

# Colorado Individual Change of Coverage Application

Please complete in blue or black ink only.



Health. Join In.

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

- Change to new product
- Rate review for (member name) \_\_\_\_\_
- Both

Applicant Social Security or ID No.									

## 1. Applicant/Subscriber Information (Current applicant/subscriber must complete this section.)

Last Name		First Name		MI	Social Security Number*	
Home Address (street and P.O. Box if applicable)			City		State	Zip
Billing Address (street and P.O. Box if different from above)			City		State	Zip
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner			Maiden Name (if applicable)		Social Security Number*	
Daytime Phone Number (    )		Evening Phone Number (    )		Fax Number (    )		Email*

## 2. Applicant/Subscriber Family Information

List yourself and all enrolled family members requesting a change in coverage. If spouse's name is different from yours, please explain:

Last Name	First Name	MI	Social Security Number*	Sex	Age	Date of Birth (mm/dd/yyyy)	Height Ft. / In.	Weight Lbs.
Applicant/Subscriber				<input type="checkbox"/> Male <input type="checkbox"/> Female		/ /	/	
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner				<input type="checkbox"/> Male <input type="checkbox"/> Female		/ /	/	
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Male <input type="checkbox"/> Female		/ /	/	
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Male <input type="checkbox"/> Female		/ /	/	
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Male <input type="checkbox"/> Female		/ /	/	
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				<input type="checkbox"/> Male <input type="checkbox"/> Female		/ /	/	

\* This information is used for internal purposes only.

COINDCOCAPP (Rev. 7/10)   

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MC0FR475A 9/10

### 3. Choice of Medical Coverage

**CoreShare Plus** .....  750 - 50% w Facility Copay (065R)     1500 - 50% w Facility Copay (065S)     2500 - 50% w Facility Copay (065T)  
 3500 - 50% (065U)     5000 - 50% (065V)     7500 - 50% (065W)  
 10,000 - 100% (065X)     15,000 - 100% (065Y)     25,000 - 100% (065Z)

**ClearProtection** .....  1000 - 70% (01HA)     3300 - 70% (01HB)     5000 - 70% (01HC)

**SmartSense Plus** .....  1000 - 70% w Standard (01GF)     1000 - 70% w Rx Upgrade (01GG)     2000 - 70% w Standard (01GH)  
 2000 - 70% w Rx Upgrade (01GJ)     3500 - 70% w Standard (01GK)     3500 - 70% w Rx Upgrade (01GL)  
 6000 - 70% w Standard (01GM)     6000 - 70% w Rx Upgrade (01GN)

**Premier** .....  1000 - 75% (01GP)     1500 - 75% (01GQ)     2500 - 75%(01GT)  
 3500 - 75% (01GU)     5000 - 75% (01GV)     6000 - 75%(01GW)

**Lumenos HSA Plus -**

**Individual Policy** .....  3000 - 100% (01GY)     4500 - 100% (01GZ)     5950 - 100% (01H1)

**Lumenos HSA Plus -**

**Family Policy** .....  3500 - 100% (01H3)     5500 - 100% (01H5)     7500 - 100% (01H7)  
 11,900 - 100% (01H8)

- Yes**, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected above.  
Anthem will provide your information to Anthem's banking partner. (Please fill in your social security number in section 1.)
- No, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above.

**Other** ..... To apply for a plan/policy not listed, write in the name here:  
 \_\_\_\_\_



#### 4. Health History of Members Listed on this Application

Your claims history with Anthem Blue Cross and Blue Shield will also be used in addition to the history listed on this application.

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.

**NOTICE:** You must provide truthful and complete answers to the health related questions below to the best of your ability. We are relying on the information you provide to determine if you are eligible for coverage. If we issue coverage to you and then discover an act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact, we may rescind your coverage, even after it has been issued. This means that you may lose your health benefits including coverage for treatment already received.

**PLEASE NOTE:** The health history questions apply to ANY medical advice, diagnosis, care or treatment that you received or that a healthcare provider recommended that you receive for any health condition or issue.

- |   |                          |                          |
|---|--------------------------|--------------------------|
|   | <b>YES</b>               | <b>NO</b>                |
| 1. Has any enrolled family member been hospitalized, seen a physician or other health care provider or taken prescription medication within the last 6 months? If yes, please provide name of applicant and details below. ....                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. ....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is any enrolled family member currently pregnant (includes positive pregnancy test within the last 30 days), an expectant parent, or in the process of adoption or surrogate pregnancy? If yes, please provide name of applicant and details below. .... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Has any enrolled member used tobacco products within the past 12 months? If yes, please provide name of applicant below.   |                          |                          |
| Cigarettes, cigars or pipes? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Chewing tobacco? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

Family Member	Hospital/Provider Name & Address	Medication Prescribed	Condition/Illness Treated



**5. Significant Terms, Conditions and Authorizations (TERMS)**

*Please read this section carefully before signing the application.*

**AGREEMENT**

**By applying for coverage, I, the undersigned, agree to the following:**

1. Anthem Blue Cross and Blue Shield 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.
2. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross and Blue Shield underwriting policy or the terms of any Anthem coverage.
3. 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.)
4. I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is mentally competent; he or she is at least 18 years old; is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
5. If I am accepted, this application will become part of the contract between Anthem BCBS and me. I agree to abide by the terms of that contract.

**Rescission of Membership**

I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that it is mandatory that I immediately notify Anthem BCBS in writing if I (or any other person for whom coverage is sought) received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date.

I understand that if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered in this application, Anthem BCBS may revoke my coverage. This means Anthem may cancel membership as if it never existed. Also, after approval for membership, if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered in this application by Anthem that was not provided to Anthem prior to the effective date of the policy, Anthem may revoke my coverage.

**REQUIREMENT FOR BINDING ARBITRATION:**

**I UNDERSTAND AND AGREE THAT ANY AND ALL DISPUTES BETWEEN ANTHEM AND ME MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT. UNDER THIS BINDING ARBITRATION REQUIREMENT, ANTHEM AND I ARE GIVING UP THE CONSTITUTIONAL RIGHT TO HAVE THE DISPUTE DECIDED IN A COURT OF LAW BY A JURY.**

**BEFORE COMMENCING ARBITRATION, THE PARTY SEEKING ARBITRATION MUST HAVE EXHAUSTED ALL LEVELS OF APPEAL AND REVIEW SET FORTH IN THE CERTIFICATE. ANY SUCH ARBITRATION WILL BE GOVERNED BY THE PROCEDURES AND RULES ESTABLISHED BY THE AMERICAN ARBITRATION ASSOCIATION. THE LAW OF THE STATE IN WHICH THE POLICY WAS ISSUED AND DELIVERED TO THE POLICYHOLDER SHALL GOVERN THE DISPUTE. THE DECISION IN ARBITRATION IS BINDING UPON BOTH ANTHEM AND ME. THE AWARD GIVEN IN ARBITRATION MAY BE ENFORCED OR REVIEWED IN ANY COURT THAT HAS PROPER JURISDICTION. IN THE EVENT ANY PERSON SUBJECT TO THIS ARBITRATION CLAUSE INITIATES LEGAL ACTION OF ANY KIND, THE OTHER PARTY MAY APPLY FOR A COURT OF COMPETENT JURISDICTION TO ENJOIN, STAY OR DISMISS ANY SUCH ACTION AND DIRECT THE PARTIES TO ARBITRATE IN ACCORDANCE WITH THIS PROVISION. THE QUESTION OF WHAT DISPUTES ARE SUBJECT TO THIS ARBITRATION CLAUSE SHALL BE DETERMINED BY THE ARBITRATOR.**



**5. Significant Terms, Conditions and Authorizations (TERMS)** (continued)

If an Applicant does not read English, the translator must sign and submit a Statement of Accountability for translating this entire application (see section 6).

**NOTICE:**

By signing this contract you are agreeing to have ANY and ALL disputes against Anthem Blue Cross and Blue Shield decided by neutral arbitration and you are giving up your right to jury OR COURT trial for both medical malpractice claims and any other disputes. *Signatures Required.*

**IMPORTANT: ALL APPLICANTS OVER AGE 18 MUST PERSONALLY READ, AGREE TO, SIGN AND DATE THIS APPLICATION.**

<b>SIGN HERE</b>	Printed name of Applicant	Signature of Applicant* or Legal Representative <b>X</b>	Date of Birth / /	Date Signed / /
	Printed name of Spouse or Domestic Partner	Signature of Spouse or Domestic Partner or Legal Representative <b>X</b>	Date of Birth / /	Date Signed / /
	Printed name of Dependent Child over 18	Signature of Dependent Child over 18 <b>X</b>	Date of Birth / /	Date Signed / /
	Printed name of Dependent Child over 18	Signature of Dependent Child over 18 <b>X</b>	Date of Birth / /	Date Signed / /

*\*(or Custodial Parent's or Guardian's signature if applicant is under age 18)*

**6. Statement of Accountability**

**APPLICANT DOES READ AND WRITE ENGLISH.**

If an Applicant does not read or write English, the translator must complete and sign the Statement of accountability below.

*To be completed when the applicant cannot complete the application.*

*NOTE: Translator must be 18 years or older to translate the application on behalf of the applicant.*

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

- 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 the:  Applicant Or by \_\_\_\_\_

**I also translated and fully explained the "Significant Terms, Conditions and Authorizations (TERMS)."**

Translator Signature (Required): <b>X</b>	Date (Required)
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**I confirm that the application was translated on my behalf.**

Applicant Signature (Required): <b>X</b>	Date (Required)
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**7. Determination of Self-employed Business Group of One**

	YES	NO
<b>1.</b> Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care coverage to your employees? ..... Self <span style="float: right;">Spouse/Domestic Partner</span>	<input type="checkbox"/>	<input type="checkbox"/>
<b>2.</b> Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage? ..... Self <span style="float: right;">Spouse/Domestic Partner</span>	<input type="checkbox"/>	<input type="checkbox"/>
<b>3.</b> Do you have gross income from your self-employment or sole proprietorship as indicated on federal Internal Revenue Service forms 1040, Schedule C, F or SE, or other forms recognized by the federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out the past three years? <b>Note:</b> "Substantial part of your income" means income derived from business activities of the business group of one that are sufficient to pay for the annual premiums for the business group of one's health benefit plan. .... Self <span style="float: right;">Spouse/Domestic Partner</span>	<input type="checkbox"/>	<input type="checkbox"/>
<b>4.</b> Do you work a minimum of 24 hours a week on a permanent basis? ..... Self <span style="float: right;">Spouse/Domestic Partner</span>	<input type="checkbox"/>	<input type="checkbox"/>

**Applicant's Statement:** I (print name), \_\_\_\_\_, attest that the answers to the questions about self-employed business group of one in the above section are true and correct.

Applicant Signature: <b>X</b>	Date
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**Spouse/Domestic Partner's Statement:** I (print name), \_\_\_\_\_, attest that the answers to the questions about self-employed business group of one in the above section are true and correct.

Spouse/Domestic Partner Signature (if applying for coverage): <b>X</b>	Date
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I, (print name) \_\_\_\_\_, meet the definition for a self-employed business group of one as attested to in the Determination of Self-employed Business Group of One, as indicated above on this application. **I understand that by purchasing an individual policy instead of a small group policy I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic or other small group health benefit plan from a small employer carrier for a period of three years after the effective date of the individual health benefit plan for which I am applying.** I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three-year period. I understand that the factors used to set new and renewal rates for the individual policy I want to purchase consist of plan design, the carrier's overall cost and utilization trends, the underwriting methodology used to evaluate individual coverage, my age, my family size, and a factor that reflects the cost of care where I live. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited to plan design, the carrier's overall cost and utilization trends ("index rate"), my age, my family size, and a factor that reflects the cost of care where I live. I have been given a Colorado Health Plan Description Form showing the benefits under Colorado's small group Standard Health Benefit Plans. I have also been given a Colorado Health Plan Description Form for the plan for which I am applying. Applicant's Statement.

**If you or your spouse/domestic partner answered "YES," to ALL four questions above, please complete the following section.** If you waive coverage for a family member who will not be covered under this policy, you must list the other coverage for the dependent and when it became effective.

Full Name	Name of Other Coverage	Effective Date of Other Coverage (mm/dd/yyyy)
Spouse/Domestic Partner		
Dependent		
Dependent		

