Anthem Anthem Life

Missouri
Change of Coverage Application

Use only for upgrade of medical benefits or risk review. **This form cannot be used to add members not currently covered.**
This form cannot be used to just add Dental or Life—you must be making Medical Coverage changes to use Sections F and G.
Please complete in blue or black ink only. Do not write in shaded areas, these are for Sales/Producer use only.

Section A – Coverage Information

Anthem individual policy coverage
Identification Number ____________________

Effective month requested: ____________________

Your renewal date will remain the same day of the month as your existing policy.

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	Height (Ft./In.)	Weight (Lbs.)	Sex	Age	Date of Birth
☐ Single ☐ Married	/		☐ M ☐ F		/ /

Daytime Phone Number	Evening Phone Number	E-mail (This information will not be shared with any third party.)
( )	( )	

Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? ☐ Yes ☐ No

Contraceptive Coverage Option: If your application is accepted, for most plans, benefits for contraceptive drugs and devices will be included in your health care coverage unless you check the box below. (Checking this option will not affect your premium.)

☐ For moral, ethical or religious reasons, I do not want benefits for contraceptive drugs and devices for myself or any family members.

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 (Lbs.)	Sex	Age	Date of Birth
	/		☐ M ☐ F		/ /

Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? ☐ Yes ☐ No

Section D – Child Dependent(s) Information (All fields required. Attach a separate sheet if necessary.)

Dependent information must be completed for all child dependents (if any) currently covered under this policy.
This form cannot be used to add members not currently covered. (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			/	
		Child		☐ M ☐ F			/	

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.

*This information is used for internal purposes only and will not be disclosed.

Section E – Medical Coverage

☐ **I wish to change my existing coverage:**

Select plan option and any optional benefits available for your selected plan:

Plan Name, In Network Coinsurance, Deductible Options		Optional Benefits
Select ONE Plan…then select ONE Individual Deductible and any optional benefits. Total Family Deductible will be 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	☐ **Upgrade Drug Coverage** ☐ **Add Maternity Coverage** (available on $2,500 or higher deductible options)
(0% coinsurance)	☐ $500 ☐ $1,000 ☐ $2,500 ☐ $3,500 ☐ $5,000 ☐ $10,000 ☐ $2,500 - no office visit copay	
☐ **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 (Must be making Medical Coverage changes to add/change Dental Coverage)

☐ Change plan to (at an extra cost per individual):

☐ **Dental Blue® Basic 100** ☐ **Dental Blue® Essential 100** ☐ **Dental Blue® Essential 200**

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

☐ Keep existing plan

Section G – Term Life Insurance (Must be making Medical Coverage changes to add/change Life Coverage)

Blue Preferred® Term Life ☐ Yes, please continue my life coverage.

☐ Yes, in addition to my medical coverage, I wish to apply for Term Life Insurance (at an extra cost per individual).

☐ Yes, I want to change my coverage amount—see below. 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 code
☐ 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 – Health History (Attach a separate sheet if necessary).

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.

	YES	NO
1. Has any enrolled family member been hospitalized, seen a physician or other health care provider or taken any prescription medication within the last six months? If yes, please provide name of applicant and details below.	☐	☐

____

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____

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	YES	NO
2. Has any enrolled member been advised to seek treatment, have surgery or testing that has not yet been completed? If yes, please provide name of applicant and details below	☐	☐

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____

____

	YES	NO
3. Are you or your spouse/domestic partner (whether currently enrolled or not) an expectant partner?	☐	☐
4. FEMALES ONLY – Please provide the following information (Applicable to ALL females listed on this application)		
Do you menstruate?	☐	☐
Has it been more than 40 days since your last menstrual period?	☐	☐
5. Has any enrolled member used tobacco products within the past 12 months?	☐	☐

Section I – 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 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, benefits denied due to the illness, injury or condition being treated as a preexisting condition.**
2. 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 Anthems' other rights or requirements.
3. I may not assign any payment under my Anthem program.
4. I am applying for the coverage selected on this application.
5. 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.
6. 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.
7. **I understand that I will be given credit for my prior creditable coverage; however, I may be subject to a waiting period for pre-existing conditions if I have less than 12 months of prior creditable coverage. 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.**
8. 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 or 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.
9. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.

Section I – Significant Terms, Conditions, and Authorizations *(continued)*

10. 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.
11. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
12. **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.**
13. If I purchase optional dental coverage, I understand that I will have a 12-month waiting period for coverage of Major services. *(For a description of Basic and Major services, please refer to your contract.)*
14. By signing this application I represent that I understand that Anthem Life has the right to deny my application for Term Life 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.
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 H is answered "NO", I understand that the signature(s) below will attest to non-tobacco usage for the past 12 months.

    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.

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 (if to be covered) X	Date
Signature of Dependent Child(ren) age 18 or over X	Date

Section J – 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 Address	

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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):

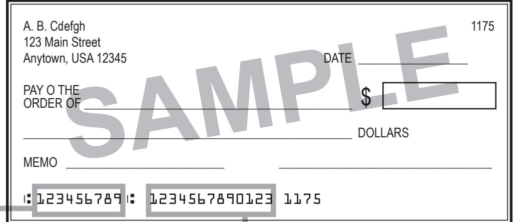
☐ Automatic Bank Payment
(You must complete Section A)

☐ 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, your bank account may be debited one month's premium as soon as the day of approval. 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.

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.)

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