



## How to Enroll with Anthem Health Care Plans

Anthem can refuse to insure you based on your health application. Before you fill out the enrollment application, take a few minutes to call us. We can spot some health conditions you may have that Anthem will automatically reject. This helps you avoid from being declined or rejected. Rejections can prevent you from getting health insurance in the future. Our Connecticut Assistance number is 1-866-508-0618. If the line is busy, leave your name, phone number and a short message and we will get back to you shortly.

Follow the 5 steps below, and send the forms to us.

1. Complete and sign the Enrollment/Change Application. (2 pages)  
Be sure to select a primary care physician. These forms are to choose your doctor and to issue ID Cards to you and your family.  
1. Enrollment Form
2. Answer all the questions on the Individual Health Statement. (2 pages) Be sure to answer the questions for all family members who are applying for medical coverage.  
2. Individual Health Statement
3. If you want to pay Anthem directly from your bank in the future, fill out the Electronic Funds Transfer Part #7. Be sure to include a check or deposit slip marked "Void". (No signature required on check)
4. Anthem will provide medical coverage for a Domestic Partner. If you have a domestic partner. Please fill out this Domestic partner Form .  
4. Domestic Partner Form
5. Send all the forms and paperwork to:

Creative Health Insurance  
230 Hartford Turnpike  
Vernon, Ct. 06066

If you have any questions you would like answered before you send us the enrollment forms, Call 1-866-508-0618, or you can fax a copy to be reviewed at 860-896-7440. Thank You

There is no charge for using Creative Health Insurance. The price of health insurance in Connecticut is fixed by law - you cannot find a better price anywhere for the same product. The insurance companies will pay us commissions to help you find the best medical plan for you and your family.

Sometimes we are able to find you the plan you wanted at a lower price. This is not because we have special prices. We can do this because we specialize in health insurance here in Connecticut. We do not handle auto insurance, or financial products. We are not employees of an insurance company. We are here to help you with your health care needs. . . . Robin Thomas Dubord AAI - Creative Health Insurance

Z 10-31-2009



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P.O. Box 2048, Manchester, CT 06045

1-866-508-0618

Anthem Individual Enrollment/Change Application (page 1)

To Be Completed By Agency / Producer
Agency Name: Creative Health
Vendor Code #: Insurance 97690
Producer Signature:
Producer Phone #: 860-647-7353
For Office Use Only
Effective Date:
Firm Division No.:

Contact your Producer to complete For assistance: all sections of this application. Call 1-866-508-0618

PLEASE USE BLACK OR BLUE INK ONLY AND PRINT CLEARLY
Please check appropriate item: [ ] New Enrollment [ ] Plan Change [ ] Add/Remove Dependent

1. Applicant Information
Name (Last/First/Middle initial)
Email Address
Home Address (Number and Street)
City/State/Zip Code
Marital Status: [ ] Single [ ] Domestic Partnership (Include "Statement of Domestic Partnership") [ ] Married
Telephone Numbers: Daytime: Evening:

2. Membership Choice
Choose one membership type: [ ] INDIVIDUAL [ ] TWO PERSON [ ] FAMILY
3. Plan Choice (Please select one deductible option. The Two Person/Family Deductibles are two times the Individual Deductible. All deductible options are calculated per calendar year.)

BlueCare Direct (HMO)
\$1,500/\$3,000 (Individual/Two Person or Family Deductible)
\$500 Drug Maximum
\$2,000 Drug Maximum
Century Preferred Direct (PPO)
Check One Deductible Option:
\$250/\$500 (Individual / Two Person or Family Deductible)
\$1,500/\$3,000 (Individual / Two Person or Family Deductible)
\$5,000/\$10,000 (Individual / Two Person or Family Deductible)
\$10,000/\$20,000 (Individual / Two Person or Family Deductible)
Prescription Drug Coverage: YES NO
Lumenos (PPO)
Lumenos Health Savings Account\*
\$1,250/\$2,500 deductible (100% In network)
\$2,500/\$5,000 deductible (100% In network)
\$2,500/\$5,000 deductible (80% In network)
\$5,000/\$10,000 deductible (100% In network)
\*For Health Savings Accounts, complete the following:
Yes, I would like to establish an H.S.A. with Anthem's banking partner. (SSN required see Section 1)
No, I do not want to establish an H.S.A. with Anthem's banking partner.
Lumenos Health Incentive Account Plus
\$2,500/\$5,000 deductible (80% In network)
\$200/\$400 Funding (Individual/Family)
Lumenos Health Incentive Account
\$1,500/\$3,000 deductible (80% In network)
\$2,500/\$5,000 deductible (80% In network)

Recommended for HMO Plan Only. Name of Applicant's Primary Care Physician (PCP) (Refer to www.anthem.com)
PCP Name: First Last City
PCP Provider No.
Existing Patient YES NO

Table with 8 columns: Name (Last/First/Middle initial), Add, Delete, Social Security Number, Sex, Date of Birth (mm/dd/yy), (Recommended for the HMO only) Primary Care Physician, (Recommended for the HMO only) PCP ID Number (10 digits), Existing Patient, Below please indicate name of recognized institution for full time students (Age 19-23). Rows include Spouse / Domestic Partner, Dependent 1, 2, 3, 4.

**5. Prior and Other Insurance Information - Please answer ALL of the following questions.**

(A) Do you have any other health insurance policy or certificate in force?  YES  NO

(B) Have you had coverage within 63 days of the application?  YES  NO

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

Name of Other Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_ Type of Coverage  Group  Individual Last Date of Coverage \_\_\_\_\_

If the answer to question (A) is yes, do you intend to replace your current medical or health policy with the policy?

Yes  No

**6. Billing Choice (Please Check One)**

Electronic Fund Transfer - complete section 7 and **attach a voided check or savings account deposit slip.**

Monthly Paper Bill

**7. Electronic Fund Transfer Authorization (EFT) (Complete if you want your payments deducted directly from your checking or savings account.)**

**I hereby authorize Anthem Blue Cross and Blue Shield to initiate a withdrawal (on or about the 5<sup>th</sup> business day of each month) from my bank account for payment of my premium. The bank account is with the bank named below, which is hereby authorized to withdraw this amount from my account each month.**

Bank Name	Phone Number
Bank Address	City/State/Zip Code
Bank Information: Routing #	Account #

Type of Account: (Check Only One):  Checking Account (must attach voided check)  
 Savings Account (must attach saving account deposit slip)

**This authorization is to remain in effect until Anthem Blue Cross and Blue Shield has received at least 30 days prior written notification from me of a termination date.**

**8. Effective Date**

If Anthem approves my application, please assign an effective date of \_\_\_\_\_. The effective date must be no earlier than the signature date and no greater than 60 days from the receipt by Anthem of this application. **NOTE: REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE COVERAGE OR ENROLLMENT AS OF THE DATE REQUESTED. Effective date will ultimately be assigned by Anthem Blue Cross and Blue Shield and communicated to you.**

**A completed, signed Health Statement must be enclosed with this completed, signed application. Important: Please attach copies of any certification or other documentation of prior creditable coverage furnished by previous carriers or employers, if available. This will help us process your application.**

Anthem Individual products are issued on an individual basis and are regulated as an individual health insurance plan.

I acknowledge receipt of an outline of coverage provided by the policy checked above. I certify that neither I nor any family member listed is eligible for Medicare. I understand the following: (a) that all coverage and services are subject to the Exclusions, Limitations and Conditions of the Subscriber Agreement or other Evidence of Coverage document; (b) that no benefits will apply until I receive written approval and confirmation of effective date, and my first month's paid premium has been processed by, Anthem Blue Cross and Blue Shield and; (c) that I will be responsible for notifying the Company of any change in dependent status or change of address. I understand that false and/or incomplete responses or statements may result in rescission of coverage and/or nonpayment of claims for myself or my dependents. I certify that my statements in this form and the attached Health Statement are true and complete to the best of my knowledge and belief.

<b>9. Applicant's Signature</b> (If applicant is under 18, parent or guardian signature required.)	Date / /
<b>Spouse's Signature</b>	Date / /



**CONNECTICUT  
INDIVIDUAL MARKETS HEALTH STATEMENT**

Anthem Blue Cross and Blue Shield is a trade name of Anthem Health Plans, Inc.  
An independent licensee of the Blue Cross and Blue Shield Association.  
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**APPLICANT AND FAMILY INFORMATION**

**PLEASE USE BLACK OR BLUE INK ONLY**

**PART A  
COMPLETE FOR YOU AND ANY FAMILY MEMBERS APPLYING FOR COVERAGE:**

	FIRST NAME	INITIAL	LAST NAME	HEIGHT	WEIGHT	DATE OF BIRTH	SEX M/F	SOCIAL SECURITY #
APPLICANT				/		/ /		
SPOUSE				/		/ /		
DEPENDENT				/		/ /		
DEPENDENT				/		/ /		
DEPENDENT				/		/ /		
DEPENDENT				/		/ /		

- PART B**
1. IS ANY PERSON TO BE INSURED CURRENTLY ON MEDICARE? YES NO
2. HAS ANYONE HAD HEALTH OR LIFE INSURANCE MODIFIED, POSTPONED OR RATED?  
 PLEASE SUBMIT DETAILS \_\_\_\_\_ YES NO

- PART C**
1. Are you or your spouse or any dependent to be insured currently disabled or unable to perform their normal activities? YES NO
2. Have you or any dependent to be insured been hospitalized, had surgery or been advised to have surgery within the past 5 years for any reason? YES NO
3. Are you or any dependents to be insured currently pregnant, or an expectant parent? YES NO
4. Are you or any dependents currently taking any medication? If yes, please specify medication and condition for which it is used: \_\_\_\_\_ YES NO
5. Do you or any dependents have any conditions or symptoms for which a physician or other medical care provider has not been consulted? YES NO
6. Have you or any dependent had medical expenses in excess of \$5,000 in the last 12 months? YES NO

- PART D**
1. Have you or any dependent to be insured ever had or been told they had, or been medically counseled, consulted or treated for any of the following? (Check **yes** or **no** and **circle the disorder**)
- A. Chest pain, heart attack, heart murmur, heart trouble, rapid, slow or irregular heart beat, other diseases of the heart, circulatory system or blood vessels, varicose veins, phlebitis, anemia or other disorder of the blood? YES NO
  - B. Cancer, tumor or lymph node enlargement? (Indicate type of cancer and location \_\_\_\_\_ ) YES NO
  - C. Sexually transmitted disease? YES NO
  - D. Mental, emotional, nervous disorder, depression, anxiety, psychotherapy or counseling of any kind? YES NO
  - E. Brain disorder, neurologic problems, seizure disorder, any disorder of the central nervous system, stroke or paralysis? YES NO
  - F. Alcohol or drug use, abuse and/or dependency? YES NO
  - G. Medical diagnosis of AIDS (Acquired Immuno Deficiency Syndrome) or ARC (AIDS Related Complex)? YES NO
  - H. Any disorder of the male/female reproductive organs including infertility and complications of pregnancy? YES NO
  - I. Back, neck, bone, joint problems, Lupus, arthritis or autoimmune disorder? YES NO
  - J. Diabetes? If so, specify date of diagnosis, type of treatment, amount of medications (if any): \_\_\_\_\_ YES NO
- 
- K. Any disorder of the stomach, intestines, gallbladder or esophagus? YES NO
  - L. Any disorder of the lungs or respiratory system or Tuberculosis? YES NO
  - M. Any disorder of the kidneys, bladder or urinary tract? YES NO
  - N. Any disorder of the liver or pancreas? YES NO
  - O. Any disorder of the endocrine system or glands? YES NO

