



Instructions for completing and submitting your *TONIK® Individual Enrollment Application*

- Type or print all information so that it is legible. Do not use pencil.
- Keep a copy of your completed enrollment application for your records.
- Mail the completed application with original signatures to the following address:

OLEG SKURSKIY
18375 Ventura Blvd. # 226
Tarzana , CA 91356

Or, fax the completed application to: [818-776-9865](tel:818-776-9865)

If you have any questions regarding this application, please call [818-654-4548](tel:818-654-4548).



TONIK® Individual Enrollment Application

The TONIK plan is offered by Anthem Blue Cross Life and Health Insurance Company. Independent licensee of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Applicant's Social Security or ID No.									

Promotion Code				

ALL INFORMATION YOU PROVIDE MUST BE ACCURATE.

1. Applicant Information (Please print)

Applicant's Last Name	First Name	M.I.
Home Address (Must be complete: P.O. Box not acceptable)		
City	State	ZIP Code

Reason for Application (Check one)

New enrollment(s) Change of Coverage

To change existing Blue Cross plan, please enter ID No:

Applicant's Social Security or ID No.	Home Phone No.	Daytime Phone No.	FAX No.
Billing Address (If different than above) or P.O. Box Personal Mail Box (PMB) No.			
City	State	ZIP Code	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
E-mail Address		Spouse's Social Security or ID No. If possible, do you want e-mail notification? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When Information is sent to you, we may be able to send it in a language other than English. What language would you prefer? (Optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Japanese <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Khmer <input type="checkbox"/> Hmong <input type="checkbox"/> Farsi <input type="checkbox"/> Arabic <input type="checkbox"/> Armenian <input type="checkbox"/> Russian <input type="checkbox"/> Other _____			

<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate (mm/dd/yyyy)	Age	Height	Weight

2. Plan Selection

Medical/Dental/Vision <input type="checkbox"/> 1500 (DN13) <input type="checkbox"/> 3000 (DN14) <input type="checkbox"/> 5000 (DN15)	Enhanced Dental <input type="checkbox"/> PPO Dental (DR53)
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Applicant's Social Security or ID No.									

3. Term Life Insurance Coverage Selection and Beneficiary

Insured	Birthdate (mm/dd/yyyy)	Amount of Benefit	Beneficiary Name	Beneficiary Social Security No.	Relationship	Allocation	% Allocation
		<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	%
						<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	%

Note: Amounts greater than or equal to \$50,000 are not available to applicants under the age of 19. If selected by an approved applicant under the age of 19, the selection will default to \$30,000.
 Note: If a beneficiary is not listed and Policy is issued, death benefits will be paid according to the Beneficiary Provision in the Policy.
 See section 6 (Application, Conditions and Agreements) for additional terms.

Please check box if the proposed life insurance coverage will replace existing life insurance coverage from a company other than Anthem Blue Cross Life and Health Insurance Company.

4. Prior Insurance History and HIPAA Eligibility - Please answer ALL of the following questions.

Anthem Blue Cross Life and Health Insurance Company credits prior coverage toward the preexisting 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 as required by law. To obtain credit toward the preexisting period, please complete the following.

- A. Do you currently have health care coverage? Yes No
 B. Have you had coverage in the last 63 days? Yes No

If you answered "Yes" to A or B above, please provide the following information:

Certificate/Policyholder No.	Plan Name	State	Most recent coverage start date

You must discontinue your current coverage if this application is accepted.

- C. HIPAA Coverage - If I do not qualify for this plan, I would like to be considered for coverage under HIPAA. HIPAA does require eligibility. I understand that no underwriting is required and rates may be higher than for the Individual Plans. If I qualify, please offer the HIPAA coverage and send complete details regarding my options and rates. Yes No

5. Health History

Applicant's Social Security or ID No.									

5A. Health History Questionnaire – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.
Give COMPLETE details of any “Yes” answers in Section 5B on the following page.

1. Have you had a physical exam, any diagnostic test or screening test such as blood tests, x-rays, CAT scan, MRI, mammogram etc within the past 60 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	h. Abnormal bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you discussed with a health care provider or been advised to have testing, treatment, therapy or surgery that has not yet been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	i. Recurrent diarrhea and/or excessive vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 day) antibiotics ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	j. Unexplained weight loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has it been more than 40 days since your last menstrual period? (no male answer required):	<input type="checkbox"/> Yes <input type="checkbox"/> No	k. Loss of consciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you been diagnosed, treated for, evaluated for or experienced any genital/gynecological/reproductive problem(s) including infertility within the last 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	l. Blood and/or sugar in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Have you been evaluated for, treated or experienced breast cyst or lumps within the last 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	m. Persistant and/or intense pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are you an expectant parent?	<input type="checkbox"/> Yes <input type="checkbox"/> No	15. Do you have any implants or prosthesis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you been diagnosed and/or treated for any Sexually Transmitted Disease (STD) within the past 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	16. Have you ever consulted a health care provider, been diagnosed, had treatment, or had treatment recommended for any of the following within the last 10 years?	
9. Have you been diagnosed and/or treated for any mental, emotional or behavioral disorder, including anorexia, attention deficit disorder and/or depression within the last 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	a. AIDS/ARC; Evaluated for or recommended Antiviral treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Heart/circulatory/bleeding disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you been treated, diagnosed, or evaluated for symptoms related to alcoholism and/or use or abuse of alcohol within the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Diabetes or other endocrine (glandular) disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
12. Have you been advised to decrease alcohol consumption, or been aware of any symptoms related to alcoholism such as blackouts, DT's, abnormal liver function test in the past 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	d. Kidney/gall bladder/stomach/intestinal disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
13. Have you ever used illicit IV Drugs, OR in the last 5 years taken illegal drugs or been treated for drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	e. Hepatitis or other liver disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
14. Have you been diagnosed, treated, evaluated for or experienced any of the following within the last six months?		f. Hernia/hermorrhoid/rectal disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Receive allergy injections	<input type="checkbox"/> Yes <input type="checkbox"/> No	g. Muscle/bone/tendon joint injuries or disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Increased heart rate	<input type="checkbox"/> Yes <input type="checkbox"/> No	h. Multiple Sclerosis, migraine heachaches, Parkinson's disease or other brain/nervous disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Irregular heart beat	<input type="checkbox"/> Yes <input type="checkbox"/> No	i. Congenital heart or other irth defects/congenital disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Heartburn (recurrent)	<input type="checkbox"/> Yes <input type="checkbox"/> No	j. Respiratory disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	17. Have you ever had or been diagnosed with or treated for cancer or a malignant tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	18. Have you been diagnosed, had symptoms or received treatment for any condition(s) not listed elsewhere on this application?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Have you been hospitalized or treated in the emergency room within the last 12 months except for pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		20. In the last 12 months, have you considered or are you considering any hospitalization, medical or surgical treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		21. Have you smoked cigarettes, cigars, or pipes, or used chewing tobacco within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>I HAVE PERSONALLY REVIEWED AND ANSWERED ALL HEALTH QUESTIONS CORRECTLY</p>			
Applicant's Signature			Date
X			

5B. Professional Services

Give COMPLETE details in all sections below of any "Yes" answers to the questions in Section 5A.

Question #	Name of Hospital, Clinic and/or Person Providing Care		Phone No. ()
Date of Treatment (Month/Year)	Date Ended (Month/Year)	<input type="checkbox"/> Still under treatment	
Name of Condition/Illness			
Treatment Rendered (i.e., X-ray, lab, surgical procedure, prescribed medications, etc.)			
Results			

Question #	Name of Hospital, Clinic and/or Person Providing Care		Phone No. ()
Date of Treatment (Month/Year)	Date Ended (Month/Year)	<input type="checkbox"/> Still under treatment	
Name of Condition/Illness			
Treatment Rendered (i.e., X-ray, lab, surgical procedure, prescribed medications, etc.)			
Results			

Question #	Name of Hospital, Clinic and/or Person Providing Care		Phone No. ()
Date of Treatment (Month/Year)	Date Ended (Month/Year)	<input type="checkbox"/> Still under treatment	
Name of Condition/Illness			
Treatment Rendered (i.e., X-ray, lab, surgical procedure, prescribed medications, etc.)			
Results			

Question #	Name of Hospital, Clinic and/or Person Providing Care		Phone No. ()
Date of Treatment (Month/Year)	Date Ended (Month/Year)	<input type="checkbox"/> Still under treatment	
Name of Condition/Illness			
Treatment Rendered (i.e., X-ray, lab, surgical procedure, prescribed medications, etc.)			
Results			

6. Application Understandings, Conditions and Agreement

It is important that you carefully read and fully understand the following. All Applicants age 18 and over must personally read, agree to and sign the following.

Applicant's Social Security or ID No. [] [] [] [] [] [] [] [] [] []

I, the undersigned, understand that under the Anthem Blue Cross Life and Health plan in which I am enrolling, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use a network hospital or physician.

Effective Date

REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED.

- If Anthem Blue Cross Life and Health Insurance Company ("Anthem") approves my application, please assign an effective date of _____. The effective date must be after the signature date but not greater than 75 days from the signature date on this application. □ If Anthem approves my application, please assign an effective date of the first day after Anthem approval.

Please note: If you are changing coverage, your effective date will always be the first of the month following approval.

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.

CURRENT HEALTH COVERAGE: If you currently have health coverage, Anthem strongly recommends that you maintain your current coverage and request an effective date of 60 to 75 days from the date of application. This will help ensure that your application is processed before you surrender your present insurance.

Agreement

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 assigned by Anthem at its discretion (except for HIPAA). 2. Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. 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 anyone else listed on it, except for the obligation to return the money submitted with this application. If this application is not accepted, I will not be entitled to benefits or coverage from Anthem. 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. 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.) 5. In no event shall Anthem or any affiliated company have any liability to the applicant if the application is not approved, except for the obligation to return the money submitted with this application if this application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by the Medical Underwriting Department of Anthem. 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.

Term Life Insurance Coverage

I am applying for the benefits provided by the policy indicated in section 2. I understand that receipt of money with this application does not create coverage. Coverage will come into effect only on approval by Anthem Blue Cross Life and Health Insurance Company.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes a claim containing any false, incomplete or misleading information to obtain the proceeds of an insurance policy is guilty of a felony.

Note: Life insurance is to be underwritten by Anthem Blue Cross Life and Health Insurance Company. [Initials]

Rescission of Membership

I have provided true and complete answers to all questions in this application, and understand that all answers are important and will be considered in the acceptance or denial of this application. I understand that all information I know, that is responsive to a question on this application, must be provided in my answers. If I misstate or omit any such information, Anthem Blue Cross Life and Health Insurance Company ("Anthem") may rescind my coverage. I understand this means that Anthem will revoke my membership as if it never existed.

Also, if I have any medical signs, symptoms, or treatment after completing this application but before coverage is effective, I will immediately tell Anthem. I understand that Anthem may deny or rescind my coverage if I do not disclose this information.

All of my dependants 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, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about all applicants, including my children under the age of 18, listed on the application is true and complete. I understand and agree that no one listed on this application will be eligible for coverage if false or incomplete information is provided, and that Anthem may rescind coverage if it discovers that in applying for coverage I misstated or omitted any information I know that is responsive to any question in this application. [Initials]

I have personally read and attest to the completeness and validity of the information provided on this application. If I am accepted, this application will become part of the contract between Anthem and me. I and any enrolled family members agree to abide by the terms of that contract. [Initials]

REQUIREMENT FOR BINDING ARBITRATION
IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT BLUE CROSS REQUIRES BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO CLAIMS OF MEDICAL MALPRACTICE IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. This means that you and Blue Cross are waiving their right to a jury trial for both medical malpractice claims, and any other disputes. 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 of any type against the other. [Initials]

Signature (Required) - IMPORTANT: ALL APPLICANTS OVER AGE 18 MUST PERSONALLY READ, AGREE TO, SIGN AND DATE.
NOTICE BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ALL DISPUTES AGAINST ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY WHERE THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS AND ANY OTHER DISPUTES.

Applicant/Parent or Legal Guardian Today's Date

If an Applicant does not read English, the translator must sign and submit a Statement of Accountability for translating this entire application (see Section 8).

7. Payment Method (Premium payment required. Please choose from A or B.)

A. Please choose from the following options for initial payment and future payments. If you choose one of these options, you are not required to send in a check for initial payment:

Monthly Checking Account Automatic Premium Payment (complete Section 7C)
 Monthly Credit/Debit Card (complete Section 7D)

B. Please choose from the options below for your initial premium payment:

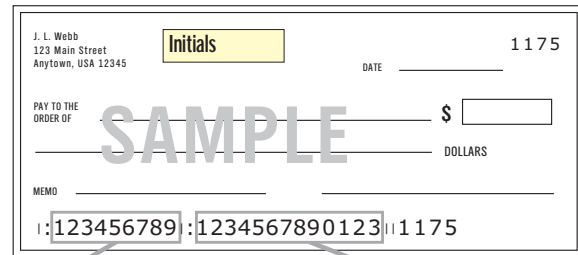
Paper Check*
 Electronic Check (complete Section 7E)
 Credit/Debit Card (complete Section 7D)

If you chose one of these three options, you will receive a bill every two months thereafter.

7C. Monthly Checking Account Automatic Premium Payment

By providing your check information to the right, you authorize us to electronically debit your bank account. If you have not sent in an initial premium payment from choice B), your bank account will be debited one month's premium the day after approval. This will include all products selected, including dental and/or life. Subsequent premium amounts will be debited on the day you request below.

Requested Debit Day: / (1st to 28th of each month) If no date is requested, your premiums will be debited on the first of each month.



Provide your Routing and Account numbers here. →

Bank Routing No.

Bank Account No.

As a convenience to me, I request and authorize Anthem Blue Cross to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross Life and Health Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross Life and Health Insurance Company to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross Life and Health Insurance Company premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed bi-monthly. You will incur a \$25 service charge for any withdrawal not honored.

Authorized Signature (As it appears in the financial institution's records)	Account Holder Name PRINT	Date
X	X	

7D. Monthly Credit/Debit Card

As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, or moving my residence. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

We accept Visa, MasterCard, Discover and Star*.
 *For Star, we accept 16 digit card numbers only.

Card No.: Exp. : / Cardholder Zip Code:

Authorized Signature (As it appears in on the credit card)	Cardholder Name (As it appears in on the credit card)	Date
X	X	

7E. Electronic Check

In lieu of sending a Paper Check, we can submit this same information electronically. You will need to complete the information below. Please void this check to prevent future use.

Account Holder Name PRINT	Bank Routing No.	Account No.	Amount \$	Date

* By sending your paper check, you authorize us to convert your check to 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.

8. *Statement of Accountability* - To be completed when the applicant cannot complete the application.

I, _____, personally read and completed this Individual Enrollment Application for the applicant named below because:

- Agent assisted application
- Applicant does not read English Applicant does not speak English Applicant does not write English
- Other (explain): _____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: _____

I also translated and fully explained the "Application Conditions and Agreement."

Signature of Translator (Required)

Today's Date (Required)

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, habits or reputation of any person listed on this application which might have a bearing on the risk? Yes No
If yes, please attach explanation.
2. Did you see the proposed subscriber at the time this application was executed? _____ Yes No
If no, please explain: _____
3. I verify that this application was completed by the applicant unless the Statement of Accountability was completed.

<i>Signature of Agent (Required)</i>	<i>Date (Required)</i>
X	

4. Total funds collected: \$ _____

Name of Agent (Print Name) OLEG SKURSKIY		Agent's Street Address Suite No./Personal Mail Box (PMB) No. 18375 Ventura Blvd. # 226	
Agent ID No. BCLNGNPVMZ	Sub-Agent ID No.	City/State/ZIP Code Tarzana , CA 91356	Location No.
Phone No. () 818-654-4548	FAX No. () 818-776-9865	E-mail address OLEG@ASKOLEG.COM	



Anthem Blue Cross Life and Health Insurance Company
Notice of Language Assistance

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-297-7647. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-297-7647. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打1-866-297-7647 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-297-7647. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin. Maaari mong ipabasa sa iyo ang mga dokumento at maaari mong hingin na ipadala ang ilang mga dokumento sa iyo sa Tagalog. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-297-7647. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

무료 통역 서비스. 귀하는 통역 서비스를 받으실 수 있습니다. 한국어로 서류를 낭독해주는 서비스 받으실 수 있으며 한국어로 번역된 서류를 받아보실 수도 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-297-7647번으로 문의해 주십시오. 보다 자세한 문의 사항은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Անվճար Լեզվական Օտառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել սալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-297-7647 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆոռնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-297-7647. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または 1-866-297-7647までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。 Japanese

خدمات مجاني مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-297-7647 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-297-7647 'ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫੋਨ ਕਰੋ। Punjabi



Anthem Blue Cross Life and Health Insurance Company
Notice of Language Assistance

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នក ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទ
មកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-297-7647 ។ សម្រាប់ជំនួយបន្ថែមទៀត
សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على
الرقم 1-866-297-7647. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم Arabic.1-800-927-4357

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv
ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-297-7647. Yog xav tau
kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357. Hmong

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Authorization for Use of Protected Health Information

By signing below:

I authorize Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, to obtain any medical records from any physicians, hospitals, pharmacies, pharmacy benefits managers, health benefits plans, and/or other health care providers or medical or pharmacy benefit administrators concerning my care and the care of any family member listed on my Application.

I also authorize any physicians, hospitals, pharmacies, pharmacy benefits managers, health benefit plans and/or other health care providers or medical or pharmacy benefit administrators to furnish any medical records concerning my care and the care of any family member listed on my Application to Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company. This information is needed to determine eligibility for coverage and Anthem Blue Cross' or Anthem Blue Cross Life and Health Insurance Company's acceptance of coverage requested for myself and/or any family members listed on my Application or so that a determination of coverage regarding a claim for specified benefits can be made.

I understand that my application will not be considered if this form is not signed and returned with my completed Application if I am initially applying for enrollment in a

medically underwritten health plan offered by Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or signed and returned with my completed Change of Coverage Form if I wish to add a family member or upgrade my coverage in the future. This Authorization will expire 24 months following Anthem Blue Cross' or Anthem Blue Cross Life and Health Insurance Company's acceptance of coverage, if not previously revoked.

I understand that I may revoke this Authorization at any time while Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company is determining eligibility for the coverage requested. To do so, I must submit a completed Authorization Revocation Form to Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company. An Authorization Revocation Form is available by calling 1-866-297-7647, going to our website, www.anthem.com/ca, or writing to: Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9041, Oxnard, CA 93031. If I revoke this Authorization after I initially apply for coverage, I understand that I/we will not be considered by Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company for enrollment in one of its medically underwritten health plans. If I revoke this Authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by recipient and, in some circumstances, may no longer be protected by federal regulations governing the privacy of health information.

Printed name of Applicant/Member

Signature of Applicant/Member
or his/her Personal Representative

Date

Printed name of Spouse or Dependent Child
age 18 or over listed on Application

Signature of Spouse/Dependent Child
or his/her Personal Representative

Date

Printed name of Dependent Child age 18 or
over listed on Application

Signature of Dependent Child
or his/her Personal Representative

Date

*A photocopy of this form will be as valid as the original.
You have the right to receive a copy of this Authorization upon request.*

For Anthem Blue Cross Use Only

HCID:

For Anthem Blue Cross Use Only

WFI:

Addendum to Individual Applications

A new law became effective January 1, 2009 (AB 2569) which requires all agents/brokers to include an attestation with each application submitted if that agent/broker assisted that applicant in completing the application.

Applicant's Social Security or ID No.

Type or Print Name

Fax: (805) 713-8829

Mail: Individual Services
P.O. Box 9041
Oxnard, CA 93031-9041

As the agent/broker, please check one of the following:

- I have not had any interactions whatsoever with this applicant either by phone, email or in person and did not provide any information, advice or assist the applicant in any manner in providing answers or responses to any questions in the application.
- I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars (\$10,000), as authorized under California Health and Safety Code Section 1389.8(c)/ Insurance Code Section 10119.3.

Signature of Agent (*required*)

OLEG SKURSKIY

Type or Print Name

Date

BCLNGNPVMZ

Agent Number

CAINDATT 3/09 MCAFR6059C 3/09