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...

Anthem

Nevada HSA Qualified Health Plans For Individuals Application

Each individual on the application is assessed separately. As a result, the underwriting decision may include accepted members, declined members and members accepted with a lifetime benefit exclusion. We will proceed with the processing of the application for all members who fall into either of the approved categories with the assumption that the coverage is still desired.

If the application is approved, with or without lifetime benefit exclusion(s), the effective date of enrollment will be listed on the subscriber's coverage notice. If you do not select an effective date, membership will be processed for the 1st of the month following approval by Anthem. If the entire application is not approved, Anthem will disclose, in writing, the reason(s) for non-acceptance and what needs to be done for reconsideration, if applicable.

If any member is approved with a lifetime benefit exclusion, the amendment will be included in the membership certificate or sent with the letter notifying the member of the lifetime benefit exclusion.

You will receive details about setting up an HSA with JP Morgan Chase Bank upon approval of your enrollment in an Anthem high-deductible health plan.

Anthem must receive a 30-day advance notification to cancel your coverage. Anthem has 60 days to process your application.

No person other than the applicant shall alter any written application for any policy without the applicant's written consent. The exception is that the insurer may make insertions, for administrative purposes only, in such manner as to indicate clearly that such insertions are not ascribed to the applicant.

In no event shall the Company incur any liability before an application is approved or with respect to an application that has been declined. No coverage shall exist under the agreement for which the application is made until approved by the Underwriting Department.

96567-NV An independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks Blue Cross and Blue Shield Association.

Nevada HSA Qualified Health Plans For Individuals Application

BROKER SIGNATURE X | DATE

Broker Name _____Oleg Skurskiy ________________Broker Phone Number: ____818-987-5000_____ Broker Fax Number: ______818-776-9865_____________

Broker Number:_BCLNGNPVMZ _Broker Address: ____18375 Ventura Blvd. # 226 Tarzana , CA 91356__ Broker e-mail: _ oleg@askoleg.com

SECTION I FORM MUST BE FILLED OUT IN BLACK BALLPOINT INK — PLEASE PRINT CLEARLY

APPLICATION TYPE (Check Appropriate box)
☐ NEW ENROLLMENT ☐ ADD FAMILY MEMBER Indicate Existing Subscriber No. ____________________________________
☐ APPLICATION FOR REINSTATEMENT ☐ COVERAGE CHANGE Deductible ___________ Coinsurance ___________ Other ________________

HAVE YOU PREVIOUSLY BEEN COVERED BY ANTHEM BLUE CROSS AND BLUE SHIELD (HEREINAFTER REFERRED TO AS ANTHEM)? ☐ YES ☐ NO

IF "YES," WAS THIS COVERAGE UNDER A ☐ GROUP OR ☐ INDIVIDUAL POLICY? (PLEASE CHECK ONE) PROVIDE CONTRACT NUMBER_____________________

MONTHLY PAYMENT METHOD ☐ ELECTRONIC FUNDS TRANSFER (EFT) [PREFERRED METHOD] OR ☐ PAPER BILL

If choosing Electronic Funds Transfer, please complete the Monthly Bank Draft / EFT Authorization (Form No. 98644) and attach a voided check.

No Application will be processed without the initial month's premium being received.

Initial month payment method: ☐ Check ☐ Money Order ☐ Credit Card ☐ Debit Card

Credit / debit card accepted for initial payment only - if paying with a credit / debit card, you must fill out the bottom section of Form No. 98644

HSA Qualified Health Plan Program Selection - Please select one of the following:

☐ $1500 Single Deductible, $3000 Family Deductible, 100% in/70% out Coinsurance
☐ $2000 Single Deductible, $4000 Family Deductible, 100% in/70% out Coinsurance
☐ $3000 Single Deductible, $6000 Family Deductible, 100% in/70% out Coinsurance
☐ $4000 Single Deductible, $8000 Family Deductible, 100% in/70% out Coinsurance
☐ $5000 Single Deductible, $10000 Family Deductible, 100% in/70% out Coinsurance
☐ $1500 Single Deductible, $3000 Family Deductible, 70% in/50% out Coinsurance
☐ $2000 Single Deductible, $4000 Family Deductible, 70% in/50% out Coinsurance
☐ $3000 Single Deductible, $6000 Family Deductible, 70% in/50% out Coinsurance

SECTION II APPLICANT INFORMATION

NAME (Last, First, Middle Initial)	SEX ☐ Male ☐ Female	BIRTHDATE (Mo. Day Yr)	HEIGHT ____ft. ____in	WEIGHT

PHYSICAL STREET ADDRESS	HOME TELEPHONE ( )	WORK TELEPHONE ( )

CITY	STATE NV	ZIP CODE	OCCUPATION (Optional)	GROSS ANNUAL INCOME (Optional)

BILLING ADDRESS (If different than above)

SOCIAL SECURITY NUMBER

NON-TOBACCO DESIGNATION AND CERTIFICATION
I certify that I, and all family members living in the household, ☐ HAVE ☐ HAVE NOT used a tobacco product in the past 12 months.

COVERAGE DESIRED
☐ INDIVIDUAL ☐ FAMILY

MARITAL STATUS
☐ SINGLE ☐ MARRIED

IF YOU AND YOUR SPOUSE ARE USING DIFFERENT LAST NAMES CHECK APPLICABLE BOX
☐ SEPARATED ☐ PROFESSIONAL ☐ MAIDEN

Information for Each Dependent Applying for Coverage (Use additional sheet of paper if necessary.)

Last Name	First Name	Relationship to Applicant	Social Security Number	Gender	Birthdate (mm/dd/yyyy)	Height	Weight (lbs.)
Spouse		Spouse		☐ M ☐ F	/ /	____ft. ____in.	
Dependent				☐ M ☐ F	/ /	____ft. ____in.	
Dependent				☐ M ☐ F	/ /	____ft. ____in.	
Dependent				☐ M ☐ F	/ /	____ft. ____in.	
Dependent				☐ M ☐ F	/ /	____ft. ____in.	

By signing below, I verify and attest that my dependent(s) (excluding my spouse), including overage dependents ages 19-24, is/are unmarried and financially dependent on me; or, regardless of age, is/are financially or otherwise dependent on me due to mental and/or physical disability; or is/are dependent on me due to a court order, and is/are therefore eligible for coverage under the policy for which I am applying. I understand that I am responsible for notifying Anthem within 31 days of any changes to the status of my dependent(s). I understand that coverage is dictated by the actual situation at the time services are rendered, and if my dependent does not qualify as a dependent when services are provided, the charges for those services are not reimbursable and may become my sole responsibility. I also understand that overage dependent eligibility must be renewed each year until the maximum age limit has been reached, as specified by the certificate. I understand that Anthem reserves the right to request, at any time, proof of overage dependency.

Primary Applicant's Signature | Date

SECTION III REQUESTED EFFECTIVE DATE

Please indicate the desired effective date* (i.e., 1st, 12th, 28th, etc.):____________ *Anthem must receive the **FULLY COMPLETED** application before the requested effective date. Please circle the desired effective month:

January February March April May June July August September October November December

All premiums will be due on the first of each month. If you are approved for an effective date other than the 1st of the month, your premium will be prorated for the first month. If you are approved for an effective date other than the date you requested, we will notify you of your actual effective date in writing. If you do not select an effective date, your application will be processed with an effective date of the first of the month following underwriting approval.

SECTION IV HEALTH STATEMENT

Have you or any family member listed on the application consulted, had diagnostic or other medical tests, or been treated by any doctor, health care professional, hospital, hospital emergency room, or clinic within the last five (5) years for any of the following conditions, diseases or disorders?
(All questions must be answered.)

CONDITION/DISEASE/DISORDER	YES	NO	CONDITION/DISEASE/DISORDER	YES	NO
Alcohol or Drug Abuse			Nervous and Mental Disorders including Anxiety, Depression, Anorexia or Attention Deficit Disorder		
Back, Spine or Bone Diseases, or Arthritis					
Brain or Nervous System Disorder or Migraine Headaches			Paralysis, Epilepsy, Stroke, Parkinson's Disease, Convulsions or Fainting		
Cancer or Malignant Conditions			Sinusitis, Tonsillitis, or Adenoid Disorders		
Cardiovascular Disorders, Chest Pain, Hypertension, Heart Disease or High Cholesterol			Stomach or Colon Disorders including Colitis, Diverticulosis, Diverticulitis, or Ulcers		
Cataract or other Eye Disorders			Have you or any family members listed on the application received medical advice, been treated or diagnosed for any other condition(s), disease(s) or disorder(s) not listed above? Must check "Yes" or "No." If "Yes," specify and complete the detailed information below.		
Cirrhosis, Hepatitis or other Liver Disorders					
Diabetes or other Endocrine (Glandular) Disorders					
Emphysema, Bronchitis, Asthma, or other Lung Disorders			Are you or any family member expecting the birth of a child or the addition of any other dependent for whom you (or that other family member) may have a duty to provide medical care?		
Gallbladder Disorders					
Hemorrhoids or other Rectal Disorders					
Hernias					
Kidney Disorders: Blood, Pus, Albumin, Sugar or Casts in Urine			Are you or any family member listed on this application currently taking any prescription drugs or medicines — including narcotics, barbiturates or amphetamines?		
Male/Female Genital Disorders including Hysterectomy, Sterilization and Infertility Procedures					

Please provide information for any "Yes" answer you checked above. Include name of family member, nature of illness or injury, dates, duration of treatment and outcome, if applicable. Show specific names of medications and quantity taken, including milligrams and times per day. **ATTACH SEPARATE SHEET IF NECESSARY. (THIS SECTION MUST BE COMPLETED).**

FAMILY MEMBER NAME	ATTENDING PHYSICIAN, HOSPITAL OR CLINIC NAME AND COMPLETE ADDRESS	NAME OF CONDITION(S) ILLNESS(ES) TREATED	TREATMENT RENDERED SUCH AS CHECK-UP, X-RAY, LAB AND SURGICAL PROCEDURES, ETC. AND OUTCOME		
NAME	NAME				
DATE STARTED (Month, Day, Year)	ADDRESS (City, State, Zip Code)	1) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
DATE ENDED (Month, Day, Year)		2) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
NAME	NAME				
DATE STARTED (Month, Day, Year)	ADDRESS (City, State, Zip Code)	1) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
DATE ENDED (Month, Day, Year)		2) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
NAME	NAME				
DATE STARTED (Month, Day, Year)	ADDRESS (City, State, Zip Code)	1) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
DATE ENDED (Month, Day, Year)		2) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
NAME	NAME				
DATE STARTED (Month, Day, Year)	ADDRESS (City, State, Zip Code)	1) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED
DATE ENDED (Month, Day, Year)		2) MEDICATION TAKEN	MILLIGRAMS	TIMES PER DAY	DATE LAST PRESCRIBED

SECTION IV (Continued) HEALTH STATEMENT

Provide information for the questions listed below, for you and each family member to be covered. **If additional space is required, attach a separate sheet.**

	YES	NO
Are you planning any hospitalization, medical or surgical treatment, or has any treatment been recommended for you or any family member listed on this application? If "Yes," give details:		
Have you or any of your listed dependents, at any time in the past been declined health, disability or life insurance or had your health, disability or life insurance cancelled or rescinded? If "Yes" give reason(s):		
Have you or any family member listed on this application tested positive for the AIDS virus or are you or any family member listed in this application currently being treated for AIDS? If "Yes," please provide the name(s) of those testing positive or currently being treated for AIDS.		

SECTION V AGREEMENT

It is understood and agreed that the foregoing answers are true and shall be the basis for the issuance of the Membership Certificate applied for, and that the omission or misstatement of any material information in answer to the foregoing questions shall void the Membership Certificate.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder, or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Nevada Division of Insurance.

I authorize release of any information regarding this application to my broker of record.

I understand that the purpose of the statement of health is to provide Anthem with information for determining the qualifications of myself (individual) and my family members (spouse and dependents) for the health coverage applied for and I agree that this statement of health shall become part of the contract between Anthem and myself.

The following authorization must be signed by the applicant and other adult persons, including adult dependents (e.g. age 18 or older in Nevada), to be covered. If the applicant does not sign this authorization, coverage cannot be issued. If any other adult person to be covered does not sign this authorization, coverage will not be extended to that person.

I hereby authorize that:

1. at the request of Anthem, any provider of health services or supplies, insurance company, organization, institution, or person may release information to Anthem about health-related services and supplies provided to me, persons covered under my health coverage, or persons to be covered under my health coverage. This authorization shall not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the rest of the provider's medical record;

2. the Medical Review and Underwriting departments or agents of Anthem, upon receiving this information may use it to review, investigate, or evaluate any application for an insurance policy, a policy reinstatement request, or a request or change in policy benefits.

3. unless I revoke this authorization, this authorization is valid for 24 months from the date I signed it, and

4. a copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original.

SIGNATURE OF APPLICANT OR LEGAL REPRESENTATIVE, IF APPLICABLE on behalf of himself/herself and all other minor Person(s) X	DATE
SIGNATURE OF SPOUSE TO BE COVERED OR Legal Representative, if applicable X	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable X	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable X	DATE
SIGNATURE OF OTHER ADULT PERSON(S) TO BE COVERED OR Legal Representative, if applicable X	DATE

If a legal representative signs on behalf of the applicant or any other adult person to be covered, a copy of the legal representative's authority must be attached to the application. This authorization is subject to revocation at any time by written notice to Anthem Blue Cross and Blue Shield except to the extent that Anthem Blue Cross and Blue Shield has already taken action in reliance on this authorization, any information received by Anthem Blue Cross and Blue Shield pursuant to this authorization is subject to restrictions on disclosure to others as set forth under applicable federal and state laws.

PLEASE INDICATE IF YOU ARE SIGNING FOR A MINOR ☐ Parent ☐ Legal Guardian ☐ Trustee (If trustee or legal guardian, please supply legal documentation)	YOUR SOCIAL SECURITY NUMBER (Optional)

Incomplete Applications Will Be Returned. Have You . . .

Completed Health Statement? Signed and Dated Application?

ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM OR FILL OUT THE CREDIT CARD AUTHORIZATION (FORM NO. 98644) AND INCLUDE IT WITH THIS APPLICATION.

Anthem

Monthly Bank Draft / Electronic Funds Transfer Authorization (Optional)

You can choose to have Anthem automatically deduct your premium and any state-mandated fees if applicable ("payment") from your checking account each month. Once your application is approved, your Electronic Funds Transfer Account (EFT) will be set up within 30 days from your effective date. Until the service is effective, Anthem will mail your bill for your monthly payment. To set up EFT, simply complete this section and be sure to include your first month's payment, or fill out the Initial Payment Only Credit Card Payment section below, when you return your completed application. Please send your completed application to Anthem Blue Cross and Blue Shield, P.O. Box 5208, Denver, CO 80217, or fax it to (303) 831-3391.

Bank Name	Name(s) on Bank Account
Your Bank's Routing Number	Your Bank's Account Number

I authorize Anthem Blue Cross and Blue Shield (listed on bank statement as Rocky Mountain Hospital and Medical Service, Inc.) to deduct my monthly payment due each month. The amount deducted each month will be a consistent amount unless there is a rate increase or change in state-mandated fees, where applicable. If there is an outstanding balance forward due, plus my regular payment due, I will be asked to provide authorization to allow for the entire amount to be deducted. This agreement remains in effect until Anthem Blue Cross and Blue Shield receives a 30-day advance written notice from the Bank Account holder or subscriber. In the event the Bank does not pay my payment for any reason, I understand that I am responsible for such payment. Failure to make full payments when due may result in termination of my coverage.

Signature (Exactly as it appears on bank records)	Date:

INTERNAL USE ONLY

AUTO ID#	SUBSCRIBER #	EFFECTIVE DATE

Initial Payment Only Credit Card/Debit Card Premium Payment (Optional)

You may choose to make your **initial** premium payment by check, money order or credit card/debit card. Credit card/debit card payment is available for your first premium payment only. **All subsequent payments will be made through monthly bills.**

If choosing to pay by credit card/debit card, you must complete ***all*** of the following information: Credit Card Debit Card

VISA MasterCard

Card# _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ ____ _____ _____

____ ____ _____ _____ _____ _____ $______________________________

Expiration Date: (mm/yyyy) MaximumPremium Amount Authorized

I authorize Anthem Blue Cross and Blue Shield to bill my VISA or MasterCard account for the payment amount shown above at the time my application is approved. I understand that the amount authorized may or may not be my final monthly premium and I am responsible for any difference in premium due on my account. Any credits will be applied to future billings.

Applicant's Name (Please Print)	Cardholders name (If different than applicant. Please Print)
Cardholder Signature:	Date:

INTERNAL USE ONLY: DO NOT WRITE BELOW THIS LINE

IPAD auto ID#	Subscriber #
Date Processed:	Processed by:

 An Independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. ® Registered marks Blue Cross and Blue Shield Association