Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 800-260-9051 Fax: 888-554-8312

Step 2

SELECT THE TYPE OF BILLING YOU WANT – Pricing is based on a per member per day rate. Be sure to remit your check for the entire premium with your application. You may also choose to pay by credit card. See attached for the per day rate.

Step 3

PLEASE CONTACT OUR OFFICE FOR DELIVERY OPTIONS

Please make your check payable to: Blue Cross of California

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 800-260-9051

Thank you for choosing...

Anthem Blue Cross

Anthem Blue Cross

Short-Term PPO Enrollment Application

1. **Please print in blue or black ink or type.**
2. **Complete both sides of this application.**
3. **Send completed application and payment in full to Anthem Blue Cross Life and Health Insurance Company. See Section 8.**

1. Applicant Information

Primary Applicant's Last Name	First Name	M.I.	Social Security or ID No.
Home Street Address *(Must be completed: P.O. Box not acceptable)*			Home Phone No. ( )
City	State	ZIP Code	Daytime Phone No. ( )
Billing Address *(If different than above)* or P.O. Box			FAX No. ( )
City	State		ZIP Code
E-mail Address			If possible, do you want e-mail notification? ☐ Yes ☐ No

2. Plan Selections

A. Deductible: ☐ **$250** ☐ **$500** ☐ **$1,000** ☐ **$2,000**

B. Policy Term: No. of Days _____ **(minimum of 30 up to a maximum of 180 days)**

3. Effective Date

- If you are approved, coverage automatically begins at 12:01 a.m. on the date following the postmark date stamped on the envelope.
  If application is faxed or submitted online, coverage begins the day after application is received.
- Or coverage (upon approval) may begin on a specific future date within 30 days of signature.
  (Please specify) _____ *(Mo/Day/Yr)*. Postmark date must precede requested effective date. **Exceptions are not permitted.**

4. Applicants for Coverage

Please list ALL applicants applying for coverage (including applicant listed in Section 1).

If a family member's last name is different than yours, please explain on a separate page.

Newborn children under 15 days of age are not eligible for coverage. Services for Well Baby and Well Child Care for insureds up to and including 6 years of age are not covered under this policy.

Dependents between the ages of 19 through 22 are eligible as dependents only if they are claimed on your Federal Income Tax.

Anthem Blue Cross Life and Health will enroll all eligible family members unless otherwise instructed.

☐ I, the Appicant, request that Blue Cross not enroll any eligible applicants unless ALL family members qualify.

Sex	Last Name	First Name	M.I.	Social Security or ID No.	Birthdate (Mo/Day/Yr)	Height	Weight
10 ☐ M 20 ☐ F	Applicant						
30 ☐ M 40 ☐ F	Spouse						
☐ M ☐ F	Dependent						
☐ M ☐ F	Dependent						
☐ M ☐ F	Dependent						

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5. *Application Questions* Answer the following questions completely and accurately.

Note: If the answer to any question from 1-4 is YES, the policy cannot be issued for that applicant. Answering NO to questions 1-6 does not guarantee coverage. All answers will be validated and a brief review of claims history will be completed.

1. a) Is any female applicant pregnant, or in the process of adoption or surrogate pregnancy? ☐ Yes ☐ No

   b) Is any male listed on this application expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not the mother is listed on this application? ☐ Yes ☐ No

2. Have you or any person listed on this application received any medical or surgical consultation, advice or treatment, including medication, within the past 5 years for: heart or circulatory system disorder including heart attack or chest pain; stroke; disorders of the blood, including hemophilia and leukemia; diabetes; cancer or tumor; alcoholism or alcohol abuse; drug abuse or chemical dependency; immune disorders; organ transplant; kidney or liver disorders? ☐ Yes ☐ No

3. Has any person listed on this application been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or ARC (AIDS Related Complex)? ☐ Yes ☐ No

4. In the past 30 days, have you or any person listed on this application been hospital confined? ☐ Yes ☐ No

If you answered YES to any questions from 1-4, please complete this section:

Question No.	Person(s) to whom it applies

5. In the past 30 days, have you or any person listed on this application taken prescription medication, (excluding birth control pills; hormone replacement therapy; Synthroid; or antibiotic therapy for 10 days)? ☐ Yes ☐ No

If you answered YES to question 5, please list medications:

Name of Applicant	Medication & Condition	Name of Applicant	Medication & Condition

6. In the past 12 months, have you or any person listed on this application been recommended by a health care professional to have or been scheduled for diagnostic testing, treatment or surgery that has not been completed? ☐ Yes ☐ No

If you answered YES to question 6, please complete this section.

Name of Applicant	Treatment & Condition	Name of Applicant	Treatment & Condition

If you answered YES to question 5 or 6, your application will be submitted for further review.

6. *Prior Insurance History* Please answer **all** of the following questions.

Anthem Blue Cross Life and Health credits prior coverage toward the pre-existing period for those applicants who apply and are accepted for coverage and request an effective date within 63 days after termination of qualifying prior coverage, (including previous Anthem Blue Cross Life and Health Short-Term policies) as required by law. To obtain credit toward the pre-existing period, please complete the following:

Do you currently have, or has anyone to be insured had coverage in the last 18 months? ☐ Yes ☐ No

If yes, please provide the following information.

Name of Insured	Insurance Carrier(s)	Effective Date	End Date

To provide further information, please use additional sheets if necessary. List the section name and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant.

No. of sheets attached

7. Accidental Death and Dismemberment Insurance Beneficiary Information

If beneficiary is not listed and Policy is issued, death benefits will be paid in accordance with the Beneficiary Provision on page 32 of the Policy.

Beneficiary	Relationship to Applicant		Birthdate
Street Address	City	State	ZIP Code

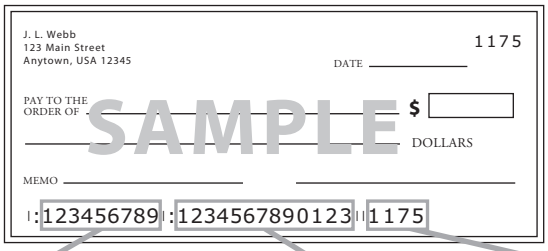
As the Short-Term PPO Plans include Accidental Death and Dismemberment (AD&D) coverage, you are submitting this application and providing the information on this application to the Life Insurance department of Anthem Blue Cross Life and Health. Initials

8. Payment Method

Premium must be paid in full and submitted with application and will be held in trust while this application is evaluated. If this application is approved and the policy is issued, no refund is permitted.

Amount of premium (per day rate) x **no. of days** = **Total premium**

☐ **Payment by Electronic Check.** By providing your check information below, you authorize us to electronically debit your bank account. If you are approved for coverage, your bank account will be debited for the total premium amount above.



With this payment option, there is no need to send a paper check with your application.

If paying by electronic check, please complete the boxes to the right

Bank Routing No.	Bank Account No.	Check No.

☐ **Payment by Paper Check.** By sending your paper check, you authorize us to convert your check into an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

☐ **Payment by Credit Card**

Credit Card ☐ VISA ☐ MasterCard ☐ Discover		Card No.	Exp. Date
Cardholder's Name	Relationship to Applicant	Signature of Authorized Cardholder **X**	Date

To be completed by your Anthem Blue Cross-Appointed Agent

1. Are you aware of any information not disclosed on this application relating to the health of any person listed on this application which might have a bearing on the risk? ..... ☐ Yes ☐ No
2. Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed? ..... ☐ Yes ☐ No
3. Total funds collected: ..... $_____
   (Premium must be paid in full and submitted with application.)

Name of Agent (Print name)		Agent's Street Address Suite No./Personal Mail Box(PMB) No.			
Nicole Pennington		530 Los Angeles Ave #115-189			
Agent I.D. No.	Sub-Agent I.D. No.	City	State	ZIP Code	Location No.
LLJKPSPRRZ		Moorpark	CA	93021	
Phone No.	Fax No.	E-mail Address			
800-260-9051	888-554-8312	Nicole@nicoleknowshealthinsurance.com			
Signature of Agent (Required)		Date (Required)			

Mail Service Agreement to: ☐ Agent ☐ Primary Applicant

PLEASE NOTE: If neither box is checked, the Service Agreement will be mailed directly to the primary applicant's mailing address:

Sending the Application

Save time by faxing this application (if paying by electronic check or credit card) to Anthem Blue Cross Life and Health at (800) 327-9255.

Please mail this application to:

Anthem Blue Cross Life and Health Insurance Company • P.O. Box 9051 • Oxnard, CA 93031-9051

For information on eligibility, please call (800) 333-0912

9. Application Conditions and Agreement IMPORTANT: It is important that you carefully read and fully understand the following.

Agreements and Understandings (all applicants)

By applying for coverage, I, the undersigned, agree to the following:

1. Anthem Blue Cross Life and Health Insurance Company ("Anthem") may decline my application. No coverage comes into effect until Anthem approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be indicated on the identification card and/or assigned by Anthem at its discretion.
2. Cashing my check does not mean my application is approved. If this application is declined, neither Anthem nor any affiliated company shall have any liability to me or any one else listed on it, except for the obligation to return the money submitted with this application.
3. The selling agent has no authority to promise me coverage or to modify Anthem underwriting policy or the terms of any Anthem coverage.
4. Any of my dependents listed on this application who are over the age of 18 years have read this application and have provided complete and accurate information for this application. Also, I have done everything necessary to be able to assure you that all information about any children under the age of 18 listed on this application is true and complete to the best of my knowledge and belief. I understand and agree that I alone am responsible for the accuracy and completeness of this application. I understand and agree that no one listed on this application will be eligible for coverage if any information is false or incomplete and that Anthem Blue Cross Life and Health may revoke coverage if it discovers that any information on this application is incomplete or false.
5. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
6. I understand Anthem may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

I have personally read and completed this application.
If I am accepted, this application will become part of the contract between Anthem and me. Any enrolled family members and I agree to abide by the terms of that contract. I understand that no benefits will be provided for any preexisting condition as defined in the policy. Preexisting condition means an illness, injury, disease, or physical condition for which medical advice, diagnosis, care or treatment, including the use of prescription drugs, was recommended or received from a licensed health practitioner during the six (6) months immediately preceding the member's effective date of coverage. This is not a continuation of any previous Anthem policy. This policy is not renewable.

Requirement for Binding Arbitration: If you are applying for coverage, please note that Anthem Blue Cross Life and Health Insurance Company requires binding arbitration to settle all disputes, including claims of medical malpractice. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: **"It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."** Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

Signatures *(Required)*
IMPORTANT: All applicants over age 18 must sign and date.

Applicant/Parent or Legal Guardian **X**	Today's Date
Applicant's Spouse **X**	Today's Date
Applicant's Dependent age 18 or over **X**	Today's Date
Applicant's Dependent age 18 or over **X**	Today's Date
Applicant's Dependent age 18 or over **X**	Today's Date

For Anthem Blue Cross Life and Health use only - Do not write

Effective Date	End Date