

# Application for Coverage under HIPAA

(Health Insurance Portability and Accountability Act)



## 1. Applicant Information

Please print in blue or black ink

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

## 2. Choice of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Individual Coverage

Choose one plan per application

- HIPAA HMO Saver (025T)\*  
 HIPAA Select HMO (025R)\*

Billing Address (If different than above.) or P.O. Box	Personal Mail Box (PMB) No.	Daytime Phone No. ( ) ( )	Fax Phone No. ( ) ( )
City / State / ZIP Code	County (Required)	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership	Applicant/Spouse Maiden Name
E-mail Address	If possible, do you want e-mail notification? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has any person listed on this application resided outside the U.S. for the past three (3) consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Language Choice (Optional)	<input type="checkbox"/> English (ENG) <input type="checkbox"/> Vietnamese (VIE)	<input type="checkbox"/> Korean (KOR) <input type="checkbox"/> Tagalog (TGL)	<input type="checkbox"/> Spanish (SPA) <input type="checkbox"/> Other (W09) _____ <input type="checkbox"/> Chinese (ZHO) (C/M)

- Applicant DOES speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a Statement of Accountability (Section 6).

## 3. Family Members and Dependents Applying

Please list ALL eligible family members and dependents applying.

If a listed family member or dependent's last name is different from your own, please explain on a separate sheet of paper.

### 3A. For HMO Use Only

Choose a physician for each family member by calling 1-866-297-7647 or from the Provider Directory, which can be found at [anthem.com/ca](http://anthem.com/ca)

Relation	Last Name	First Name	M	Social Security or ID No.	Date of Birth	Age	PMG/ IPA**	Primary Care Physician (PCP)	Current Patient
10 <input type="checkbox"/> Male 20 <input type="checkbox"/> Female	Yourself								<input type="checkbox"/> Yes <input type="checkbox"/> No
30 <input type="checkbox"/> Male 40 <input type="checkbox"/> Female	Spouse*								<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No

**Dependent Information:** Do you claim any child listed above who is between the ages of 19 through 22 as a dependent on your Federal Income Tax?  Yes  No

If "No," any child between the ages of 19 through 22 who is not claimed on your Federal Income Tax is NOT eligible as a dependent but may apply individually.

\*Spouse includes domestic partner (when applicable).

\* These products are administered by Anthem Blue Cross and are regulated by the California Department of Managed Health Care. All other products are administered by Anthem Blue Cross Life and Health and are regulated by the California Department of Insurance.

\*\*PMG = Participating Medical Group; IPA = Independent Practice Association



**4. Eligibility**

1. Have all applicants had a minimum of 18 months of continuous health coverage most recently under an employer-sponsored group health plan that ended within the last 63 days for a reason other than fraud or non-payment of premium? .....  Yes  No  
**If yes**, please attach the Certificate of Creditable Coverage provided by your former employer or carrier OR letter from the employer giving us the start and end date of coverage.  
 Name of insurance carrier: \_\_\_\_\_ Phone No. ( \_\_\_\_\_ )  
**If no** for any applicant, then he or she is **not eligible** for this guarantee issue plan.
2. Did all applicants elect and exhaust any continuation coverage available under COBRA or Cal-Cobra?.....  Yes  No  
**If yes**, date coverage started (Mo/Day/Yr) \_\_\_\_\_ Date coverage ended (Mo/Day/Yr) \_\_\_\_\_  
**If no**, please explain:  
 If all available COBRA or Cal-COBRA is not exhausted for any applicant, then he or she is **not eligible** for this coverage.
3. Is any applicant currently covered by or eligible for Medicaid, Medicare or any health coverage? .....  Yes  No  
**If yes** for any applicant, then he or she is **not eligible** for this coverage.
4. Has any applicant lost coverage for fraud or failure to pay premiums? .....  Yes  No  
**If yes**, then he or she is **not eligible** for this coverage.

**5. Prior Insurance History**

For any period of creditable coverage for which you are unable to provide a certificate of creditable coverage, please complete the following section for the last two years, beginning with the most recent coverage. Please include any COBRA and Cal-COBRA continuation coverage. Attach additional sheet if necessary.

Applicant name(s) OR <input type="checkbox"/> All applicants	Insurer Name(and Phone Number)	Policyholder ID Number	
Plan/Policy Name	State	Effective Date of Coverage	Coverage End Date

Type of Coverage:  Group  Individual  Other

**6. Application Understandings, Conditions and Agreement –**

**IMPORTANT: You, the applicant, are solely responsible to review and attest to the completeness and validity of information provided on this application. It is important that you carefully read and fully understand the following:**

**All Applicants**

I, the undersigned, understand that under the Anthem Blue Cross plan and/or Anthem Blue Cross Life and Health Insurance Company policy for which I am applying, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician. Contact customer service at 1-800-333-0912 with any questions about the use of network providers and the financial impact of using out-of-network providers.

**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.**

**Agreement**

By requesting coverage, I, the undersigned, agree to the following:

1. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may decline my application. No coverage comes into effect until Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company based on when payment is received. Anthem will send you billing information within 30 days of approving your application. Payment must be provided within 30 days. If payment is not received within 30 days, you will not be enrolled under the HIPAA plan applied for and will have no coverage. If your payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage shall begin no later than the first day of the following month. When that payment is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.
2. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company underwriting policy or the terms of any Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company 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. In no event shall Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company or any affiliated company have any liability to the applicant if the 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 Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.

5. I understand and agree that I am applying for an individual health coverage policy which is not part of any employer-sponsored plan and the policy, if issued, shall not be used as an employer-sponsored health benefit plan. If the policy is issued, I understand and agree that I am responsible for 100% of the premium and I must ensure that premiums are paid timely. I certify that no employer of any person covered under this policy will pay any premium for this health coverage policy, directly or indirectly, through wage adjustments or otherwise. If my employer has agreed to remit my premium payment to Anthem Blue Cross and/or Anthem Blue Cross Life and Health on my behalf, my employer will not directly or indirectly contribute to that payment and will only forward to Anthem Blue Cross and/or Anthem Blue Cross Life and Health my premium payment that is directly funded by the regular wages paid to me by my employer.
6. I expressly consent to receive calls made by or on behalf of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliated companies, contractors and vendors that use an automated dialing system or deliver prerecorded messages, including telemarketing sales calls that encourage the purchase of goods or services, to any of the telephone numbers I have provided in this Application. All calls made pursuant to this provision shall be limited to information regarding benefits, services or discounts available under health benefit plans offered or administered by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and its affiliated companies. I also understand that my consent to receive such calls is voluntary. The benefits available under health benefit plans offered or administered by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and its affiliates will not be altered if I do not consent to calls made under this provision.  Initials
7. I understand that my domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.
8. 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 be considered and applied only to the individual in question.



## 6. Application Understandings, Conditions and Agreement - continued

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 plan contract/policy between Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and me.

I, and any enrolled family members, agree to abide by the terms of that plan contract/policy. With the exception of minors and persons for whom this application has been interpreted (a signed Statement of Accountability must be attached, see Section 7) all persons applying for coverage agree that they have personally answered all questions directed to them. If an Applicant does not read English, the interpreter must sign and submit a Statement of Accountability for interpreting this entire application (see Section 7).

### REQUIREMENTS FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. *It is understood that any disputes including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including 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. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.*

**Signatures (Required) – IMPORTANT: All applicants age 18 and over must personally read, agree to, sign and date this application.**

Applicant/ Parent or Legal Guardian	Today's Date	Applicant's Spouse/Domestic Partner	Today's Date
X		X	
Applicant's Dependent age 18 or over	Today's Date	Applicant's Dependent age 18 or over	Today's Date
X		X	

■ **IMPORTANT: All signatures MUST include today's date** ■



**7. Statement of Accountability – Complete when the applicant cannot fill out the application for coverage under HIPAA.**

I, \_\_\_\_\_, personally read and completed this 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     
  Applicant is Limited English Proficient     
  Other (explain): \_\_\_\_\_

I interpreted the contents of this form and to the best of my knowledge obtained and listed all the requested information disclosed by the:  Applicant or by: \_\_\_\_\_

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

Signature of Interpreter (Required) <b>X</b>	Today's Date (Required)
I confirm that the application was interpreted on my behalf. Signature of Applicant (Required) <b>X</b>	Today's Date (Required)

Language interpreted (e.g. Spanish): \_\_\_\_\_

**8. To be completed by the Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company Appointed Agent**

- Are you aware of any information not disclosed on this application relating to the health of any person listed on this application that may have a bearing on underwriting? .....  Yes  No
- Did you see the proposed subscriber (and spouse/domestic partner, if applying) at the time this application was executed? .....  Yes  No  
If no, please explain: \_\_\_\_\_
- I certify that, to the best of my knowledge and belief, the responses herein are accurate.
- Please check one of the following and complete the information below:
  - I have not had any interactions whatsoever with this applicant either by phone, e-mail or in person and did not provide any information, advise 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)		Date (Required)
Name of Agent (Print name) DAVID J. FLUKER		Agent's Street Address 767 MARIA WAY Suite No.
Agent I.D. No. F   K   D   F   Q   P   R   Q   V   Z		City / State / ZIP Code GILROY, CA 95020
Phone No. ( 408 ) 847-6139	Fax No. (408 ) 762-4450	E-mail Address dave@davefluker.com

**Please mail to:**

Anthem Blue Cross  
 P.O. Box 9041  
 Oxnard, CA 93031-9041  
 OR  
 Fax to: (800) 327-9255

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