /

Policy/Certificate Holder's Name	Social Security Number	Date of birth / /	Relationship to applicant	Family members covered by Medicare:

Medicare ID #	Part A effective date	Part B effective date	*Medicare eligibility reason (check all that apply)* ☐ Age ☐ Disability ☐ ESRD: Onset Date ____

Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date / /	Medicare Part D term date / /

Enrollment Application

Anthem. AnthemLife

Group size 2-99 eligible employees Name: ______________________ SSN: ____ - ____ - ______

10. Life and Disability Insurance

☐ Basic Life ☐ Basic AD&D ☐ Short Term Disability ☐ Dependent Life ☐ Optional AD&D ☐ Long Term Disability ☐ Optional Life: ________ x annual earnings OR $ ________ ☐ Current income: $ ________ ☐ Hour ☐ Week ☐ Month ☐ Year	☐ Anthem By Design® Short Term Disability-BUY UP ☐ Anthem By Design® Long Term Disability-BUY UP ☐ Anthem By Design® Basic Life-BUY UP (Complete separate election form)	Life Class

	Last name	First name, M.I.	Social Security #	Relationship to applicant	Age
Primary Beneficiary			- -		
Contingent Beneficiary			- -		

11. SIGNIFICANT TERMS, CONDITIONS AND (UNDERWRITES LIFE AND DISABILITY COVERAGES ONLY) AUTHORIZATIONS (TERMS) ***Please read this section carefully before signing the application in Section 4.***

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: Except as otherwise provided in any agreement between me and *the financial custodian*, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before *the financial custodian* may provide Anthem Blue Cross Blue Shield with information regarding my HSA. I hereby authorize *the financial custodian* to provide Anthem Blue Cross Blue Shield with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem Blue Cross Blue Shield with a written request to revoke my authorization at any time.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied (Anthem Life Insurance Company (underwrites life and disability coverages only) may accept certain persons or conditions for coverage. If accepted, my plan may exclude coverage for pre-existing conditions (Not applicable to MO HMO and Life insurance).
3. I understand that Anthem imposes a pre-existing condition exclusion. The pre-existing exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period (90 days in Kansas) prior to enrollment. This exclusion may last up to 12 months (90 days in Kansas) from the first day of coverage, or if in a waiting period, from the first day of the waiting period. The pre-existing condition exclusion does not apply to pregnancy or to a dependent that is enrolled in the plan prior to his/her 19th birthday.
   I understand the pre-existing exclusion waiting period is reduced by the number of days of prior creditable coverage provided there has not been a break in coverage of more than 63 days. To reduce the pre-existing exclusion waiting period, Anthem must receive a copy of the certificate of prior creditable coverage from the prior Health Insurance Carrier. (Not applicable to MO HMO products.)
4. If I am declining enrollment for myself or my dependent(s) (including my spouse) because of other health insurance or group health plan coverage, I understand that I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards my coverage or my dependent's other coverage). However, I must request enrollment within 31 days after my coverage or my dependent's other coverage ends (or after the employer stops contribution toward the other coverage). In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependent(s) provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. I also understand that my dependents and I may enroll under two additional circumstances:
   - Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
   - My dependent or I become eligible for a subsidy (state premium assistance program)

   In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.
5. Life and disability products are underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross Blue Shield Association.

By signing Section 4, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms. I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. ***Thank you for choosing Anthem Blue Cross and Blue Shield.***

In Missouri, (excluding 30 counties in the Kansas City area) Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Employee Change Form Application

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Anthem Blue Cross and Blue Shield is used collectively as the trade name for RightChoice Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), HMO Missouri, Inc., and Anthem Life Insurance Company (ALIC). HALIC underwrites PPO and traditional health coverages; HMO Missouri, Inc. underwrites HMO and POS coverages; and ALIC underwrites Life, Accidental Death and Dismemberment, Short Term Disability and Long Term Disability coverages.

Please complete this form ONLY when making changes to your existing coverage. If you are APPLYING for coverage or ADDING a dependent(s), complete the "Anthem Enrollment Application" instead of this form. When completing section 2, be sure to include the date of the event causing the change(s). If you are cancelling coverage for a dependent, changing a PCP, or changing a name, please provide a reason in the designated sections.

Complete in ink and return to your employer, using extra sheets of paper if necessary.

NOTE: Some changes may be made by accessing www.anthem.com. Anthem's Primary Care Physician (PCP) listings, for HMO/POS products can be obtained through **www.anthem.com**.

1. Employer/Group Use: Employer Name and Address:

Group #	Sub-group #/Life Division #	Request Effective Date	Life Classification	Applicant #/Dept. name

Anthem use: Plan	Health Effective Date	Life Effective Date	Dental Effective Date	Vision Effective Date	PCP	COB	Pre-ex (date)
	/ /	/ /	/ /	/ /	☐Yes ☐No	☐Yes ☐No	/ /

2. Reason for Change

Event date ___/___/___

- ☐ Address
- ☐ Change Life Beneficiary
- ☐ Change Life Classification
- ☐ Enrollment in Medicare (see section 7)
- ☐ Cancel/Waiving Coverage (Refer to section 9)
- ☐ Conversion
- ☐ Benefit change
- ☐ Cancel dependent
- ☐ PCP change
- ☐ Name change
- ☐ Other ________

3. Type of Coverage/Plan

Health Coverage

- ☐ HMO* ☐ POS* ☐ PPO ____
- ☐ Anthem Essential℠ PPO
- ☐ Anthem Essential℠ Choice PPO
- ☐ Anthem Essential℠ Select
- ☐ Blue Preferred® Select
- ☐ Hospital Surgical
- ☐ Lumenos® Health Savings Account
- ☐ Lumenos® Health Reimbursement Account
- ☐ Lumenos® Health Incentive Account
- ☐ Lumenos® Health Incentive Account Plus
- ☐ Employee only ☐ Employee+spouse
- ☐ Employee + child(ren)
- ☐ Family coverage
- ☐ No coverage
- ☐ Do you have, or are you establishing a Health Savings Account? ☐ Yes ☐ No

Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.

Dental Coverage

- ☐ PPO ____
- ☐ DentaBlue (PPO)
- ☐ DentaBlue Select (PPO)
- ☐ Dental Blue® 100
- ☐ Dental Blue® 100/200/300
- ☐ Employee only
- ☐ Employee + spouse
- ☐ Employee + child(ren)
- ☐ Family coverage
- ☐ No coverage

Vision Coverage

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + child(ren)
- ☐ Family Coverage
- ☐ No coverage

Life Coverage

- ☐ Life (see section 7)

Genetic Information Non-discrimination Act (GINA): When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Health Savings Account Notice: Except as otherwise provided in any agreement between me and *the financial custodian*, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before *the financial custodian* may provide Anthem Blue Cross and Blue Shield with information regarding my HSA. I hereby authorize *the financial custodian* to provide Anthem Blue Cross and Blue Shield with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem Blue Cross and Blue Shield with a written request to revoke my authorization at any time.

4. Employee Information **Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products.*

Last name	First name, M.I.	Date of birth	Sex	Social Security # (SS# required)		Height	Weight
		/ /	☐M ☐F	- -	☐ Single ☐ Divorced ☐ Married		

Home address	City	State	Zip code	County

Hours worked per week	Anthem PCP name and address*	Anthem PCP ID number*	New patient? ☐ Yes ☐ No

If PCP is a change, please indicate the reason for the change.

5. Family Information *Spouse and dependents to be changed/cancelled. (Attach a separate sheet if necessary.)* Only complete Primary Care Physician (PCP) information if enrolling in HMO or POS products. (SS # required for spouse/domestic partner)*

1 ☐ Change ☐ Cancel	Last name	First name, M.I.

Date of birth	Sex	Social Security #	Relationship to insured	Reason for change
/ /	☐M ☐F	- -	☐ Spouse ☐ Daughter ☐ Son ☐ Other ____	

Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)

Anthem PCP name and address*	Anthem PCP ID number*	New patient? ☐ Yes ☐ No

If PCP is a change, please indicate the reason for the change.

NAME ______________________ SSN ______________________

2 ☐ Change ☐ Cancel		Last name		First name, M.I.	
Date of birth / /	Sex ☐ M ☐ F	Social Security #	Relationship to insured ☐ Spouse ☐ Daughter ☐ Son ☐ Other ____	Reason for change	
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)					
Anthem PCP name and address*				Anthem PCP ID number*	New patient? ☐ Yes ☐ No
If PCP is a change, please indicate the reason for the change.					

3 ☐ Change ☐ Cancel		Last name		First name, M.I.	
Date of birth / /	Sex ☐ M ☐ F	Social Security #	Relationship to insured ☐ Spouse ☐ Daughter ☐ Son ☐ Other ____	Reason for change	
Is dependent's address different than applicant's address? ☐ Yes ☐ No (If Yes, provide full address)					
Anthem PCP name and address*				Anthem PCP ID number*	New patient? ☐ Yes ☐ No
If PCP is a change, please indicate the reason for the change.					

6. Life and Disability Insurance

☐ Basic Life ☐ Basic AD&D ☐ Short Term Disability ____ %
☐ Dependent Life ☐ Supplemental AD&D ☐ Long Term Disability ____ %
☐ Supplemental Life: ____ x annual earnings OR $ ____
☐ Current Income: $ ____ ☐ *Hour* ☐ *Week* ☐ *Month* ☐ *Year*

☐ Anthem By Design Short Term Disability-BUY UP
☐ Anthem By Design Long Term Disability-BUY UP
☐ Anthem By Design Basic Life-BUY UP
(Complete separate election form)

Are you currently actively at work? ☐ Yes ☐ No
If no, reason: ____

	Last name	First name, M.I.	Social Security #	Relationship to applicant	Age
Primary Beneficiary					
Contingent Beneficiary					

7. Other Health Coverage *Please check one:* ☐ *YES (complete below)* ☐ *NO*

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Provide name, phone number and address of the HMO or insurance company		Policy/certificate number		Effective date / /
Policy/certificate holder's name	Social security number	Date of birth / /	Relationship to applicant	

If you and/or your dependents are enrolled in Medicare, complete the following.

Enrollee's name(s)		Medicare ID #	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
			/ /	/ /	/ /
			/ /	/ /	/ /
Medicare Part D ID#	Medicare Part D Carrier		Medicare Part D effective date / /	Medicare Part D term date / /	

Reason for Medicare entitlement: ☐ Age ☐ Disability ☐ ESRD & Disability ☐ End Stage Renal Disease (ESRD)

8. Read these Significant Terms, Conditions and Authorizations carefully before signing. Please review your application for errors or omissions.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage for which I, or any dependents have applied.
3. I am applying for the coverage selected on this application. If I select a coverage, or combination of coverages, not available to me and/or a class for which I am not eligible, I agree that my selection(s) is hereby automatically amended to be consistent with the employer's application.
4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company, which underwrites only life and disability coverages, may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions.
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
6. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.

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 I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Applicant Signature ______________________ Date / /

NAME ____________________ SSN ____________________

9. Waiver of coverage for employee and/or any eligible dependent not enrolling

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All		
Name of person waiving		Already protected by coverage of ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #) ☐ Other carrier (give name, ID #)	

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All		
Name of person waiving		Already protected by coverage of ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #) ☐ Other carrier (give name, ID #)	

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All		
Name of person waiving		Already protected by coverage of ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #) ☐ Other carrier (give name, ID #)	

Check all that apply. Waiving: ☐ Health ☐ Dental ☐ Vision ☐ Life ☐ All		
Name of person waiving		Already protected by coverage of ☐ Spouse ☐ Parent ☐ None
Employer name	Carrier: ☐ Anthem (give certificate/policy #) ☐ Other carrier (give name, ID #)	

Check all that apply

☐ I represent that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. The pre-existing exclusion may not apply to a dependent who is enrolled in the plan prior to his/her 19th Birthday. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption. I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption. I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependent or I become eligible for a subsidy (state premium assistance program)

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

☐ I represent that I have been given the opportunity to apply for the available group life benefits offered by my employer/group, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither my dependent(s) nor I were induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.

Please check if any of the following apply: (WI only)

☐ I am covered or will be covered under another plan that is **not** sponsored by my employer. I am not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).

☐ My dependents are covered or will be covered under another plan that is **not** sponsored by my employer. My dependents are not enrolled for coverage under Health Insurance Risk Sharing Program (HIRSP).

☐ Other:

Applicant signature	Date / /

In Missouri, (excluding 30 counties in the Kansas City area) Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Formulario de solicitud de cambios del empleado

Anthem. AnthemLife

Anthem Blue Cross and Blue Shield se usa en forma conjunta como el nombre comercial de RightChoice Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC), HMO Missouri, Inc. y Anthem Life Insurance Company (ALIC). HALIC ofrece coberturas médicas tradicionales y PPO; HMO Missouri, Inc. ofrece coberturas HMO y POS; y ALIC ofrece coberturas de vida, por muerte y desmembramiento accidental, de discapacidad a corto plazo y de discapacidad a largo plazo.

Complete este formulario SÓLO cuando realice cambios a su cobertura existente. Si SOLICITA una cobertura o AGREGA a uno o más dependientes, complete la "Solicitud de inscripción de Anthem" en lugar de este formulario. Al completar la sección 2, asegúrese de incluir la fecha del evento que causa el (los) cambio(s). Si cancela la cobertura para un dependiente, cambia de médico de atención primaria o cambia un nombre, brinde un motivo en las secciones designadas.

Complete en tinta y entrégueselo a su empleador; use hojas adicionales de ser necesario.

NOTA: Se pueden realizar algunos cambios accediendo a www.anthem.com. Los listados de médicos de atención primaria (PCP) de Anthem para los productos HMO/POS pueden obtenerse en **www.anthem.com**.

1. Para uso del empleador/grupo:				
Nombre y dirección del empleador:				
N.° de grupo	N.° de subgrupo/ N.° de división de vida	Fecha de entrada en vigencia de solicitud	Clasificación de seguro de vida	N.° de solicitante/Nombre del dep.

Para uso de Anthem: Plan	Fecha de entrada en vigencia de cobertura médica	Fecha de entrada en vigencia de seguro de vida	Fecha de entrada en vigencia de cobertura odontológica	Fecha de entrada en vigencia de cobertura oftalmológica	Médico de atención primaria	COB	Pre-ex (fecha)
	/ /	/ /	/ /	/ /	☐ Sí ☐ No	☐ Sí ☐ No	/ /

2. Motivo del cambio

Fecha del evento __/__/__

- ☐ Dirección
- ☐ Cambio de beneficiario del seguro de vida
- ☐ Cambio de clasificación del seguro de vida
- ☐ Inscripción en Medicare (consulte la sección 7)
- ☐ Cancelación/ renuncia de cobertura (consulte la sección 9)
- ☐ Conversión
- ☐ Cambio de beneficio
- ☐ Cancelar dependiente
- ☐ Cambio de PCP
- ☐ Cambio de nombre
- ☐ Otro ________

3. Tipo de cobertura/plan

Cobertura médica

- ☐ HMO* ☐ POS* ☐ PPO ________
- ☐ PPO de Anthem Essential℠
- ☐ Choice PPO de Anthem Essential℠
- ☐ Cirugías hospitalarias
- ☐ Cuenta de ahorro de salud Lumenos®
- ☐ Cuenta de reembolso de salud Lumenos®
- ☐ Cuenta de incentivo de salud Lumenos®
- ☐ Cuenta de incentivo de salud extra Lumenos®
- ☐ Empleado únicamente
- ☐ Empleado+cónyuge
- ☐ Empleado + hijo(s)
- ☐ Cobertura familiar
- ☐ Sin cobertura
- ☐ ¿Tiene o está estableciendo una cuenta de ahorro de salud? ☐ Sí ☐ No

Anthem facilitará la apertura de una cuenta de ahorro de salud a su nombre, si así lo indica su empleador.

Cobertura odontológica

- ☐ PPO ________
- ☐ DentaBlue (PPO)
- ☐ DentaBlue Select (PPO)
- ☐ Dental Blue®
- ☐ Dental Blue® Choice 100
- ☐ Dental Blue® Choice 300
- ☐ Empleado únicamente
- ☐ Empleado + cónyuge
- ☐ Empleado + hijo(s)
- ☐ Cobertura familiar
- ☐ Sin cobertura

Cobertura oftalmológica

- ☐ Empleado únicamente
- ☐ Empleado + cónyuge
- ☐ Empleado + hijo(s)
- ☐ Cobertura familiar
- ☐ Sin cobertura

Cobertura de vida

- ☐ Cobertura de vida (consulte la sección 7)

Ley en materia de anti-discriminación de la información genética (GINA): Al responder las preguntas de esta solicitud de inscripción, la información suministrada para cada persona debe incluir sólo la información acerca de dicha persona y no debe incluir ninguna información genética. La información genética incluye el historial médico de la familia e información relacionada con las pruebas genéticas de la persona, sus servicios genéticos, asesoramiento genético o enfermedades genéticas por las que la persona pueda estar en riesgo. Todas las respuestas pertinentes a una persona sólo se tendrán en cuenta y aplicarán a la persona en cuestión.

Aviso sobre cuenta de ahorro de salud: Excepto que se prevea lo contrario en cualquier acuerdo entre mí y el custodio financiero, el custodio de mi cuenta de ahorro de salud (HSA), comprendo que se requiere mi autorización antes de que el custodio financiero pueda proporcionar a WellPoint la información acerca de mi HSA. Por la presente, autorizo al custodio financiero a proporcionar a WellPoint la información acerca de mi HSA, incluidos el número de cuenta, el resumen de cuenta y la información acerca de la actividad de la cuenta. También comprendo que puedo proporcionar a WellPoint una solicitud por escrito para revocar mi autorización en cualquier momento.

NOMBRE ______________________ SSN ______________________

4. Información del empleado

**Sólo complete la información del médico de atención primaria (PCP) si se inscribe en productos HMO o POS.* *(N.° de S. S. obligatorio)*

Apellido	Primer nombre, I. M.	Fecha de nacimiento / /	Sexo ☐ M ☐ F	Nº de seguridad social – –	☐ Soltero ☐ Divorciado ☐ Casado	Altura	Peso
Dirección particular	Ciudad		Estado	Código postal	Condado		
Horas de trabajo semanales	Nombre y dirección de PCP de Anthem*			N.° de ID de PCP de Anthem*		¿Paciente nuevo? ☐ Sí ☐ No	
Si PCP es un cambio, indique el motivo del cambio.							

5. Información familiar *Cónyuge y dependientes que se cambiarán/cancelarán. (Adjunte una hoja adicional si es necesario).* Sólo complete la información del médico de atención primaria (PCP) si se inscribe en productos HMO o POS. (N.° de S. S. obligatorio para cónyuge/compañero de vivienda)*

1 ☐ Cambio ☐ Cancelar		Apellido		Primer nombre, I. M.	
Fecha de nacimiento / /	Sexo ☐ M ☐ F	Nº de seguridad social – –	Relación con el asegurado ☐ Cónyuge ☐ Hija ☐ Hijo ☐ Otro ______	Motivo del cambio	
¿La dirección del dependiente es diferente a la dirección del solicitante? ☐ Sí ☐ No (Si es Sí, proporcione la dirección completa)					
Nombre y dirección de PCP de Anthem*				N.° de ID de PCP de Anthem*	¿Paciente nuevo? ☐ Sí ☐ No
Si PCP es un cambio, indique el motivo del cambio.					
2 ☐ Cambio ☐ Cancelar		Apellido		Primer nombre, I. M.	
Fecha de nacimiento / /	Sexo ☐ M ☐ F	Nº de seguridad social – –	Relación con el asegurado ☐ Cónyuge ☐ Hija ☐ Hijo ☐ Otro ______	Motivo del cambio	
¿La dirección del dependiente es diferente a la dirección del solicitante? ☐ Sí ☐ No (Si es Sí, proporcione la dirección completa)					
Nombre y dirección de PCP de Anthem*				N.° de ID de PCP de Anthem*	¿Paciente nuevo? ☐ Sí ☐ No
Si PCP es un cambio, indique el motivo del cambio.					
3 ☐ Cambio ☐ Cancelar		Apellido		Primer nombre, I. M.	
Fecha de nacimiento / /	Sexo ☐ M ☐ F	Nº de seguridad social – –	Relación con el asegurado ☐ Cónyuge ☐ Hija ☐ Hijo ☐ Otro ______	Motivo del cambio	
¿La dirección del dependiente es diferente a la dirección del solicitante? ☐ Sí ☐ No (Si es Sí, proporcione la dirección completa)					
Nombre y dirección de PCP de Anthem*				N.° de ID de PCP de Anthem*	¿Paciente nuevo? ☐ Sí ☐ No
Si PCP es un cambio, indique el motivo del cambio.					

NOMBRE ______________________ SSN ______________________

9. Renuncia de cobertura para el empleado y/o cualquier dependiente elegible que no se inscriba

Marque todas las que correspondan. Renuncia a: ☐ Cobertura médica ☐ Cobertura odontológica ☐ Cobertura oftalmológica ☐ Seguro de vida ☐ Todas

Nombre de la persona que renuncia:		Cuenta con la cobertura de ☐ Cónyuge ☐ Padre ☐ Ninguno
Nombre del empleador	Compañía de seguros: ☐ Anthem (indique n.° de certificado/política) ☐ Otra compañía de seguros (indique nombre, n.° de ID)	

Marque todas las que correspondan. Renuncia a: ☐ Cobertura médica ☐ Cobertura odontológica ☐ Cobertura oftalmológica ☐ Seguro de vida ☐ Todas

Nombre de la persona que renuncia:		Cuenta con la cobertura de ☐ Cónyuge ☐ Padre ☐ Ninguno
Nombre del empleador	Compañía de seguros: ☐ Anthem (indique n.° de certificado/política) ☐ Otra compañía de seguros (indique nombre, n.° de ID)	

Marque todas las que correspondan. Renuncia a: ☐ Cobertura médica ☐ Cobertura odontológica ☐ Cobertura oftalmológica ☐ Seguro de vida ☐ Todas

Nombre de la persona que renuncia:		Cuenta con la cobertura de ☐ Cónyuge ☐ Padre ☐ Ninguno
Nombre del empleador	Compañía de seguros: ☐ Anthem (indique n.° de certificado/política) ☐ Otra compañía de seguros (indique nombre, n.° de ID)	

Marque todas las que correspondan. Renuncia a: ☐ Cobertura médica ☐ Cobertura odontológica ☐ Cobertura oftalmológica ☐ Seguro de vida ☐ Todas

Nombre de la persona que renuncia:		Cuenta con la cobertura de ☐ Cónyuge ☐ Padre ☐ Ninguno
Nombre del empleador	Compañía de seguros: ☐ Anthem (indique n.° de certificado/política) ☐ Otra compañía de seguros (indique nombre, n.° de ID)	

Marque todas las que correspondan

☐ Declaro que he tenido la oportunidad de solicitar la cobertura de Anthem Blue Cross and Blue Shield y que, después de considerarlo cuidadosamente, he decidido no aprovechar esta oferta. En caso de que desee solicitar dicha cobertura en el futuro, podré hacerlo, sujeto a procedimientos establecidos. Si rechazo mi inscripción o la de mis dependientes (incluido mi cónyuge) debido a otra cobertura médica, en el futuro podré inscribirme o inscribir a mis dependientes en este plan, siempre y cuando dicha inscripción se solicite dentro de los 31 días posteriores a la finalización de la otra cobertura. Mi(s) dependiente(s) o yo podremos estar sujetos a restricciones por enfermedades preexistentes o a los periodos de espera especificados en el certificado de grupo, si un dependiente o yo nos inscribimos fuera de plazo. Además, si tengo un dependiente como resultado de un matrimonio, nacimiento, adopción o entrega en adopción, podré inscribirme e inscribir a mis dependientes siempre y cuando solicite la inscripción dentro de los 31 días posteriores al matrimonio, nacimiento, adopción o entrega en adopción. También comprendo que mis dependientes y yo podemos inscribirnos en dos circunstancias adicionales:

- O bien la cobertura de Medicaid o del Programa de Seguro de Salud para Niños (CHIP) finaliza como resultado de la pérdida de elegibilidad; o
- Mi dependiente o yo pasamos a ser elegibles para un subsidio (programa estatal de asistencia de primas)

En estos casos, es posible que pueda inscribirme e inscribir a mis dependientes, siempre y cuando solicite la inscripción dentro de los 60 días posteriores a la pérdida de Medicaid/CHIP o de la determinación de elegibilidad.

☐ Declaro que he tenido la oportunidad de solicitar los beneficios de vida de grupo disponibles ofrecidos por mi empleador/grupo, que se me han explicado los beneficios, y que yo y/o mi(s) dependiente(s) decidimos no participar. Ni mi(s) dependiente(s) ni yo fuimos inducidos o presionados por mi empleador/grupo, agente o compañía de seguros de vida para rechazar esta cobertura sino que lo decidimos voluntariamente. Comprendo que si quisiera solicitar dicha cobertura en el futuro, podré tener que presentar por mi cuenta pruebas de asegurabilidad.

Marque la que corresponda: (Sólo en WI)

☐ Tengo o recibiré cobertura mediante otro plan no patrocinado por mi empleador. **No** estoy inscrito para recibir cobertura mediante el programa Health Insurance Risk Sharing Program (HIRSP).

☐ Mis dependientes tienen o recibirán cobertura mediante otro plan **no** patrocinado por mi empleador. Mis dependientes no están inscritos para recibir cobertura mediante el programa Health Insurance Risk Sharing Program (HIRSP).

☐ Otro:

Firma del solicitante	Fecha / /

Los productos de seguros de vida y discapacidad son asegurados por Anthem Life Insurance Company. Anthem Blue Cross and Blue Shield es el nombre comercial de RightCHOICE Managed Care, Inc. (RIT), Healthy Alliance Life Insurance Company (HALIC) y HMO Missouri, Inc. suelen hacer negocios en la mayor parte de Missouri. RIT y ciertos afiliados administran los beneficios no HMO asegurados por HALIC y los beneficios HMO asegurados por HMO Missouri, Inc., titulares de licencias independientes de la Blue Cross Blue Shield Association. ® Marcas registradas de la Blue Cross and Blue Shield Association.

NOMBRE ______________________ SSN ______________________

6. Seguro de vida y discapacidad

☐ Seguro de vida básico ☐ AD&D básico
☐ Discapacidad a corto plazo ______ %
☐ Seguro de vida del dependiente ☐ AD&D suplementario
☐ Discapacidad a largo plazo ______ %
☐ Seguro de vida suplementario: ______ x ingresos anuales O $ ______
☐ Ingreso actual: $ ______ ☐ *Hora* ☐ *Semana* ☐ *Mes* ☐ *Año*

☐ Anthem By Design Discapacidad a corto plazo-BUY UP
☐ Anthem By Design Discapacidad a largo plazo-BUY UP
☐ Anthem By Design Seguro de vida básico-BUY UP (complete el formulario de elección por separado)

¿Se encuentra trabajando activamente en la actualidad? ☐ Sí ☐ No
Si la respuesta es No, explique el motivo: ______

	Apellido	Primer nombre, I. M.	Nº de seguridad social	Relación con el solicitante	Edad
Beneficiario principal			– –		
Beneficiario contingente			– –		

7. Otra cobertura médica ***Marque una:*** ☐ Sí *(complete abajo)* ☐ No

El día que comienza su cobertura, especifique los miembros de la familia, incluido usted, que estarán cubiertos por cualquier otra cobertura médica.

Proporcione el nombre, el número telefónico y la dirección de la compañía de seguro o HMO	Número de política/certificado	Fecha de entrada en vigencia
		/ /

Nombre del titular de la política/certificado	Número de seguridad social	Fecha de nacimiento	Relación con el solicitante
	– –	/ /	

Si usted y/o sus dependientes están inscritos en Medicare, complete la siguiente información.

Nombre(s) del afiliado	N.º de ID de Medicare	Fecha de entrada en vigencia de Medicare Parte A	Fecha de entrada en vigencia de Medicare Parte B	Fecha de aparición de ERET
		/ /	/ /	/ /
		/ /	/ /	/ /

N.º de ID de Medicare Parte D	Compañía de seguros de Medicare Parte D	Fecha de entrada en vigencia de Medicare Parte D	Fecha de finalización de Medicare Parte D
		/ /	/ /

Motivo para obtener beneficios de Medicare: ☐ Edad ☐ Discapacidad ☐ ESRD y discapacidad ☐ Enfermedad renal en etapa terminal (ERET)

8. Lea estos Términos, condiciones y autorizaciones relevantes detenidamente antes de firmar. Revise que su solicitud no tenga errores ni omisiones.

1. No puedo asignar ningún pago bajo mi programa de Anthem Blue Cross and Blue Shield.
2. Autorizo la deducción de mi salario/pensión, si fuera necesario, para la prima obligatoria de la cobertura solicitada por mí o por alguno de mis dependientes.
3. Solicito la cobertura seleccionada en esta solicitud. Si elijo una cobertura o una combinación de coberturas no disponible para mí y/o una clase para la que no soy elegible, acepto que mi(s) selección(es) se modifique(n) automáticamente mediante el presente documento a fin de coincidir con la solicitud del empleador.
4. Comprendo que, hasta donde lo permita la ley, Anthem se reserva el derecho de aceptar o rechazar esta solicitud (y que Anthem Life Insurance Company, que ofrece únicamente coberturas de vida y discapacidad, puede aceptar sólo a determinadas personas o condiciones para la cobertura) y que no se crea ningún tipo de derecho mediante esta solicitud. Comprendo también que esta cobertura, en caso de ser aprobada, puede no incluir la cobertura de enfermedades preexistentes.
5. Soy responsable de notificar de manera oportuna a mi empleador sobre cualquier cambio que hiciera que yo o algún dependiente no fuera elegibles para la cobertura.
6. Al firmar esta solicitud, doy mi consentimiento para la grabación y/o monitoreo de cualquier conversación telefónica entre mi persona y Anthem.

Reconozco que he leído los Términos, condiciones y autorizaciones relevantes, y acepto dichas disposiciones como condición de cobertura. Declaro que las respuestas a todas las preguntas de esta solicitud son verdaderas y exactas a mi leal saber y entender, y comprendo que Anthem se basa en ellas para aceptar la presente solicitud. Comprendo que cualquier tergiversación u omisión de datos médicos nuevos antes de mi fecha de entrada en vigencia puede provocar un cambio sustancial en las tarifas de la prima o la cobertura. Toda tergiversación u omisión significativa que se encuentre en esta solicitud puede provocar la denegación de los beneficios o la rescición o cancelación de mi(s) cobertura(s).

Doy mi autorización en nombre de cualquier dependiente elegible y de mi persona, si estuviéramos cubiertos por el Plan. Actúo como su agente y representante.

Si existe un conflicto entre la aplicación en idioma inglés y su versión en español, prevalecerá la versión en inglés.
If there is a conflict between the English language application and the Spanish version, the English version shall control.

Firma del solicitante	Fecha / /

Employer Application

Anthem. Anthem Life

Group size 2-50 eligible employees
Please complete in blue or black ink and use extra sheets of paper if necessary
For more information about Anthem, its products and services, visit **www.anthem.com.**

Anthem use:				
Group/Account #	Approved SIC: (WI only - SIC applies to Life and Disability only)	Anthem's Approved Effective Date	State ☐ Wisconsin ☐ Missouri	Tracking ID

1. Effective date

2. The benefits you have selected are outlined on the attached proposal, herein incorporated by reference.

☐ Blue Access® (PPO)
☐ Blue Access® Choice (PPO) (MO only)
☐ Blue Preferred® Plus (POS)
☐ Blue Preferred® Select (MO only)
☐ Blue Preferred® (HMO) (MO only)
☐ Blue Priority® Plus POS (WI only)
☐ Anthem Essential℠ PPO
☐ Anthem Essential℠ Choice PPO (MO only)
☐ Anthem Essential℠ Select (MO only)
☐ Anthem Essential℠ POS (WI only)

☐ Anthem ByDesign® (ABD) Buy-up/Health Saving Account (HSA)
☐ Lumenos® Health Saving Account
☐ Lumenos® Health Reimbursement Account
☐ Lumenos® Health Incentive Account
☐ Lumenos® Health Incentive Account Plus
☐ DentaCare (HMO) (WI only)
☐ Dental Blue® 100
☐ Dental Blue® 100/200/300

☐ Vision

☐ Basic Life
☐ Basic AD&D
☐ Dependent Life
☐ Optional Life
☐ EE only
☐ SPS only
☐ CHD only
☐ SP/CHD

☐ Optional AD&D
☐ Short Term Disability
☐ Long Term Disability

3. Employer Information

Applicant (legal name of group)		Name of association (if applicable)		
Name and title of head of firm		Name and title of administrative contact		
Home office address	City	County	State	ZIP Code
eMail address		Phone number *(include area code)*	Fax number *(include area code)*	
Billing address and/or contact *(if different from above)*		Tax ID/FEIN (Required)	Number of years in business	
Type of business				

Is any part of group subject to bargaining agreement? ☐ Yes ☐ No	Will bargaining agreement participants be considered eligible employees? ☐ Yes ☐ No	Total # of employees residing/working outside of Home Office state

List all affiliates/subsidiaries/divisions (list names, locations, number employed at each location.) Attach a separate page to show any separate billing addresses, and any separate billings for life classes.

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414? If yes, please give the legal names, federal tax ID no. and number of employees employed by each. ☐ Yes ☐ No

Name of current health and/or life carrier(s)		Next Renewal Date
Do you want Anthem to facilitate opening a Health Savings Account with Mellon? ☐ Yes ☐ No		Is your group Section 125? ☐ Yes ☐ No
Is your group subject to COBRA? ☐ Yes ☐ No	Do you have a COBRA administrator? ☐ Yes ☐ No	Do you want an Anthem affiliate to administer COBRA for your group? ☐ Yes ☐ No *If yes, please complete and sign the COBRA agreement.*
List employee/dependents on Continuation of Coverage/COBRA		Names of persons in COBRA eligibility period

4. Medicare Secondary Payer

☐ Does **not** employ 20 or more employees (full-time, part-time, leased) under the terms of the Medicare Secondary Payer statute *(The group agrees to notify Anthem Blue Cross and Blue Shield as soon as this statement is no longer true.)*
☐ Does employ 20 or more employees (full-time, part-time, leased) under the terms of the Medicare Secondary Payer statute

5. Eligibility

Eligible full-time employees must work at least 30 hours per week, must be Actively At Work, must have satisfied any applicable eligibility waiting period. Eligible full-time employees do not include temporary or seasonal employees.

Number of full time employees (including those within their waiting period and individually contracted individuals)	Total number of employees (including part-time, seasonal and temporary (MO - include individually contracted))	Total number of employees not Actively At Work	Employees currently in their waiting period will have coverage effective: ☐ On group's effective date ☐ Same waiting period that applies to new persons or on group effective date, whichever is later

New eligible enrollees will become effective on:
(MO) the day after ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days of employment *or the* ***first billing date*** *after* ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days of employment
(WI) the 1st of the month following ☐ 30 days ☐ 60 days ☐ 90 days ☐ Other (no more than 180 days) ☐ Date of hire ☐ Waive probationary Period

Do any classes of employees have a different waiting period? ☐ Yes ☐ No	If yes, explain

Group Name: ______

6. Contribution and Minimum Participation Requirements *Employer must have at least two employees enrolled in health to maintain coverage under this plan.*
Group contribution level for health: 50% of the single fee premium; at least 25% of total premium. For life, AD&D, STD, LTD: at least 25% of premium for each coverage except dependent life (MO only). If group contribution is 100%, 100% participation is required (N/A WI). Group minimum participation for Health: at least 75% of "Net Eligible Employees". "Net Eligible Employees" is the total number of eligible employees less those employees with other group health coverage through a spouse or as part of a collectively bargained or union plan (N/A WI). For Life and Disability participation requirements, please refer to the Benefit Plan highlights on your proposal.

Group contribution level for insurance
Health ______% Dental ______% Basic Life ______% Basic AD&D ______% Dependent Life ______% Optional Life ______%
Optional AD&D ______% STD ______% LTD ______%
WI only: Flat Dollar Amount (Minimum $100 per employee per month): $______ Other: ______
(Dental/Vision contributions should match the medical; however, when it does not, it must be at least 25 percent of the total, but not less than 50 percent of the single rate.)

Do any classes have a percentage of group contribution different than above? ☐ Yes ☐ No | If yes, explain

7. Participation Requirements *(WI Only)*
These participation requirements must be observed and maintained for a Group to remain eligible for coverage. It is the Group's responsibility to maintain these requirements. The number of employees in medical coverage initially and when reviewed periodically thereafter determine the size of group for participation requirement purposes.

*Group Size**	*Participation Required*	
2-4	*2*	
5-6	*3*	
7	*4*	
8-9	*5*	
10	*6*	
11 & Up	*70%*	**Eligible employees*
For Non-Small Employers:	*75%*	*Small Employer has the meaning given in Wis. Stat. s.635.02(7).*

a. Eligible employees who waive coverage due to coverage under a health plan that constitutes "creditable coverage" for pre-existing condition purposes (e.g., COBRA, spouse's group health coverage) will not be used to determine participation.

b. For Small Employers, an employee who waives coverage because the employee's annual premium exceeds 10% of the employee's annual gross earnings will not be used to determine participation.

c. For all groups, eligible employees who waive coverage because they are part of another health plan offered by the Group will be used to determine participation.

8. Signature ***PLEASE ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM (Read Section 9, below, carefully before signing)***

Signature and title of authorized group representative	Print name of authorized group representative	City/state where signed	Date
Accepted by Anthem's Underwriting Department — Signature and title			Date

9. Read this section carefully before signing. Please review your application for errors or omissions.

The employer and/or authorized representative hereby requests that it be approved for coverage through Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company (hereinafter "Anthem" unless otherwise specified) and to be bound by Anthem's and Anthem Life's rules and regulations pertaining to coverage under the insurance contracts and policies, as adopted and/or revised from time to time. Employer understands and represents the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative represents on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and also accepts enrollment under the Anthem Life trust policy(ies), if applicable.

2. To make the coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.

3. To maintain records and furnish to Anthem or their designated agent(s), any information required in connection with administration of the coverage.

4. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.

5. That statement of medical history will be required of employees and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem.

6. That approval for this coverage may cancel any prior contracts and/or coverage with Anthem effective immediately preceding the effective date of the employer's coverage.

7. To pay Anthem, by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and state-mandated continued group coverage and/or conversion process, if applicable.

8. That claims filed by or on behalf of members may, at Anthem's option, be suspended if premiums are not timely received. (Does not apply in Wisconsin)

9. If applicable, Employer will receive on behalf of members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.

10. The advance premium check does not create temporary or interim coverage and that receipt and deposit of that payment does not guarantee issuance of coverage. Rather, issuance of coverage is expressly conditioned on Anthem's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.

11. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem may be different that the coverage applied for herein. In that event, Anthem shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.

12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical

information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rates as of the effective date of coverage.

13. The entire application for Group coverage has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.

14. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work 30 hours per week if the employer is located in Wisconsin, or work 30 or more hours per week if the employer is located in Missouri (unless otherwise approved by Anthem in writing), and meet any other eligibility requirements for coverage; employer meets the definition of small employer under applicable law of the state where it is domiciled, which is: MO - An employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. In Wisconsin, a small employer is defined as an employer that employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year, or that is reasonably expected to employ an average of at least 2 but not more than 50 employees on business days during the current calendar year if the employer was not in existence during the preceding calendar year, and that employs at least 2 employees on the first day of the plan year.

15. The requested coverage is not in effect unless and until this application is approved by Anthem, that approval of coverage shall be evidenced by issuing Group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem.

16. The employer acknowledges that he has signed the attached benefit proposals indicating the coverages requested.

17. The broker listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.

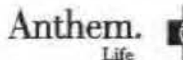
10. Broker Representation - I hereby represent that:

1. I have reviewed the attached employee and group applications and waivers for completeness and accuracy.
2. I am not aware of any health history of any applicant that does not appear on the application.
3. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials on the application.
4. I have not signed any of the applications for a group representative or individual applicant.
5. I have advised the group that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the group's premium retroactive to the effective date and that coverage shall not be effective until Anthem Blue Cross and Blue Shield reviews and approves the application and the group receives a written notice and contract from Anthem.

Broker name		Broker Signature	
Address			Broker ID number
Tax ID number to be paid	Broker phone number	Broker e-Mail address	Broker fax number
Agency name *(if applicable)*		General agency broker	
Address	Date	Anthem sales representative	

Anthem Blue Cross and Blue Shield is the trade name of: In Missouri, (excluding 30 counties in the Kansas City area) of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Wisconsin: Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin ("BCBSWI"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Enrollment Application
Group size 51+ eligible employees



INSTRUCTIONS:

Please read carefully, complete electronically, or in blue or black ink, all the required sections and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer.

SECTION 1: EMPLOYER/GROUP USE - Required

Employer name		Employer address		
Group no.	Sub-group no./ Life division no.	Requested effective date	Life classification	Employee no./Dept. name

SECTION 2: REASON FOR APPLICATION - Required

☐ New enrollment ☐ Annual open enrollment (N/A to Life)	☐ COBRA Qualifying event______ event date______ ☐ Waiver (To decline ALL coverage skip to Section 12)	☐ New hire ☐ Rehire date______	☐ Add dependent (Fill in Section 3)

SECTION 3: STATUS CHANGE/EVENT - Required, if you checked "Add dependent" option in Section 2.

Event date	☐ Marriage ☐ Birth	☐ Adoption (Attach legal documentation) ☐ Legal guardianship (Attach legal documentation)	☐ Loss of coverage (reason)______ ☐ Other______	☐ Termed employment

SECTION 4: PLAN/TYPE OF COVERAGE - Required. To decline a plan type, check "No coverage". If you are waiving all coverage, go to Section 12.

Medical
If multiple Medical Plans are available, please indicate the plan type below and write plan number in the space provided.

			Type of coverage
☐ HMO ☐ POS ☐ PPO	☐ Anthem Essential℠ PPO ☐ Lumenos® HSA PPO* ☐ Lumenos® HRA PPO	☐ Lumenos® HIA PPO ☐ Lumenos® Health Incentive Account Plus PPO ☐ Lumenos® Deductible First HRA PPO	☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage

If multiple Medical Plans are available, write plan number:

*Anthem will facilitate the opening of a Health Savings Account (HSA) in your name, if directed by your Employer.

Dental To apply for BUY-UP coverage, check PPO and write in the plan number on the line provided.		Vision	Life
☐ Dental Blue® 100/200/300 ☐ Dental Blue® 100	Type of coverage ☐ Employee only ☐ Employee+spouse ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage	Type of coverage ☐ Employee only ☐ Employee+spouse (DP) ☐ Employee+child(ren) ☐ Family coverage ☐ No coverage	☐ Life (Fill in Section 7)

SECTION 5: EMPLOYEE INFORMATION - Required

Last name	First name	M.I.	Date of birth		Age	Social security no. (required)	
Sex ☐ M ☐ F	☐ Single ☐ Married ☐ Divorced	Height	Weight	Home phone	Business phone	Email address	
Address			City	State	ZIP code	County	
Retired ☐ Yes ☐ No	Disabled ☐ Yes ☐ No	Hospitalized ☐ Yes ☐ No	Occupation	Full-time hire date	Hours working per week	Income reported by ☐ W2 ☐ 1099 ☐ Other______	

In Missouri, (excluding 30 counties in the Kansas City area) Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Employee name ______________________ Social security no. ______________________

SECTION 6: FAMILY INFORMATION – Required. List only dependents you wish to enroll, attach a separate sheet if necessary.

Please read the Genetic Information Non-discrimination Act (GINA) information on page 3 of the application, under Section 10, Significant Terms, Conditions and Authorizations, prior to answering the questions in Section 6.

Spouse/Domestic Partner

Last name				First name		M.I.	Social security no. (required)
Date of birth	Height	Weight	Sex ☐M ☐F	Relationship to employee ☐ Spouse ☐ Domestic Partner	Currently hospitalized or disabled ☐Yes ☐No (If yes, give reason)		
If spouse/DP address is different than employee, please provide full address							

Dependent

Last name				First name	M.I.	Social security no.	Full-time student ☐Yes ☐No
Date of birth	Height	Weight	Sex ☐M ☐F	Relationship to employee ☐ Child ☐ Other ______	Currently hospitalized or disabled ☐Yes ☐No (If yes, give reason)		
Court ordered health care coverage ☐Yes ☐No (If yes, attach legal documentation)			If dependent address is different than employee, please provide full address				

Dependent

Last name				First name	M.I.	Social security no.	Full-time student ☐Yes ☐No
Date of birth	Height	Weight	Sex ☐M ☐F	Relationship to employee ☐ Child ☐ Other ______	Currently hospitalized or disabled ☐Yes ☐No (If yes, give reason)		
Court ordered health care coverage ☐Yes ☐No (If yes, attach legal documentation)			If dependent address is different than employee, please provide full address				

SECTION 7: LIFE AND DISABILITY INSURANCE - Required, if this type of coverage was selected in Section 4.

Current income $ ______ ☐Hour ☐Week ☐Month ☐Year ☐Life Class

☐ Basic Life ☐ Optional Life ______ x Annual Earnings ☐ Basic AD&D ☐ Short-Term Disability ______
☐ Dependent Life OR $ ______ ☐ Optional AD&D ☐ Long-Term Disability ______

Anthem ByDesign Buy-Up. Check appropriate box and write in the percentage next to the benefit selected. Complete separate election form.

☐ Short-Term Disability ______ % ☐ Long-Term Disability ______ % ☐ Basic Life

Primary beneficiary

Last name	First name	M.I.	Social security no.	Relationship to employee	Age

Contingent beneficiary

Last name	First name	M.I.	Social security no.	Relationship to employee	Age

SECTION 8: OTHER HEALTH COVERAGE - Required

Do you and/or your dependents have other health coverage? ☐Yes ☐No **If yes, complete below.**

On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage

Provide name, phone number and address of the HMO or insurance company		Policy/certificate no.	Effective date
Policy/certificate holder name	Social security no.	Date of birth	Relationship to employee

Are you and/or your dependents enrolled in Medicare or Medicaid? ☐Yes ☐No **If yes, complete below.**

Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Enrollee name	Medicare/Medicaid ID no.	Medicare Part A effective date	Medicare Part B effective date	ESRD onset date
Medicare Part D ID no.		Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date

Reason for Medicare entitlement: ☐Age ☐Disability ☐ESRD & Disability ☐End Stage Renal Disease (ESRD)

SECTION 9: PRIOR HEALTH COVERAGE - Required

Have you and/or your dependents had prior health coverage? ☐ Yes ☐ No **If yes, complete below.**

Have you been covered by Anthem within the past two (2) years ☐ Yes ☐ No	Policy/certificate no.		
Group name/ID no.		Date policy in effect	Date policy termed

Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years ☐ Yes ☐ No

List prior carrier(s)	Date policy in effect	Date policy termed

Please check the type of prior coverage

☐ Employee ☐ Employee+Spouse/DP ☐ Employee+Child(ren) ☐ Employee+Spouse/DP+Child(ren)

Termination reason:

☐ Divorce/legal separation ☐ Employment terminated ☐ Employer/group contribution ceased ☐ Other

☐ Death of spouse/DP ☐ COBRA coverage exhausted ☐ Group plan terminated

SECTION 10: SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) – Please read this section carefully before signing the application.

Genetic Information Non-discrimination Act (GINA): When answering questions about a person on this form, only give answers about that person, and do not include any genetic information. Genetic information includes family health history, genetic testing, genetic services, genetic counseling, or genetic diseases for which the person may be at risk. All responses about a person will only be considered and used for that person.

Health Savings Account Notice: I authorize the financial custodian of my Health Savings Account (HSA) to give Anthem Blue Cross and Blue Shield facts about my HSA, including account number, account balance and account activity. I understand that I may take back my authorization by written request to Anthem Blue Cross and Blue Shield at any time.

1. I understand that I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I agree to have money taken from my wages/pension, if necessary, to cover the premium cost for the coverage applied for.
3. I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.
4. I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline to this application for coverage (and that Anthem Life Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage. I also understand that I may not be covered for pre-existing conditions.
5. I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.
6. By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

I have read and accept the Significant Terms, Conditions and Authorizations as a condition of coverage. My answers to all questions are true to the best of my knowledge, and I understand that Anthem relies on these answers in accepting this application. I understand that any untrue answers or failure to report new medical information before my effective date may cause a material change in coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits, rescission or cancellation of coverage. I agree to these terms for myself and on behalf of any dependents covered by the Plan. I am acting as their agent and representative.

Thank you for choosing Anthem Blue Cross and Blue Shield.

SECTION 11: SIGNATURE – Required, if you are applying for coverage. Please review your application for errors or omissions.

Read Section 10 carefully before signing.
I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Employee signature X	Date

Employee name ______________________ Social security no. ______________________

SECTION 12: WAIVER OF COVERAGE – Complete for yourself and/or any eligible dependents. Check all that apply.

Type of coverage	Waived for	Name	Reason for waiving (already protected by coverage)	
☐ Medical	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ Dental	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ Vision	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ Life	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	Certificate/policy no. or Carrier name and ID no.
☐ All	☐ Self ☐ Spouse/DP ☐ Child(ren)		☐ Anthem ☐ Other carrier ☐ No coverage	

Check all that apply:

☐ I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. If I want to apply for such coverage at a later date, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse or domestic partner) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. The pre-existing exclusion may not apply to a dependent who is enrolled in the plan prior to his or her 19th birthday. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.

I also understand that my dependents and I may enroll under two additional circumstances:

- Either my or my dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- My dependents or I become eligible for a subsidy (state premium assistance program).

In these cases, I may be able to enroll myself and my dependents provided that I request enrollment within 60 days of the loss of Medicaid/CHIP or of the eligibility determination.

☐ I have been given an opportunity to apply for the available group life benefits offered by my employer/group. The benefits have been explained to me, and I and/or my dependent(s) decline to participate. My dependent(s) or I were not induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for coverage in the future, I may be required to provide evidence of insurability at my expense.

SIGNATURE – Required, if you want to waive coverage for yourself and your dependents.

Employee signature	Date
X	

Solicitud de inscripción del empleado

Anthem.

Tamaño de grupo 51 + empleados elegibles

Anthem Life

Para los residentes de Kansas únicamente: Cobertura correspondiente a:
- ☐ Org. de prov. pref. (PPO)/tradicional (Healthy Alliance Life Insurance Company)
- ☐ Seguro de vida y discapacidad (Anthem Life Insurance Company)

Su solicitud de inscripción de Anthem se encuentra en el interior. Es esencial que la lea detenidamente y que complete todas las secciones necesarias.

Si es un afiliado nuevo:

a) que realiza la solicitud para cobertura médica, oftalmológica y/u odontológica más un seguro de vida y discapacidad, complete las secciones 2, 4, 5, 6, 7, 8, 9 y 10. En la Sección 10, se requiere su firma.

b) que realiza la solicitud para cobertura médica, oftalmológica y/u odontológica pero renuncia al seguro de vida y discapacidad, complete las secciones 2, 4, 5, 6, 8, 9, 10 y 11. En la Sección 10, se requiere su firma.

c) que realiza la solicitud para el seguro de vida y discapacidad pero renuncia a la cobertura médica, complete las secciones 2, 5, 6, 7, 10 y 11. En la Sección 10, se requiere su firma.

d) que renuncia a toda la cobertura, complete las secciones 2, 5 y 11. En la Sección 11, se requiere su firma.

Si agrega a uno o más dependientes,

complete la sección 3 además de la información mencionada arriba.

Si es un afiliado nuevo de la cobertura Anthem ByDesign Buy up:

que realiza la solicitud para la cobertura médica, odontológica u oftalmológica de Anthem ByDesign Buy up, complete la casilla de verificación correspondiente de PPO en la sección 4, "Tipo de plan de cobertura", y escriba el número del plan médico, odontológico u oftalmológico del beneficio que ha seleccionado en el renglón provisto junto a la casilla de verificación de PPO.

que realiza la solicitud para la cobertura de discapacidad a corto plazo o discapacidad a largo plazo de Anthem ByDesign Buy Up, complete la casilla de verificación de STD o LTD en la sección 7, "Seguro de vida y discapacidad", y escriba el porcentaje de beneficio que ha seleccionado en el renglón provisto junto a STD o LTD.

Es importante que lea y comprenda los Términos, condiciones y autorizaciones relevantes en la Sección 10.

Nota: *Es posible que se le solicite que proporcione información adicional.*

Gracias por elegir Anthem Blue Cross and Blue Shield.

www.anthem.com

En Missouri (excluidos 30 condados del área de la ciudad de Kansas): Anthem Blue Cross and Blue Shield es el nombre comercial de RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC) y HMO Missouri, Inc. RIT y ciertos afiliados administran los beneficios no HMO asegurados por HALIC y los beneficios HMO asegurados por HMO Missouri, Inc. RIT y ciertos afiliados sólo brindan servicios administrativos para los planes de financiación propia y no aseguran beneficios. Los titulares de licencias independientes de la Blue Cross and Blue Shield Association. ®ANTHEM es una marca comercial registrada de Anthem Insurance Companies, Inc. Los nombres y los símbolos de Blue Cross and Blue Shield son marcas registradas de la Blue Cross and Blue Shield Association.

Solicitud de inscripción

Anthem.

AnthemLife

Tamaño de grupo 51 + empleados elegibles

Complete con tinta azul o negra y entrégueselo a su empleador. Use hojas adicionales de ser necesario.
Toda la información suministrada se debería aplicar a este empleador.
Los listados de médicos de atención primaria (PCP) de Anthem para los productos HMO/POS pueden obtenerse en www.anthem.com

1. Para uso del empleador/grupo:								
Nombre y dirección del empleador:								
N.° de grupo	N.° de subgrupo/ N.° de división de vida		Fecha de entrada en vigencia de solicitud		Clasificación de seguro de vida		N.° de solicitante/ Nombre del dep.	
Para uso de Anthem: Plan	Fecha de entrada en vigencia de cobertura médica	Fecha de entrada en vigencia de seguro de vida	Fecha de entrada en vigencia de cobertura odontológica	Fecha de entrada en vigencia de cobertura oftalmológica		Médico de atención primaria	COB	Pre-ex (fecha)
	/ /	/ /	/ /	/ /		☐ Sí ☐ No	☐ Sí ☐ No	/ /

2. Motivos de solicitud

☐ Inscripción nueva
☐ Inscripción abierta anual (N/D para seguro de vida)
☐ COBRA
Evento de calificación ____________
Fecha del evento ___/___/___
☐ Renuncia (consulte la Sección 11)
☐ Contratación nueva
☐ Recontratación (fecha) ___/___/___
☐ Agregar dependiente (consulte la sección 3)

3. Cambio de estado/evento

Fecha del evento ___/___/___
☐ Matrimonio
☐ Nacimiento
**Incluya la documentación legal.*
☐ Adopción*
☐ Custodia legal*
☐ Finalización de empleo
☐ Otro ________

4. Tipo de cobertura/plan

Cobertura médica

☐ HMO* ☐ POS* ☐ PPO ________
☐ PPO de Anthem Essential℠
☐ Cirugías hospitalarias
☐ PPO Anthem Essential℠ PPO
☐ Cuenta de ahorro de salud Lumenos®
☐ Cuenta de reembolso de salud Lumenos®
☐ Cuenta de incentivo de salud Lumenos®
☐ Cuenta de incentivo de salud extra Lumenos®
☐ Cuenta de ahorro de salud Blue Access℠
☐ Cuenta de ahorro de salud Blue Access℠Choice
☐ Empleado únicamente ☐ Empleado+cónyuge
☐ Empleado + hijo(s) ☐ Cobertura familiar
☐ Sin cobertura
☐ ¿Tiene o está estableciendo una cuenta de ahorro de salud? ☐ Sí ☐ No
Anthem facilitará la apertura de una cuenta de ahorro de salud a su nombre, si así lo indica su empleador.

Cobertura odontológica

☐ PPO ________
☐ DentaBlue (PPO)
☐ DentaBlue Select (PPO)
☐ Dental Blue®
☐ Dental Blue® Choice 100
☐ Dental Blue® Choice 300
☐ Empleado únicamente
☐ Empleado + cónyuge
☐ Empleado + hijo(s)
☐ Cobertura familiar
☐ Sin cobertura

Cobertura oftalmológica

☐ Empleado únicamente
☐ Empleado + cónyuge
☐ Empleado + hijo(s)
☐ Cobertura familiar
☐ Sin cobertura

Cobertura de vida

☐ Cobertura de vida (consulte la sección 7)

5. Información del empleado **Sólo complete la información del médico de atención primaria (PCP) si se inscribe en un HMO o POS médico y odontológico.*

Apellido	Primer nombre, I. M.	Fecha de nacimiento / /	Edad	Sexo ☐ M ☐ F	N.° de seguridad social (obligatorio) - -	☐ Soltero ☐ Divorciado ☐ Casado	Altura	Peso
Dirección particular		Ciudad		Estado	Código postal	Condado		
Teléfono particular ( )		Teléfono comercial ( )			Dirección de correo electrónico			
¿Está *usted*: Jubilado? ☐ Sí ☐ No	Discapacitado? ☐ Sí ☐ No / Hospitalizado? ☐ Sí ☐ No	Ocupación			Fecha de cont. de jornada comp. / /	Horas de trabajo semanales	Ingresos declarados por: ☐ W2 ☐ 1099 Otro: ________	
Nombre y dirección de PCP de Anthem*					N.° de ID de PCP de Anthem*		¿Paciente nuevo?* ☐ Sí ☐ No	

NOMBRE ____________________ ________________ SSN ______________ ____________________

6. Información familiar **Cónyuge y dependientes incluidos (adjunte una hoja adicional si es necesario)*
** Sólo complete la información del médico de atención primaria (PCP) si se inscribe en productos HMO o POS.*

*** Lea la Ley en materia de anti-discriminación de la información genética (GINA) en la página 4, en la sección Términos, condiciones y autorizaciones relevantes, antes de contestar las preguntas a continuación.**

1 Apellido	Primer nombre, I. M.	Relación con el solicitante ☐ Cónyuge ☐ Hija ☐ Hijo ☐ Otro ______	¿Estudiante de jornada completa? ☐ Sí ☐ No

¿La dirección del dependiente es diferente a la dirección del solicitante? ☐ Sí ☐ No (Si es Sí, proporcione la dirección completa)

Fecha de nacimiento / /	Sexo ☐ M ☐ F	N.° de seguridad social (obligatorio para cónyuge/ compañero de vivienda) - -	Altura	Peso	¿Cobertura de atención a la salud por oden judicial? ☐ Sí ☐ No (Si es Sí, incluya la documentación legal) ¿Actualmente hospitalizado o discapacitado? ☐ Sí ☐ No (Si es Sí, indique el motivo)

Nombre y dirección de PCP de Anthem*	N.° de ID de PCP de Anthem*	¿Paciente nuevo?* ☐ Sí ☐ No

2 Apellido	Primer nombre, I. M.	Relación con el solicitante ☐ Cónyuge ☐ Hija ☐ Hijo ☐ Otro ______	¿Estudiante de jornada completa? ☐ Sí ☐ No

¿La dirección del dependiente es diferente a la dirección del solicitante? ☐ Sí ☐ No (Si es Sí, proporcione la dirección completa)

Fecha de nacimiento / /	Sexo ☐ M ☐ F	N.° de seguridad social (obligatorio para cónyuge/ compañero de vivienda) - -	Altura	Peso	¿Cobertura de atención a la salud por oden judicial? ☐ Sí ☐ No (Si es Sí, incluya la documentación legal) ¿Actualmente hospitalizado o discapacitado? ☐ Sí ☐ No (Si es Sí, indique el motivo)

Nombre y dirección de PCP de Anthem*	N.° de ID de PCP de Anthem*	¿Paciente nuevo?* ☐ Sí ☐ No

3 Apellido	Primer nombre, I. M.	Relación con el solicitante ☐ Cónyuge ☐ Hija ☐ Hijo ☐ Otro ______	¿Estudiante de jornada completa? ☐ Sí ☐ No

¿La dirección del dependiente es diferente a la dirección del solicitante? ☐ Sí ☐ No (Si es Sí, proporcione la dirección completa)

Fecha de nacimiento / /	Sexo ☐ M ☐ F	N.° de seguridad social (obligatorio para cónyuge/ compañero de vivienda) - -	Altura	Peso	¿Cobertura de atención a la salud por oden judicial? ☐ Sí ☐ No (Si es Sí, incluya la documentación legal) ¿Actualmente hospitalizado o discapacitado? ☐ Sí ☐ No (Si es Sí, indique el motivo)

Nombre y dirección de PCP de Anthem*	N.° de ID de PCP de Anthem*	¿Paciente nuevo?* ☐ Sí ☐ No

7. Seguro de vida y discapacidad

☐ Seguro de vida básico ☐ AD&D básico
☐ Discapacidad a corto plazo ☐ Seguro de vida de dependiente
☐ AD&D opcional ☐ Discapacidad a largo plazo
☐ Seguro de vida opcional: ______ x ingresos anuales O $ ______
☐ Ingreso actual: $ ☐ *Hora* ☐ *Semana* ☐ *Mes* ☐ *Año*

☐ Anthem By Design Discapacidad a corto plazo-BUY UP
☐ Anthem By Design Discapacidad a largo plazo-BUY UP
☐ Anthem By Design Seguro de vida básico-BUY UP (complete el formulario de elección por separado)

Clase de seguro de vida

	Apellido	Primer nombre, I. M.	Nº de seguridad social	Relación con el solicitante	Edad
Beneficiario principal			- -		
Beneficiario contingente			- -		

8. Otra cobertura médica ***Marque una:*** ☐ Sí *(complete abajo)* ☐ No

El día que comienza su cobertura, especifique los miembros de la familia, incluido usted, que estarán cubiertos por cualquier otra cobertura médica.

Proporcione el nombre, el número telefónico y la dirección de la compañía de seguro o HMO	Número de política/certificado	Fecha de entrada en vigencia / /

Nombre del titular de la política/certificado	Número de seguridad social - -	Fecha de nacimiento / /	Relación con el solicitante

NOMBRE ______________________ SSN ______________________

Si usted y/o sus dependientes están inscritos en Medicare, complete la siguiente información.				
Nombre(s) del afiliado	N.° de ID de Medicare	Fecha de entrada en vigencia de Medicare Parte A / /	Fecha de entrada en vigencia de Medicare Parte B / /	Fecha de aparición de ERET / /
		/ /	/ /	/ /
N.° de ID de Medicare Parte D	Compañía de seguros de Medicare Parte D	Fecha de entrada en vigencia de Medicare Parte D / /	Fecha de finalización de Medicare Parte D / /	
Motivo para obtener beneficios de Medicare: ☐ Edad ☐ Discapacidad ☐ ERET y discapacidad ☐ Enfermedad renal en etapa terminal (ERET)				

9. Cobertura médica anterior ***Marque una:*** ☐ Sí *(complete abajo)* ☐ No		
¿Estuvo cubierto por Anthem en los últimos dos (2) años? ☐ Sí ☐ No N.° de política/certificado	Nombre de grupo/N.° de ID	Fecha de vigencia de política: / / — / /
¿Usted y/o sus dependientes tuvieron una cobertura anterior con otra(s) compañía(s) de seguros en los últimos dos (2) años? ☐ Sí ☐ No	Especifique las compañías de seguros anteriores	Fecha de vigencia de política: / / — / /
Marque el tipo de cobertura anterior ☐ Empleado ☐ Empleado / Cónyuge ☐ Empleado / Hijo(s) ☐ Empleado / Cónyuge / Hijo(s)		
Motivo de finalización: ☐ Divorcio/separación legal ☐ Muerte del cónyuge ☐ Cobertura COBRA agotada ☐ Empleo finalizado ☐ Contribución del empleado/grupo interrumpida ☐ Otro:		

Términos, condiciones y autorizaciones relevantes (TÉRMINOS)

Lea esta sección detenidamente antes de firmar la solicitud.

Ley en materia de anti-discriminación de la información genética (GINA): Al responder las preguntas de esta solicitud de inscripción, la información suministrada para cada persona debe incluir sólo la información acerca de dicha persona y no debe incluir ninguna información genética. La información genética incluye el historial médico de la familia e información relacionada con las pruebas genéticas de la persona, sus servicios genéticos, asesoramiento genético o enfermedades genéticas por las que la persona pueda estar en riesgo. Todas las respuestas pertinentes a una persona sólo se tendrán en cuenta y aplicarán a la persona en cuestión.

Aviso sobre cuenta de ahorro de salud: Excepto que se prevea lo contrario en cualquier acuerdo entre mi y el custodio financiero, el custodio de mi cuenta de ahorro de salud (HSA), comprendo que se requiere mi autorización antes de que el custodio financiero pueda proporcionar a WellPoint la información acerca de mi HSA. Por la presente, autorizo al custodio financiero a proporcionar a WellPoint la información acerca de mi HSA, incluidos el número de cuenta, el resumen de cuenta y la información acerca de la actividad de la cuenta. También comprendo que puedo proporcionar a WellPoint una solicitud por escrito para revocar mi autorización en cualquier momento.

1. No puedo asignar ningún pago bajo mi programa de Anthem Blue Cross and Blue Shield.
2. Autorizo la deducción de mi salario/pensión, si fuera necesario, para la prima obligatoria de la cobertura solicitada por mi o por alguno de mis dependientes.
3. Solicito la cobertura seleccionada en esta solicitud. Si elijo una cobertura o una combinación de coberturas no disponible para mi y/o una clase para la que no soy elegible, acepto que mi(s) selección(es) se modifique(n) automáticamente mediante el presente documento a fin de coincidir con la solicitud del empleador.
4. Comprendo que, hasta donde lo permita la ley, Anthem se reserva el derecho de aceptar o rechazar esta solicitud (y que Anthem Life Insurance Company, que ofrece únicamente coberturas de vida y discapacidad, puede aceptar sólo a determinadas personas o condiciones para la cobertura) y que no se crea ningún tipo de derecho mediante esta solicitud. También comprendo que esta cobertura, en caso de ser aprobada, puede no incluir la cobertura de enfermedades preexistentes. (A menos que realice la solicitud de una cobertura HMO/POS, en cuyo caso dicha exclusion no se aplica).
5. Soy responsable de notificar de manera oportuna a mi empleador sobre cualquier cambio que hiciera que yo o algún dependiente no fuera elegibles para la cobertura.
6. Al firmar esta solicitud, doy mi consentimiento para la grabación y/o monitoreo de cualquier conversación telefónica entre mi persona y Anthem.

Reconozco que he leído los Términos, condiciones y autorizaciones relevantes, y acepto dichas disposiciones como condición de cobertura. Declaro que las respuestas a todas las preguntas de esta solicitud son verdaderas y exactas a mi leal saber y entender, y comprendo que Anthem se basa en ellas para aceptar la presente solicitud. Comprendo que cualquier tergiversación u omisión de datos médicos nuevos antes de mi fecha de entrada en vigencia puede provocar un cambio sustancial en las tarifas de la prima o la cobertura. Toda tergiversación u omisión significativa que se encuentre en esta solicitud puede provocar la denegación de los beneficios o la rescición o cancelación de mi(s) cobertura(s).

Doy mi autorización en nombre de cualquier dependiente elegible y de mi persona, si estuviéramos cubiertos por el Plan. Actúo como su agente y representante.

Su cobertura médica será suministrada por una de las siguientes compañías:

Healthy Alliance Life Insurance Company para PPO, HMO Missouri, Inc. para HMO, y para POS tanto Healthy Alliance Life Insurance Company como HMO Missouri, Inc.

Gracias por elegir Anthem Blue Cross and Blue Shield.

Si existe un conflicto entre la aplicación en idioma inglés y su versión en español, prevalecerá la versión en inglés.
If there is a conflict between the English language application and the Spanish version, the English version shall control.

NOMBRE ______________________ SSN ______________________

10. Lea la sección TÉRMINOS en la página 3 detenidamente antes de firmar. Revise que su solicitud no tenga errores ni omisiones

Al firmar esto, indico que he leído y comprendido lo expresado en la sección TÉRMINOS de esta solicitud y acepto todos sus términos.

Firma del solicitante	Fecha / /

11. Renuncia de cobertura para el empleado y/o cualquier dependiente elegible que no se inscriba

Marque todas las que correspondan. Renuncia a: ☐ Cobertura médica ☐ Cobertura odontológica ☐ Cobertura oftalmológica ☐ Seguro de vida ☐ Todas		
Nombre de la persona que renuncia:		Cuenta con la cobertura de ☐ Cónyuge ☐ Padre ☐ Ninguno
Nombre del empleador	Compañía de seguros:	☐ Anthem (indique n.º de certificado/política) ☐ Otra compañía de seguros (indique nombre, n.º de ID)
Marque todas las que correspondan. Renuncia a: ☐ Cobertura médica ☐ Cobertura odontológica ☐ Cobertura oftalmológica ☐ Seguro de vida ☐ Todas		
Nombre de la persona que renuncia:		Cuenta con la cobertura de ☐ Cónyuge ☐ Padre ☐ Ninguno
Nombre del empleador	Compañía de seguros:	☐ Anthem (indique n.º de certificado/política) ☐ Otra compañía de seguros (indique nombre/n.º de ID)
Marque todas las que correspondan. Renuncia a: ☐ Cobertura médica ☐ Cobertura odontológica ☐ Cobertura oftalmológica ☐ Seguro de vida ☐ Todas		
Nombre de la persona que renuncia:		Cuenta con la cobertura de ☐ Cónyuge ☐ Padre ☐ Ninguno
Nombre del empleador	Compañía de seguros:	☐ Anthem (indique n.º de certificado/política) ☐ Otra compañía de seguros (indique nombre/n.º de ID)
Marque todas las que correspondan. Renuncia a: ☐ Cobertura médica ☐ Cobertura odontológica ☐ Cobertura oftalmológica ☐ Seguro de v/ida ☐ Todas		
Nombre de la persona que renuncia:		Cuenta con la cobertura de ☐ Cónyuge ☐ Padre ☐ Ninguno
Nombre del empleador	Compañía de seguros:	☐ Anthem (indique n.º de certificado/política) ☐ Otra compañía de seguros (indique nombre/n.º de ID)

Marque todas las que correspondan

☐ Declaro que he tenido la oportunidad de solicitar la cobertura de Anthem Blue Cross and Blue Shield y que, después de considerarlo cuidadosamente, he decidido no aprovechar esta oferta. En caso de que desee realizar la solicitud de dicha cobertura en el futuro, lo puedo hacer, con sujeción a los procedimientos establecidos.

Si rechazo mi inscripción o la de mis dependientes (incluido mi cónyuge) debido a otra cobertura médica, en el futuro podré inscribirme o inscribir a mis dependientes en este plan, siempre y cuando dicha inscripción se solicite dentro de los 31 días posteriores a la finalización de la otra cobertura. Mi(s) dependiente(s) o yo podremos estar sujetos a restricciones por enfermedades preexistentes o a los períodos de espera especificados en el certificado de grupo, si un dependiente o yo nos inscribimos fuera de plazo. Asimismo, si tengo un dependiente como resultado de matrimonio, nacimiento, adopción o solicitud de adopción, puedo inscribirme e inscribir a mis dependientes siempre y cuando solicite la inscripción dentro de los 31 días posteriores al matrimonio, nacimiento, adopción o solicitud de adopción. También comprendo que mis dependientes y yo podemos inscribirnos en dos circunstancias adicionales:

- O bien la cobertura de Medicaid o del Programa de Seguro de Salud para Niños (CHIP) finaliza como resultado de la pérdida de elegibilidad; o
- Mi dependiente o yo pasamos a ser elegibles para un subsidio (programa estatal de asistencia de primas)

En estos casos, es posible que pueda inscribirme e inscribir a mis dependientes, siempre y cuando solicite la inscripción dentro de los 60 días posteriores a la pérdida de Medicaid/CHIP o de la determinación de elegibilidad.

☐ Declaro que he tenido la oportunidad de solicitar los beneficios de vida de grupo disponibles ofrecidos por mi empleador/grupo, que se me han explicado los beneficios, y que yo y/o mi(s) dependiente(s) decidimos no participar. Ni mi(s) dependienti(s) ni yo fuimos inducidos o presionados por mi empleador/grupo, agente o compañía de seguros de vida para rechazar esta coberturasino que lo decidimos voluntariamente. Comprendo que si quisiera solicitar dicha cobertura en el futuro, podré tener que presentar por mi cuenta pruebas de asegurabilidad.

Firma del solicitante	Fecha / /

Employer Application

Anthem. AnthemLife

Group size 51+ eligible employees
Please complete in ink and use extra sheets of paper if necessary
For more information about Anthem, its products and services visit **www.anthem.com.**

Anthem use:	Group/Account #	Effective Date	State	UGT#
☐ New ☐ Termination ☐ Reclass		/ /	☐IN ☐KY ☐OH ☐MO ☐WI	

1. Effective date Requested effective date: / /

2. The benefits you have selected are outlined on the attached proposal, herein incorporated by reference.

☐ Blue Access® (PPO)
☐ Blue Access® Choice (PPO) (MO only)
☐ Anthem Essential PPO
☐ Anthem Essential Choice PPO (MO only)
☐ Anthem Essential℠ Select (MO only)
☐ Anthem Essential POS (WI only)
☐ Blue Preferred® Plus (POS)
☐ Blue Preferred® (HMO)
☐ Blue Preferred® Select (MO only)
☐ Blue Traditional® (Indemnity) (IN, KY, OH only)
☐ Blue Priority® (HMO) (Ohio only - Exclusive Provider Organization or "EPO")
☐ Blue Priority® Plus (POS) (OH/WI only)
Lumenos® H S A ☐ PPO (IN/KY/OH/MO/WI) ☐ POS (WI Only)
Lumenos® H R A ☐ PPO (IN/KY/OH/MO/WI) ☐ POS (WI Only)

Lumenos® H I A ☐ PPO (IN/KY/OH/MO/WI) ☐ POS (WI Only)
Lumenos® HIA Plus ☐ PPO (IN/KY/OH/MO/WI) ☐ POS (WI Only)
☐ Medicare Supplement (MO only) ____________
☐ Dental Traditional (IN/OH only)
☐ DentaCare (HMO) (WI only)
☐ DentaBlue (PPO) (MO only)
☐ DentaBlue Select (PPO) (MO only)
☐ Dental Blue® 100
☐ Dental Blue® 100/200/300
☐ Dental PPO

☐ Vision
☐ Basic Life
☐ Basic AD&D
☐ Dependent Life
☐ Optional Life
☐ Optional AD&D
☐ Short Term Disability
☐ Long Term Disability

3. Medicare Part D

Prescription Drug Benefits: ☐ Wrap ☐ Waiver ☐ Subsidy

If Subsidy (CMS Information needed): Plan Sponsor ID: ____________ Application ID: ____________
Unique Benefit Option Identifier: ____________

☐ Does **not** employ 20 or more employees (full-time, part-time, leased) under the terms of the Medicare Secondary Payer statute
(The group agrees to notify Anthem Blue Cross and Blue Shield as soon as this statement is no longer true.)
☐ Does employ 20 or more employees (full-time, part-time, leased) under the terms of the Medicare Secondary Payer statute

4. Employer Information

Applicant (legal name of group)	Name of association (if applicable)
Name and title of head of firm	Name and title of administrative contact

Home office address	City	County	State	ZIP Code

eMail address	Phone number *(include area code)*	Fax number *(include area code)*
Billing address and/or contact *(if different from above)*	Tax ID/FEIN (Required)	Number of years in business

Standard industry code (SIC)	Type of business	Type of organization ☐ Partnership ☐ Corporation ☐ Sole Proprietorship ☐ Other: ☐ Labor Union ☐ Trust ☐ Government Unit

Is any part of group subject to bargaining agreement? ☐ Yes ☐ No	Union name, number, contract expiration date *(attach a copy of agreement)*	Will bargaining agreement participants be considered eligible employees? ☐ Yes ☐ No

List all affiliates/subsidiaries/divisions *(list names, locations, number employed at each location.)* Attach a separate page to show any separate billing addresses, and any separate billings for life classes.

Total # of employees residing/working outside of Home Office state	List # of employees at each office location
Has your group been turned down for coverage in the last 12 months? ☐ Yes ☐ No	If yes, by whom, when and why?

Name of current health and/or life carrier(s)	Will any insurance carrier(s), in addition to Anthem, provide health coverage as part of the Group's employee benefit plan? ☐ Yes ☐ No	If yes, list carrier(s) and product(s) offered

In the past 36 months, has the company or any affiliate entity filed for protection or operated under federal/state bankruptcy laws (Chapter 11 or 7) or state receivership? ☐ Yes ☐ No	In the past 36 months, has any creditor filed or threatened to file a petition requesting the company or any affiliated entity to be placed voluntarily into bankruptcy? ☐ Yes ☐ No

Do you want Anthem to facilitate opening a Health Savings Account with Mellon? ☐ Yes ☐ No

Is your group subject to COBRA? ☐ Yes ☐ No	Do you have a COBRA administrator? ☐ Yes ☐ No	Do you want an Anthem affiliate to administer COBRA for your group? ☐ Yes ☐ No *If yes, please complete and sign the COBRA agreement.*

List employee/dependents on Continuation of Coverage/COBRA	Names of persons in COBRA eligibility period

List all totally disabled employees and dependents

Group Name ______________________

5. Eligibility

Eligible full-time employees must work at least 30 (25 in OH) hours per week, must be actively at work, must have satisfied any applicable eligibility waiting period. Eligible full-time employees do not include temporary or seasonal employees.

Number of full time employees (including those within their waiting period)	Total number of employees (including part-time)	Full-time eligible enrollees as of this plan's effective date will have coverage: ☐ On group's effective date ☐ Same waiting period that applies to new persons or on group effective date, whichever is later

New eligible enrollees will become effective on:
The day after ☐ 0 ☐ 30 ☐ 60 ☐ 90 ☐ 180 days of employment *OR*
First billing date after ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days *OR*
The first of the month following ☐ 0 ☐ 30 ☐ 60 ☐ 90 ☐ 180 days of employment (MO, WI only)

Do any classes of employees have a different waiting period? ☐ Yes ☐ No | If yes, explain

6. Contribution Requirements *Employer must have at least two enrolled employees enrolled in health to maintain coverage under this plan.*

Group contribution level for insurance
Health ______% Dental ______% Vision ______% Basic Life ______% Basic AD&D ______% Dependent Life ______%
Optional Life ______% Optional AD&D ______% STD ______% LTD ______%

Do any classes have a percentage of group contribution different than above? ☐ Yes ☐ No | If yes, explain

7. Premium Contributions *(WI Only)*

☐ **Single-Product Offering:** *Required Contribution:* At least 50% of individual coverage premium and 25% of family coverage premium for employee benefits.

What percentage of the monthly premium is paid by the employer? Single: ______% Family: ______% Other: ______% Retiree: ______%

☐ **Multiple-Product Offering:** *Required Contribution:* At least 75% of the single premium of the **Core/Low** plan, regardless of the plan in which the employee actually enrolls.

Single: ______% Family: ______% Other: ______% Retiree: ______% -**OR**- Flat Dollar Amount* of $ ____ per employee and $ ______ per family per month

**Must be equal to or greater than Required Contribution for multiple-product offerings.*

8. Participation Requirements *(WI Only)*

These participation requirements must be observed and maintained for a Group to remain eligible for coverage. It is the Group's responsibility to maintain these requirements. The number of employees in medical coverage initially and when reviewed periodically thereafter determine the size of group for participation requirement purposes.

Requirements* when either Anthem IS NOT the exclusive carrier:
• For groups in size 51-99 eligible employees - 50% participation • For groups in size 100+ eligible employees - 25% participation
Requirements* when either Anthem IS the exclusive carrier: 75% participation
**Anthem reserves the right to revise its offering if these requirements are not met.*

a. Eligible employees who waive coverage due to coverage under a health plan that constitutes "creditable coverage" for pre-existing condition purposes (e.g., COBRA, spouse's group health coverage) will not be used to determine participation.

b. For all groups, eligible employees who waive coverage because they are part of another health plan offered by the Group will be used to determine participation.

9. Open Enrollment

Our standard open enrollment period is at least 31 days prior to the Group's renewal date and 31 days following, which is held no less frequently than once in any 12 consecutive months. If you want to designate a different open enrollment period, please indicate the following:

__________ Start Date __________ End Date

10. Signature ***PLEASE ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM (Read section 11 carefully before signing)***

Signature and title of authorized group representative/title	Location where signed	Date / /
Accepted by Anthem's Underwriting Department — Signature and title		Date / /

11. Read this section carefully before signing. Please review your application for errors or omissions.

The employer and/or authorized representative hereby requests that it be approved for coverage through Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company (hereinafter "Anthem" unless otherwise specified) and to be bound by Anthem's and Anthem Life's rules and regulations pertaining to coverage under the insurance contracts and policies, as adopted and/or revised from time to time. Employer understands and certifies the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Anthem Life trust policy(ies), if applicable.
2. To make the coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Anthem or their designated agent(s), any information required in connection with administration of the coverage.
4. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.
5. That statements of medical history will be required of employees, and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem.
6. That approval for this coverage may cancel any prior contracts and/or coverage with Anthem effective immediately preceding the effective date of the employer's coverage.
7. To pay Anthem by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and state-mandated continued group coverage and/or conversion process, if applicable.
8. That claims filed by or on behalf of members may, at Anthem's option, be suspended if premiums are not timely received. (N/A in Wisconsin)
9. If applicable, Employer will receive on behalf of members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.

Group Name ______________________

10. The advance premium check does not create temporary or interim coverage and that receipt and deposit of that payment does not guarantee issuance of coverage. Rather, issuance of coverage is expressly conditioned on Anthem's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.

11. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem may be different than the coverage applied for herein. In that event, Anthem shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.

12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any misstatements on employees' application or failure to report new medical information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rates as of the effective date of coverage.

13. The entire application for Group coverage has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.

14. All employees applying for coverage are employees of the employer and receive salary or wages documented on state and/or federal payroll reports. Eligible full-time employees must work at least 30 hours per week (25 in OH if the employer is a "small employer" as defined by Ohio law, or if employer participates in a trust to which a group policy has been issued which contains a minimum 25 hours per week eligibility requirement), must be actively at work, must have satisfied any applicable eligible waiting period.

15. The requested coverage is not in effect unless and until this application is approved by Anthem, that approval of coverage shall be evidenced by issuing Group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem.

16. The employer acknowledges that he has signed the attached benefit proposals indicating the coverages requested.

17. The broker listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.

Fraud Notice

KY - Any person who knowingly and with intent to defraud an insurance company, health maintenance organization or other person files an application for insurance or other form of health coverage 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.

OH - Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

12. Broker Certification - I hereby certify that:

1. I have reviewed the attached employee and group applications and waivers for completeness and accuracy.
2. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials on the application.
3. I have not signed any of the applications for a group representative or individual applicant.
4. I have advised the group that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the group's premium retroactive to the effective date and that coverage shall not be effective until Anthem Blue Cross and Blue Shield reviews and approves the application and the group receives a written notice and contract from Anthem.

Broker name		Broker Signature	
Address			
Broker ID number	Tax ID number to be paid	Broker phone number	Date / /
Agency name *(if applicable)*		General agency broker	
Address		Anthem sales representative	

Life and Disability products underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association.
Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc (13550 Triton Park Blvd. Louisville, KY 40223). In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWI"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

Contraceptive Benefits Option Form

You need to complete this form only if you want to make changes in your contraceptive coverage.

OPTION 1: TO EXCLUDE CONTRACEPTIVES

Complete Option 1 *only* if your health benefits plan includes benefits for contraceptive drugs and devices *and* you want to exclude these benefits from your coverage for moral, ethical or religious reasons.

I understand that the health benefits plan provided through Anthem Blue Cross and Blue Shield (Anthem) includes benefits for contraceptive drugs and devices. However, because of my moral, ethical and/or religious beliefs, I do not want benefits for contraceptive drugs and devices as part of the coverage for myself or for any family members to be included on my membership. I understand that *my premium will not be reduced because of this change.*

Printed last name	First name	M.I.	Date of birth

Member signature	Date	Social security no. or Anthem identification no.
X		

If you are enrolling through a group, please complete the following:

Anthem group name	Anthem group no. (if known)

OPTION 2: TO INCLUDE CONTRACEPTIVES

Complete Option 2 *only* if your health benefits plan excludes benefits for contraceptive drugs and devices, but you want contraceptive coverage.

I understand that the health benefits plan provided through Anthem Blue Cross and Blue Shield (Anthem) covers prescription drugs but does not cover contraceptive drugs and devices. However, I wish to include benefits for contraceptive drugs and devices as part of the coverage for myself and for any family members to be included on my membership. I understand that *mv premium will not be increased because of this benefit change.*

Printed last name	First name	M.I.	Date of birth

Member signature	Date	Social security no. or Anthem identification no.
X		

If you are enrolling through a group, please complete the following:

Anthem group name	Anthem group no. (if known)

In Missouri (excluding 30 counties in the Kansas City area) Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association.
® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Notice to Applicant/Subscriber
Concerning Contraceptive Coverage

If the coverage offered to you includes benefits for prescription drugs (pharmaceuticals), it probably also includes benefits for contraceptive drugs and devices.

The following information applies to you and any family members to be covered under your health benefits plan through Anthem Blue Cross and Blue Shield (Anthem):

- If the coverage offered to you includes benefits for contraceptive drugs and devices, you may exclude them from your own coverage because of your moral, ethical or religious beliefs.
- If the coverage offered to you does not include benefits for contraceptive drugs and devices, you may add them to your own coverage.

If you do not wish to change your benefits for contraceptive drugs and devices, please discard this form.

To make one of the choices indicated above, please complete the Contraceptive Benefits Option Form on the reverse side. Date of birth and Social Security Number information will be used only to identify the person completing this form.

Please mail your completed form directly to Anthem at the address shown below:

Anthem Blue Cross and Blue Shield
P.O. Box 659804
San Antonio, TX 78265-9104

Your Individual Application Kit is enclosed

Here is a checklist to review before you return your application.

- ☐ Print clearly and complete the application in blue or black ink.
- ☐ If you make any changes while completing this form (for example, if you cross out something you wrote), be sure to **initial and date** those changes.
- ☐ If any **corrections** are needed or if the form is incomplete, the application may have to be returned to you, or we may try to call you, to obtain the necessary information. In that case, we will record your information on a form that will be attached to your application.
- ☐ You may request an effective date of any day of the month after the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.
- ☐ **The primary applicant, spouse/domestic partner, if applicable, and any dependent children age 18 or over must sign and date the application in two places (in Section K).**
- ☐ List the height and weight for each applicant.
- ☐ List the date of birth for each applicant.
- ☐ For applicants age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, if you have had creditable health coverage in the past 63 days, please fill out Section H to apply for preexisting credit. Creditable Coverage is defined as prior coverage from a group plan, Medicare, Medicaid, health plan for active military personnel, including TRICARE, Indian Health Service, state risk pool, Federal Employees Health Benefits Program, state children's health insurance program, public health plan, U.S. Government plans, foreign health plans, individual insurance policy or Peace Corps service. Prior coverage does not count as Creditable Coverage if there was a break of 63 days or more prior to applying for this coverage.
- ☐ Select the plan, deductible amount, Rx option and any applicable riders requested.
- ☐ Answer all health history questions in Section J. Failure to do so will delay the processing of your application.
- ☐ If you answered "yes" to any of the health history questions, give complete details on page 10.
- ☐ If you are eligible for Medicare, you are not eligible to apply for our individual products.

If you need assistance filling out the application, please contact your agent.

EXHIBIT
E

In Missouri (excluding 30 counties in the Kansas City area): Anthem Blue Cross and Blue Shield is the trade name for RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Life products underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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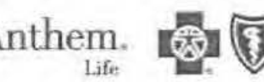
Missouri
Individual Enrollment Application



Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one): ☐ New Coverage ☐ Change Anthem Individual policy coverage - Policy No. ______
☐ Add dependent(s) to current coverage - Policy No. ______

Effective date requested: If your application is approved, your coverage can start on any day of the month **after** the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.

Please choose the date you would like your coverage to start: ____/____/______ MM/DD/YYYY

Section B – Applicant Information

Risk Tier	Last Name		First Name			MI	Social Security Number*
Home Address (street and P.O. Box if applicable)							
City				State	ZIP		County
Marital Status ☐ Single ☐ Married		Height (Ft. / In.) /	Weight	Sex ☐M ☐F	Age		Date of Birth / /
Daytime Phone Number ( )		Evening Phone Number ( )		E-mail*			

Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? .... ☐ Yes ☐ No

Are all applicants listed on this application United States citizens? .... ☐ Yes ☐ No

If NO, who? ______

and how many years/months have they resided in the United States? ______ years and ______ months

Tobacco Use: Have you used tobacco in the last 12 months? .... ☐ Yes ☐ No

If cigarettes, how many do you smoke per day? ______

Autism Extended Coverage Option: If your application is accepted, benefits for the diagnosis and treatment of Autism will be enhanced in your health care coverage by checking the box below to purchase the additional coverage.

☐ I wish to purchase the Autism Extended Coverage. (Checking this option will affect your premium.)

Section C – Spouse or Domestic Partner Information

Risk Tier	Last Name		First Name			MI	Relationship ☐ Spouse ☐ Domestic Partner
Social Security Number*		Height (Ft. / In.) /	Weight	Sex ☐M ☐F	Age		Date of Birth / /

Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? .... ☐ Yes ☐ No

Tobacco Use: Have you used tobacco in the last 12 months? .... ☐ Yes ☐ No

If cigarettes, how many do you smoke per day? ______

**This information is used for internal purposes only and will not be disclosed.*

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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). (List all dependents beginning with the eldest.)

Risk Tier	First, MI (last name if different)	Relationship to Applicant	Social Security Number*	Sex	Age	Date of Birth mm/dd/yyyy	Height Ft. / In.	Weight Lbs.
		Child		M ☐ F ☐			/	
		Child		M ☐ F ☐			/	
		Child		M ☐ F ☐			/	
		Child		M ☐ F ☐			/	
		Child		M ☐ F ☐			/	

**This information is used for internal purposes only and will not be disclosed.*

Section E – Medical Coverage

Plan Name, In Network Coinsurance, Deductible Options | **Optional Benefits**

Select ONE Plan...then select ONE Individual Deductible and any optional benefits.
Total Family Deductible is two (2) times the amount shown.

☐ **SmartSense® Plus**

(30% coinsurance) ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $3,500 ☐ $5,000 ☐ $10,000

☐ **Upgrade Drug Coverage**

☐ **Premier Plus**

(20% coinsurance) ☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $1,500 - no office visit copay

(0% coinsurance) ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $3,500 ☐ $5,000 ☐ $10,000 ☐ $2,500 - no office visit copay

☐ **Upgrade Drug Coverage**

☐ **Add Maternity Coverage** (available on $2,500 or higher deductible options)

☐ **CoreShare**

(40% coinsurance) ☐ $750 ☐ $1,500 ☐ $2,500 ☐ $3,500 ☐ $5,000

(0% coinsurance) ☐ $7,500 ☐ $10,000 ☐ $15,000 ☐ $25,000

HSA Compatible Plans

Select ONE Plan...then select ONE Deductible (Individual/Family).

☐ **Lumenos® HSA Plus**

(40% coinsurance) ☐ $1,500/3,000

(20% coinsurance) ☐ $1,750/3,500

(0% coinsurance) ☐ $1,500/3,000 ☐ $2,500/5,000 ☐ $3,500/7,000 ☐ $5,500/11,000

☐ **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.

Section F – Dental Coverage Selection

☐ Dental Blue® Basic 100 ☐ Dental Blue® Essential 100 ☐ Dental Blue® Essential 200

☐ Yes, I wish to add dental coverage (at an extra cost per individual)

If Yes, select ONE coverage type (applies to individuals listed on this application only):

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

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

☐ Yes, if myself or any listed family member are declined for medical coverage, still enroll **all members selected above, if eligible.**

Section G – Anthem Life Insurance Company's Term Life Insurance

Blue Preferred® Term Life

☐ Yes, in addition to my medical coverage, I wish to apply for Term Life Insurance (at an extra cost per individual). Provide information below.

Applicants must meet Anthem Life's Underwriting Guidelines to qualify for Term Life Insurance Coverage. Applicants under the age of one year are not eligible for Life Insurance. All Term Life policies terminate at age 65.

Applicants	Coverage Amount (select one)	Beneficiary**	Relationship	Beneficiary Street Address City/State/ZIP
☐ Applicant	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		
☐ Spouse ☐ Domestic Partner	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		
☐ Child(ren)	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		

* The $50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to $25,000.

** **If a beneficiary is not listed** and a policy is issued, death benefits will be paid in accordance with the Beneficiary Provision of the Policy.

Section H – Other Health Coverage

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

If yes, give name. ______

Did you or your eligible dependents have creditable coverage within the past 63 days, including any Anthem coverage? (You may be eligible for preexisting credit. Preexisting condition limitations do not apply to applicants under the age of nineteen (19), if applying for non-grandfathered coverage.) ☐ Yes ☐ No

The following information must be completed in order for credit to be given. Please provide the previous 18 months of 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)		Reason for cancellation
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	Cancellation Date of Coverage

Will you be canceling this coverage if approved for Anthem coverage? ☐ Yes ☐ No

Complete this section if you've had more than one carrier in the last 18 months (attach a separate sheet if necessary).

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)		Reason for cancellation
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	Cancellation Date of Coverage

Will you be canceling this coverage if approved for Anthem coverage? ☐ Yes ☐ No

Section I – Healthy Lifestyle (optional)

You and your spouse or domestic partner may qualify for a better rate based on your lifestyle. Complete the section below if you would like to be considered for this special rate.

	Applicant	Spouse or Domestic Partner
1. Have you been tobacco-free for the last 3 years?	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you exercise regularly?	☐ Yes ☐ No	☐ Yes ☐ No
3. Are you in excellent health with no ongoing medical conditions?	☐ Yes ☐ No	☐ Yes ☐ No
4. How many times a week do you exercise?	☐ 0-2 ☐ 3-4 ☐ 5-7	☐ 0-2 ☐ 3-4 ☐ 5-7

Section J – Health History (IMPORTANT: This section has two steps)

STEP 1: Health history questions must be answered by each/every person applying for coverage.

Health History Questionnaire — All Questions Must Be Answered Or The Application Will Be Returned.

GIVE COMPLETE DETAILS IN STEP 2 (page 10) FOR ALL QUESTIONS ANSWERED "YES".

When answering questions on this enrollment application the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. We are relying on the information you provide to determine whether you are eligible for coverage. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician(s) to clarify your specific condition. We have the right to review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, do not assume we will review all of your medical records before approving your application. If we issue coverage to you and then discover an act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact, we may rescind your coverage, even after it has been issued. This means that you may lose your health benefits including coverage for treatment already received. Rescission may occur even if we review your medical records or seek medical confirmation of your health information as part of processing your application. Even if you currently have health insurance coverage or had prior coverage with Anthem Blue Cross and Blue Shield, you must fully disclose and answer all health history questions.

	YES	NO
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	☐	☐
2. Within the last 12 months have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	☐	☐
3. Have you been prescribed or taken any prescription medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (This includes any prescription samples provided by your physician. If yes, explain in Step 2.)	☐	☐
4. Are you pregnant or an expectant father, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	☐	☐
5. Do you have implants, prosthesis or retained hardware?		
A. Breast implants	☐	☐
B. Eye/limb prosthesis	☐	☐
C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump	☐	☐
D. Joint replacement/internal fixations (i.e. pins, plates, rods etc.), neurostimulators	☐	☐
E. Any other prosthesis or implant (other than dental)	☐	☐

	YES	NO
6. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following? *(all answers must be checked yes or no)*		
A. Headaches requiring prescription medication	☐	☐
B. Loss of consciousness	☐	☐
C. Sleep apnea/breathing difficulties while sleeping	☐	☐
D. Recurrent fainting, weakness or dizziness	☐	☐
E. Paralysis or numbness/tingling in limbs	☐	☐
F. Chest pain	☐	☐
G. Increased/irregular heart beat	☐	☐
H. Low or high blood pressure	☐	☐
I. High cholesterol	☐	☐
J. Shortness of breath	☐	☐
K. Heartburn (recurrent)	☐	☐
L. Abnormal and/or Recurrent bleeding (unrelated to menstruation)	☐	☐
M. Recurrent diarrhea and/or recurrent vomiting	☐	☐
N. Unexplained weight loss	☐	☐
O. Blood, sugar, and/or protein in urine	☐	☐
P. Recurrent pain (including back pain)	☐	☐
Q. Jaundice	☐	☐
R. Mass, cyst(s), or lump(s) in any body part including breast	☐	☐

Section J – Health History (IMPORTANT: This section has two steps) *(continued)*

	YES	NO
7. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following?		
A. Abnormal Pap smear	☐	☐
B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease)	☐	☐
C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)?	☐	☐
D. Male infertility	☐	☐
E. Female fertility/infertility	☐	☐
F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart, circulatory or blood disorder(s)	☐	☐
G. Kidney, bladder or prostate disorder(s)	☐	☐
H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s)	☐	☐
I. Hernia; hemorrhoid; rectal, or intestinal disorder(s)	☐	☐
J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s)	☐	☐
K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s)	☐	☐
L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay	☐	☐
M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems	☐	☐
N. Psoriasis, rosacea, acne or skin disorder(s)	☐	☐
O. Cataract, glaucoma, eye or ear disorder(s)	☐	☐
P. Diabetes, thyroid, endocrine glands	☐	☐
8. Within the last 5 years, have you experienced, suffered from, consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol?	☐	☐

	YES	NO
9. Within the last 5 years, have you been advised by a health care professional to reduce alcohol intake?	☐	☐
10. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	☐	☐
11. Within the last five years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If you answered yes, please check any that apply below and explain in Step 2.)	☐	☐
A. Obsessive Compulsive Disorder	☐	☐
B. Minor depression	☐	☐
C. Anxiety/panic attacks	☐	☐
D. Attention Deficit Disorder (ADD/ADHD)	☐	☐
12. In the last 10 years have you had consultation, experienced symptoms, been diagnosed, had treatment or treatment recommended for any of the following:		
A. Schizophrenia, Major Depression/ BiPolar Disorder	☐	☐
B. Eating disorder (i.e. anorexia/bulimia)	☐	☐
13. Within the last 10 years, have you experienced (suffered from) or consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to drug abuse?	☐	☐
14. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor?	☐	☐
15. Have you ever been diagnosed with hepatitis? (check all types that apply)	☐	☐
A. Hepatitis A	☐	☐
B. Hepatitis B	☐	☐
C. Hepatitis C, D, E	☐	☐

Section J – Health History (IMPORTANT: This section has two steps) *(continued)*

	YES	NO
16. Have you ever been positively diagnosed with, or treated for any of the following?		
A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment for AIDS or ARC	☐	☐
B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Diabetes, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma.	☐	☐
17. Are you a candidate for, or have you ever received an organ or bone marrow transplant?	☐	☐
18a. Within the last five years, have you had any illness, physical injury, persisting or new physical symptoms and/or health problems not mentioned elsewhere on this application that have not been evaluated or that you plan to have evaluated by a licensed health practitioner?	☐	☐
18b. Within the last two years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application?	☐	☐
19. Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy?	☐	☐

Prescription Medications

List ***ALL*** prescription medications taken within the last 12 months by any family member listed on this application (if not indicated in Step 2.)

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (mm/dd/yyyy)	Date Discontinued (mm/dd/yyyy)	Name, Phone No. of Physician or Hospital
					Name: ____ Phone: ____
					Name: ____ Phone: ____
					Name: ____ Phone: ____
					Name: ____ Phone: ____
					Name: ____ Phone: ____
					Name: ____ Phone: ____
					Name: ____ Phone: ____

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

Section J – Health History (IMPORTANT: This section has two steps) *(continued)*

STEP 2: If you answered "YES" to any of the health history questions, give complete details (see the example below)

Question Number	Patient First Name	Physician Name & Telephone (with area code)	Specific Diagnosis & Treatment	Name & Dosage of Medication & Dates of Use		Duration of Condition		Was Surgery Performed?		Description of Surgery/ Procedures & Date(s) (mm/yyyy)	Current Status
				Begin (mm/yyyy)	End (mm/yyyy)	Begin (mm/yyyy)	End (mm/yyyy)	YES	NO		
#18b	Mary	Dr Joe Doe 555 555-1000	Tonsillitis	Amoxicillin 250 mg 4x day 08/2009	09/2009	08/2009	09/2009	☑	☐	Tonsillectomy 09/2009	Good
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		
								☐	☐		

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

Section K – Significant Terms, Conditions and Authorizations (Please read carefully.)

Please read this section carefully before signing the application.

1. **I understand that it is mandatory that I notify Anthem, in writing, immediately if I (the applicant) or any other person for whom coverage is sought has a symptom of, has been advised of, or received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date. I understand that in this situation, Anthem has the right to underwrite my application again, using the new information and that, as a result, my coverage/ family members' coverage might be delayed or reformed or, for applicants age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, benefits denied due to the illness, injury or condition being treated as a preexisting condition.**

2. I understand that sending my initial premium with this application, and the receipt of my payment by Anthem, does not mean that coverage has been approved. I understand that if my application is denied, my bank account or credit card will not be charged.

3. If my request for coverage is being handled by a producer, I understand that the producer is not authorized to waive a complete answer to any question in the application, pass on insurability, make or alter any contract or waive any of Anthem's other rights or requirements.

4. I may not assign any payment under my Anthem program. I am applying for the coverage selected on this application. I understand that any premium quote provided is preliminary and review of my application by medical underwriting may change the premium or result in a denial of coverage. 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.

5. **For applicants age nineteen (19) and older applying for non-grandfathered coverage and all applicants applying for grandfathered plans, I understand that pre-existing conditions are not covered for 12 months after my enrollment. I also understand that a pre-existing condition is any condition for which medical advice, diagnosis, care or treatment was recommended or received within the 12 months immediately prior to my enrollment or that produced symptoms within 12 months immediately prior to my enrollment that would have caused an ordinarily prudent person to seek medical diagnosis or treatment. Pregnancy is considered a pre-existing condition.**

6. If the plan I purchase offers maternity coverage, and I purchase that coverage, I understand that 1) these benefits apply only to me or my covered spouse/domestic partner and not to any dependent child and 2) these benefits will not begin until after my membership has been in effect for 18 months.

7. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.

8. 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.

9. 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.

10. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.

11. **I understand and agree I am applying for individual health 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.**

12. If I purchase optional dental coverage for the Dental Blue® Essential plan, I understand that I will have a twelve month waiting period for coverage of Major Restorative Services. *(For a description of Preventive, Diagnostic and Major Restorative services, please refer to your marketing materials.)*

13. By signing this application I represent that I understand that Anthem Life has the right to deny my application for Term Life Insurance Coverage, and if it does, I will be notified in writing. I understand that if Anthem Life declines this coverage, no benefits will be payable. I understand that I alone am responsible for reading and accurately completing this application, and I must communicate any changes to my status. I also understand that all other conditions of my medical application apply for the life application.

Section K – Significant Terms, Conditions and Authorizations (Please read carefully.) *(continued)*

14. Please check the box below, if appropriate:

    ☐ Instead of sending communications by mail, I authorize and expressly consent that Anthem and its affiliated companies may send e-mail communications, 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 Anthem.com.

15. 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).

    If tobacco use question in Section B or Section C is answered "NO", I understand that the signature(s) shown on the following page will attest to non-tobacco usage for the past 12 months.

    Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

    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.

SIGN HERE

Signature	Date
Signature of Applicant ***(or Custodial Parent's or Guardian's signature if applicant is under age 18)*** X	Date
Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

Section L – Agent Certification

To be completed by your Anthem-appointed agent:

1. Does the applicant intend to replace, discontinue or change any existing life policy or annuity contract? .... ☐ Yes ☐ No
2. Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting? .... ☐ Yes ☐ No
3. **I certify to the best of my knowledge and belief, the responses herein are accurate.**

Agent Signature X			Date
Agent Name (please print)	Agent Street Address/Suite No./Personal Mail Box (PMB) No.		
Agent ID No.	City/State/ZIP	County Code	Area
Agent Phone No.	Agent Fax No.	Agent E-mail	

Authorization for Use of Protected Health Information

The following authorization must be signed by all of the following persons if they are applying for coverage or changing existing coverage:

- the applicant;
- the applicant's spouse or domestic partner; and
- any Dependent Child age 18 or over.

If the authorization is not signed by all of the persons listed above who are seeking coverage, the application may be returned to you as incomplete or acted upon without regard to any person whose required signature was not included. This Authorization will expire 24 months following Anthem Blue Cross and Blue Shield's or Anthem Life Insurance Company's acceptance of coverage, if not previously revoked.

By signing below:

I authorize Anthem Blue Cross and Blue Shield or Anthem Life Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield or Anthem Life Insurance Company, to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, MIB, Inc., formerly Medical Information Bureau (MIB), and/or insurance support organizations. I further authorize Anthem Blue Cross and Blue Shield or Anthem Life Insurance Company to disclose protected health information it may collect about me to MIB, which may re-disclose such information to other insurance companies pursuant to the MIB information exchange.

I also authorize any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans, medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations to furnish any medical records or health history information concerning me and any family member listed on my Application to Anthem Blue Cross and Blue Shield or Anthem Life Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield or Anthem Life Insurance Company. This information is needed to determine eligibility for coverage and Anthem Blue Cross and Blue Shield's or Anthem Life Insurance Company's acceptance of coverage requested for myself and/or any family members listed on my Application or so that a determination of coverage regarding a claim for specified benefits can be made.

This authorization is subject to revocation at any time by written notice to Anthem except to the extent that Anthem has already taken action in reliance on this authorization. If I revoke this authorization after I initially apply for coverage, I understand that I/we will not be considered for coverage. If I revoke this authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that if my and/or my family's information is to be received by individuals or organizations that are not health care providers, health care clearinghouses or health plans governed by federal privacy regulations, my/our information might be re-disclosed by any of those recipients and will not be protected by federal privacy regulations. A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

SIGN HERE

X	X	
Printed name of Applicant/Member	Signature of Applicant/Member or his/her Legal Representative	Date
X	X	
Printed name of Spouse or Domestic Partner or Dependent Child* age 18 or over listed on Application	Signature of Spouse or Domestic Partner or Dependent Child* or his/her Legal Representative	Date
X	X	
Printed name of Dependent Child* age 18 or over listed on Application	Signature of Dependent Child* or his/her Legal Representative	Date

**If listed on your application or change form, your spouse/domestic partner and each dependent child age 18 or over must sign above. If a legal representative signs on behalf of the applicant or spouse or domestic partner, a copy of the legal representative's authority must be attached to the application.*

A photocopy of this form will be as valid as the original.
You or an authorized representative have the right to receive a copy of this Authorization upon request.

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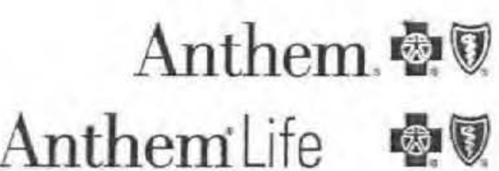
If you have an Anthem agent, please mail directly to:
your Anthem agent.

If you do NOT have an Anthem agent, please mail to:

Anthem Blue Cross and Blue Shield
P.O. Box 659806
San Antonio, TX 78265-9106

In Missouri (excluding 30 counties in the Kansas City area): Anthem Blue Cross and Blue Shield is the trade name for RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Life products underwritten by Anthem Life Insurance Company. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Payment Methods for Individual Coverage
Missouri



Please complete in blue or black ink.

Applicant / Member Name (Please Print):	Primary Applicant's Social Security Number:

INITIAL PREMIUM PAYMENT IS REQUIRED WITH APPLICATION. PLEASE CHOOSE ONE:

- ☐ Automatic Bank Payment (complete Section A). **If you choose this option, you must also select the Automatic Bank Payment option for future premiums.**
- ☐ Credit/Debit Card (complete Section B)
- ☐ One-time Electronic Bank Payment (complete Section C)
- ☐ Check or Money Order attached (make payable to Anthem)*

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

FUTURE PREMIUM PAYMENTS (MAKE ONE SELECTION OUT OF EACH COLUMN):

Frequency (you must select one):

- ☐ Monthly
- ☐ Quarterly
- ☐ Semi-annually
- ☐ Annually

Method of payment (you must select one):

- ☐ Automatic Bank Payment (You must complete Section A)
- ☐ Bill me for future premiums. (Bills will be sent to address on application, unless a different address is listed below.)

Name ____________ Address ____________

City ____________ State ____ ZIP ____

A. **Automatic Bank Payment – If you select this option for your initial payment, <u>your bank account may be debited one month's premium as soon as the day of approval</u>. This will include all products selected, including dental and/or life. I hereby authorize Anthem to initiate a withdrawal on the same day of each month as my assigned effective date from the bank account named below.**

- ☐ Checking Account
- ☐ Savings Account **(account number will be different than that of checking account)**. Check with your financial institution to be sure automatic recurring deductions are allowed against this account.

A. B. Cadigh 123 Main Street Anytown, USA 12345 — PAY TO THE ORDER OF — $ — DOLLARS — MEMO — SAMPLE — ⑆123456789⑆ 1234567890123 1175

Provide your Bank Account Information here:

9-Digit Bank Routing Number	Bank Account Number

I authorize Anthem to initiate premium deductions (and corrections to premium deductions) from the bank account indicated, and the designated financial institution to debit the same account. **I understand that the initial premium amount may vary as a result of change(s) during the underwriting process and that following premium amounts may vary as a result of change(s) I make once enrolled.** These may include, but are not limited to, adding and deleting dependents or moving my residence. I understand that Anthem's rights with each premium deduction are the same as if I submit a check signed by me. This authorization is in effect until I provide Anthem thirty (30) days written notice that I no longer desire this service, and Anthem and the designated financial institution have the right to discontinue the premium deductions if they wish to do so. **I also understand that a service charge may be incurred for any withdrawal not honored.**

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

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

B. **Credit/Debit Card – As a convenience to me, I request and authorize** Anthem to charge the credit/debit card indicated one time for the initial premium payment amount upon approval. I understand that if this option is selected, the credit/debit card indicated will be charged for the initial premium payment amount as early as the date of approval. **If the initial premium payment amount varies from the quote generated by the system or due to changes during the underwriting process, I also authorize Anthem to charge the credit/debit card indicated for the different amount.** I agree that Anthem is fully protected in honoring any credit/debit card payments. I further agree that if any credit/debit card payment is dishonored, with or without cause, intentionally or inadvertently, Anthem is under no liability whatsoever, including any fees imposed by credit/debit card company or my bank, if my credit/debit card is rejected even though such dishonor results in termination of coverage. **We accept Visa and MasterCard.**

Type Of Card: ☐ Visa ☐ MasterCard

Card Number: |_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|_|

Expiration Date: |_|_|/|_|_|

Authorized Signature (as it appears on the credit/debit card) X	Cardholder Name (as it appears on the credit/debit card – Please PRINT)		Date
Cardholder Billing Address	City	State	ZIP

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

C. **One-time Electronic Bank Payment** – Please complete the information below.

Account Holder Name (Please PRINT)	9-Digit Bank Routing Number	Account Number
Authorized Signature (as it appears on the financial institution's records) X		Date

☐ Checking Account

☐ Savings Account (**account number will be different than that of checking account**). Check with your financial institution to be sure automatic deductions are allowed against this account.

I authorize Anthem to initiate a one-time deduction from the bank account indicated and the designated financial institution to debit the same account.

I understand that the initial premium amount may vary as a result of change(s) during the underwriting process, and I authorize Anthem to debit the bank account for the different amount. If this option is selected, I understand my account may be debited the initial premium payment amount as early as the date of approval.

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

☐ NEW LIST BILL – Billing through third-party ☐ CHANGE TO EXISTING LIST BILL **List Bill Arrangement Number:** ________________

(This option must have prior approval and requires separate List Bill forms to be completed and submitted with the application.)

Life and Disability products underwritten by Anthem Life Insurance Company. In Missouri (excluding 30 counties in the Kansas City area): Anthem Blue Cross and Blue Shield is the trade name for RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Thursday, Oct 25, 2012 03:59 PM