

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: (818) 987-5000 Fax: (818) 776-9865

Step 2

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

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy
18375 Ventura Blvd. # 226
Tarzana, CA 91356

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: (818) 987-5000

Thank you for choosing...





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).

Nevada Short-Term Enrollment Application RUSH

1. Applicant Information

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

2. Plan Selections

A. Deductible: <input type="checkbox"/> \$250 (BA90) <input type="checkbox"/> \$500 (BA91) <input type="checkbox"/> \$1,000 (BA92) <input type="checkbox"/> \$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)
<input type="checkbox"/> M <input type="checkbox"/> F	Applicant					
<input type="checkbox"/> M <input type="checkbox"/> F	Spouse					
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent					
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent					
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent					
<input type="checkbox"/> M <input type="checkbox"/> F	Dependent					

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.

<p>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? ... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>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)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
<p>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? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, when will existing coverage expire? (Mo/Day/Yr) _____</p>	<p>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?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
<p>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? <input type="checkbox"/> Yes <input type="checkbox"/> 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?.. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>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?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
<p>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; organ transplant; kidney or liver disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If you answered YES to any question from 1-7, please complete this section. Person(s) listed below are excluded from coverage.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:15%;">Question No.</th> <th>Person(s) to whom it applies</th> </tr> </thead> <tbody> <tr> <td style="height: 20px;"> </td> <td> </td> </tr> <tr> <td style="height: 20px;"> </td> <td> </td> </tr> <tr> <td style="height: 20px;"> </td> <td> </td> </tr> </tbody> </table>	Question No.	Person(s) to whom it applies						
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6. Other Coverage Please answer **all** of the following questions

<p>A. Do you currently have, or has anyone to be insured had coverage in the last 18 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information.</p>			
Name of insured	Insurance carrier(s)	Effective date	End date
<p>Do you agree to discontinue your current coverage if this application is accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:</p>			
<p>B. Has anyone on this application been insured by Anthem in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the following information.</p>			
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.

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

Payment by Credit Card

Credit Card <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> 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 Blue Cross and Blue Shield • Individual Product Administration • P.O. Box 173334 • Denver, CO 80217-9411

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) Oleg Skurskiy		Agent's Street Address Suite No./Personal Mail Box(PMB) No. 18375 Ventura Blvd # 226			
Agent/Agency I.D. No. BCLNGNPVMZ	Sub-Agent I.D. No. BCLNGNPVMZ	City Tarzana	State ca	ZIP Code 91356	Location No.
Phone No. 818 -987-5000	Fax No. 818-776-9865	E-mail Address oleg@askoleg.com			
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 • Individual Product Administration • P.O. Box 173334 • Denver, CO 80217-9411

05-00121 8/05 03

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)

