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: Fax:

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction or paper bill).

Step 3

SEND THE COMPLETED APPLICATION TO:

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.

If you have questions please contact our office at:

Thank you for choosing...

Nevada Short-Term Enrollment Application RUSH

1. Please print in blue or black ink.
2. Complete both sides of this application.
3. Send completed application and payment in full to Anthem Blue Cross and Blue Shield. (See Section 7).

1. Applicant Information

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

2. Plan Selections

A. Deductible: ☐ **$250 (BA90)** ☐ **$500 (BA91)** ☐ **$1,000 (BA92)** ☐ **$2,000 (BA93)**

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, or date received by Anthem.
If application is faxed or submitted online, and you are approved, coverage begins on 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

Check one: ☐ Insure all eligible applicants ☐ Insure no one unless all are accepted for coverage

Please list ALL applicants applying for coverage. *(List children youngest to oldest)*

If a family member's last name is different than yours, please attach explanation to the application.

Newborn children under 15 days of age are not eligible for coverage.

Dependents between the ages of 19 through 23 are eligible as dependents only if they are a full-time student and financially dependent upon the parent.

Sex	Last Name	First Name	M.I.	Social Security No.	✓ Full Time Student	Date of Birth (Mo/Day/Yr)
☐ M ☐ F	Applicant					
☐ M ☐ F	Spouse					
☐ M ☐ F	Dependent					
☐ M ☐ F	Dependent					
☐ M ☐ F	Dependent					
☐ M ☐ F	Dependent					

Print Applicant's Name	Applicant's Business Name
Applicant's Signature	Date

In Nevada: Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. An independent licensee of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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

Note: If the answer to any question below is YES, the policy cannot be issued.

1. Has any person applying for coverage resided outside the United States continuously for the past 6 months without current U.S. citizenship or permanent U.S. residency? . . ☐ Yes ☐ No

2. Do you or any person applying have any hospital, major medical, group health, or medical insurance coverage in force that will not terminate prior to or on the effective date of this coverage? . . . . ☐ Yes ☐ No

   If YES, when will existing coverage expire?) *(Mo/Day/Yr)*________

3. (a) Is the applicant, spouse or any female dependent, whether or not listed on the application, currently 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 the application?. . . . . ☐ Yes ☐ No

4. Have you or any person applying received any medical or surgical consultation, advice or treatment, including medication, within the past 10 years for: heart or circulatory system disorder including heart attack or chest pain; stroke; hypertension; disorders of the blood, including hemophilia and leukemia; diabetes; cancer or tumor; alcoholism or alcohol abuse; drug abuse or chemical dependency; immune disorders; organtransplant; kidney or liver disorders?. . . . . ☐ Yes ☐ No

5. Has any person listed on this application ever been diagnosed or received treatment by a physician or health care professional for hepatitis, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)? . . . . ☐ Yes ☐ No

6. Do you, or any person applying, engage in hazardous activities such as car racing, SCUBA diving, mountain climbing, bungee jumping, hang gliding or sky diving?. . . . . ☐ Yes ☐ No

7. In the past 12 months, have you or any person to be insured been recommended by a physician or 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 any question from 1-7, please complete this section.

Person(s) listed below are excluded from coverage.

Question No.	Person(s) to whom it applies

6. *Other Coverage* Please answer **all** of the following questions

A. 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

Do you agree to discontinue your current coverage if this application is accepted?. ☐ Yes ☐ No

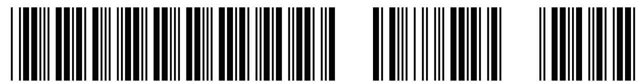
If no, please explain:

B. Has anyone on this application been insured by Anthem in the last 5 years? . . . . ☐ Yes ☐ No

If yes, please provide the following information.

Name of Insured	Plan/I.D. No.	Group No.	
Name of Plan	**City**	**State**	**Date Cancelled**

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. *Payment Method* Submit non-refundable application fee and premium payment with application *(required)*

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

Non-Refundable $10 Application Fee Payment

Only one application fee is required for families submitting more than one application at the same time.

☐ Please charge the separate, non-refundable application fee to my credit card.

☐ I am attaching a separate check for the non-refundable application fee.

Amount of premium (per day rate)	x	no. of days	=	premium	+	$10 Non-refundable application fee

☐ **Payment by Credit Card**

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

If paying by credit card, you may fax applications to Anthem AT 303-764-7282.

☐ **Payment by Check**

Mail application with a check for premium and another for the non-refundable application fee (payable to Anthem Life & Health Insurance Company) to:

Anthem Blue Cross and Blue Shield · P.O. Box 9041 · Oxnard, CA 93031-9041

8. *To be completed by your Anthem-Appointed Agent*

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

Name of Writing Agent (Print name)	Agent's Street Address Suite	No./Personal Mail Box(PMB) No.			
Agent/Agency I.D. No.	Sub-Agent I.D. No.	City	State	ZIP Code	Location No.
Phone No.	Fax No.	E-mail Address			
Signature of Writing 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:

Agent: Please mail this application to the following address:

Anthem Blue Cross and Blue Shield · P.O. Box 9041 · Oxnard, CA 93031-9041

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Anthem Blue Cross and Blue Shield

Short Term Conditional Receipt and Special Instruction

(To be completed by the agent and given to the applicant)

For information on eligibility, please call 888-231-5046

Received from ________________________________ $____________ as a non-refundable application fee;

$____________ as the full premium payment for the Short Term

Policy purchased for a period of _______ days, payable to Anthem Blue Cross and Blue Shield.

(over)

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

AUTHORIZATION

I hereby authorize any health care facility, physician, surgeon, counselor, therapist or insurance company to provide Anthem's authorized Underwriters or Medical Directors, all information, pertaining to me or any of my dependents who are also applying for coverage, regarding past or present medical or mental conditions, any examination or treatment, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), and to any illness, injury or condition that I or my dependents have had at any time in the past or in the future up until the expiration of this Authorization. I understand this information is collected in connection with the evaluation and processing of an application for coverage or change in benefits, or to determine eligibility for benefits. The Authorization is valid from the date listed below through thirty (30) months. A photocopy of this Authorization is as valid as the original. My authorized representative, Anthem agent, or I am entitled to receive a copy of this form.

I understand and agree to all the Conditions of Application. I understand that coverage is subject to the provisions in the Conditional Receipt. I have read and understand this Application in its entirety.

AGREEMENT ***(All applicants)***

I, the undersigned, agree to the following:

a. I understand and agree to pay a non-refundable application fee of $10 to be paid on a separate check or through a separate credit card deduction and to pay the premium amount required with this application. If my application is denied, Anthem will return only the premium payment. If my application is accepted, this premium amount will be applied to the premium charges.

b. If my application for Anthem coverage is accepted as applied for, the coverage date will be as specified above, but I agree I have no coverage under this application until I am notified in writing by Anthem that my application is approved.

c. I understand that Anthem has the right to deny my application, and if it does so, I will be notified in writing and the premium I submitted will be returned.

d. **MINOR CHILDREN:** I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding minor children.

e. **CONCERNING DEPENDENTS AGE 18 AND OVER:** I represent that my dependents age 18 and over (1) have read this application, and have provided such full and accurate information necessary to complete this application, (2) I have discussed all provisions of this application, especially Section 5 with them, and (3) all information contained in this application regarding them is complete and accurate.

f. I understand and agree that if Anthem rejects my application, under no circumstance will any benefits be payable for any person listed on this application. Receipt of money, and/or cashing of my non-refundable application fee check or cashing of my premium check or charging either of these amounts to my credit card by Anthem does not constitute approval of my application or create Anthem coverage.

g. If I am accepted, this application will become part of the agreement between Anthem and myself.

h. Anthem may request additional information, and this may delay processing of this application. If the health care provider charges a fee for these services, Anthem will determine payment, and I will be responsible for any difference.

i. The selling agent has no authority to promise me coverage or to modify Anthem underwriting policy or terms of any Anthem coverage.

j. I have personally read and completed this application. Nothing has been left off regarding the past or present health of anyone listed on this application. I understand that no one listed is eligible for benefits if any information on this application is false, incomplete or omitted. Anthem may void all coverage from the original effective date of the agreement for such material misstatements or omissions.

   If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided.

   PLEASE NOTE: If the listed minor dependent does not reside with the applicant purchasing this plan, the custodial parent or guardian must complete Section 5 and sign the Application Conditions and Agreement accepting legal responsibility for full and complete disclosure of the minor applicant, including any history of substance abuse. Also, if the responsible adult is not the natural parent, please submit court papers authorizing guardianship.

k. My Anthem agent may receive copies of any correspondence about my medical history when correspondence is required.

l. I understand that a Short Term Policy is not a group plan and therefore, coverage under a Short Term Policy may make a person ineligible for HIPAA.

Signatures ***(Required)***

IMPORTANT: All applicants over age 18 must sign and date.

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

For Anthem use only - Do not write below	
Effective Date	End Date

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This amount is tendered with the application for the referenced Policy as a deposit against the premium due, subject to the following: **IN NO EVENT SHALL Anthem HAVE ANY LIABILITY TO THE APPLICANT IF THE APPLICATION IS NOT ACCEPTED BY Anthem AT ITS HOME OFFICE, AND NEITHER SHALL ANY COVERAGE EXIST NOR SHALL THE APPLICANT BE ENTITLED TO ANY BENEFITS UNLESS AND UNTIL THE APPLICATION IS APPROVED BY Anthem AND THE PREMIUM PAYMENT IS MADE. If the application is accepted, the applicant shall be advised in writing by Anthem. If the application is not accepted, Anthem will advise the applicant and promptly refund the premium deposit paid; and refund of such deposit will fully discharge any and all obligations of Anthem to the applicant.**

Dated this __________ **day of** ________________________________.

Agent acknowledges receipt of money and delivery of conditional Receipt.

By:________________________________ ____________________

Signature of Agent Agent ID Number

Notice of Information Practices

If you apply for or are covered by an Anthem health care plan, Anthem may collect personal information about you in order to evaluate your application or to administer benefits. This information is normally limited to the condition of your health. For example, Anthem may provide information to a hospital in order to verify benefits. Upon your request, Anthem will provide details of the nature of personal information that may be collected, the circumstances under which it may be disclosed without authorization, and your right to access and correction if you believe it to be inaccurate. Anthem can choose to furnish the medical record information either directly to you or to a medical professional designated by you.