Please call and allow us to assist you with your application

1 800 721-2618

Avoid headaches and delays by allowing our office to assist you. You'll be surprised at how easy completing an application can be! Once your application is complete, please mail it to:

JustHealthplans.com
1344 Disc Dr. #210
Sparks, NV 89436

You may fax your application to: 844 309-8787

Thank you!

Primary applicant name: _____

Welcome

Nevada Individual Application

Thanks for choosing us. We're glad you're here.

If you have any questions while filling out this form, give us a call at 1 (877) 212-1793. But if you've worked with an agent or broker, contact them first.

About this form

Use this form to apply for new medical, dental or vision coverage or to change existing coverage with Anthem Blue Cross and Blue Shield (Anthem).

You can apply or change coverage:

1. During the annual Open Enrollment (OE) period
   The earliest your coverage can start is the 1st of the year. Your coverage will start based on when we receive your complete application (including payment). If we get it:
   - Between the 1st and 15th day of the month, coverage is effective the 1st day of the following month.
   - Between the 16th and last day of the month, coverage is effective the 1st day of the second following month.
2. Due to a qualifying event (such as getting married, having a baby, etc.)
   When you're done with this form, fill out Appendix A: Special Enrollment, which includes information about when coverage starts.
3. Any time (for new dental or medical coverage)
   You can enroll for new coverage at any time during the year, but may be subject to a waiting period where permitted by law. Dependents cannot be added or change plans outside the OE period or without a qualifying event.

Tips when filling out this form

1. Answer all questions. Please print clearly using blue or black ink only.
2. You can also apply online at anthem.com.
3. Refer to your Health Plan Guide for plan and enrollment details. Don't have a copy? Ask your agent or contact us.
4. If you're enrolling in a medical plan, you must choose a Primary Care Physician (PCP). View a list of doctors for your plan on anthem.com or call us. If you don't choose a PCP, we'll pick one close to you.

Some Frequently asked questions

1. Do I need to include a payment?
   Yes. We can't complete your application without your first month's premium payment. Without it, your enrollment will be delayed. Don't worry though – we won't charge your card or cash your check until you've been enrolled.
2. What if I already have coverage with another company?
   Don't cancel your other coverage yet – your health coverage is too important. We'll contact you when you're approved. Then you'll need to cancel your other coverage.
3. Why do you need my Social Security Number?
   The IRS requires us to collect it. It won't be shared unless required by law. If you enroll in a health savings account (HSA) compatible plan with us, we'll give it to our HSA banking partner.

Step 1: Who is applying?

Primary Applicant ☐ New coverage ☐ Change coverage ☐ Add dependent to existing coverage ID No. _____

Last Name (Legal Name)	First Name (Legal Name)	M.I.	Social Security Number

Marital status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)	Legal resident of NV: ☐ Y ☐ N US Citizen or National: ☐ Y ☐ N	County (for home address)	Tobacco use* ☐ Yes ☐ No

Home address	City	State	ZIP
Billing address (optional - if different than your home)	City	State	ZIP
Mailing address (optional - if different than your home)	City	State	ZIP

Primary phone	Secondary phone	Email address

Preferred written language ☐ English (ENG) ☐ Spanish (SPA) Preferred spoken language ☐ English (ENG) ☐ Spanish (SPA)

If the applicant doesn't speak, read and/or write English, the interpreter must sign and submit Appendix B: Statement of Accountability.

Primary Care Physician (PCP)	PCP ID	Current patient ☐ Yes ☐ No	Medical group ID

Spouse or Domestic partner

Last Name (Legal Name)	First Name (Legal Name)	M.I.	Social Security Number

Relationship to applicant ☐ Spouse ☐ Domestic partner	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)	Legal resident of NV ☐ Yes ☐ No	US Citizen or National ☐ Yes ☐ No	Tobacco use* ☐ Yes ☐ No

Primary Care Physician (PCP)	PCP ID	Current patient ☐ Yes ☐ No	Medical group ID

Child dependent Children must be under age 26.

Last Name (Legal Name)	First Name (Legal Name)	M.I.	Social Security Number

Relationship to applicant ☐ Child ☐ Other _____	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)	Legal resident of NV ☐ Yes ☐ No	US Citizen or National ☐ Yes ☐ No	Tobacco use* ☐ Yes ☐ No

Primary Care Physician (PCP)	PCP ID	Current patient ☐ Yes ☐ No	Medical group ID

Child dependent

Last Name (Legal Name)	First Name (Legal Name)	M.I.	Social Security Number

Relationship to applicant ☐ Child ☐ Other _____	Sex ☐ M ☐ F	Date of birth (mm/dd/yyyy)	Legal resident of NV ☐ Yes ☐ No	US Citizen or National ☐ Yes ☐ No	Tobacco use* ☐ Yes ☐ No

Primary Care Physician (PCP)	PCP ID	Current patient ☐ Yes ☐ No	Medical group ID

Child dependent

☐ Check here if you have more dependents. Print an extra copy of this page and attach to your application.

Last Name (Legal Name)	First Name (Legal Name)	M.I.	Social Security Number

Relationship to applicant	Sex	Date of birth (mm/dd/yyyy)	Legal resident of NV	US Citizen or National	Tobacco use*
☐ Child ☐ Other _____	☐ M ☐ F		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Primary Care Physician (PCP)	PCP ID	Current patient	Medical group ID
		☐ Yes ☐ No	

*Tobacco use is the use of tobacco products 4 or more times per week, on average, in the last 6 months (excluding religious or ceremonial reasons).

Eligibility

Are any applicants eligible for Medicare?
☐ No ☐ Yes If yes, who?

Are any applicants currently incarcerated (with more than 60 days left to serve before release) as a result of a conviction? (not just pending disposition of charges)
☐ No ☐ Yes If yes, who?

Are any applicants currently receiving Social Security Disability, Medicare, Medicaid or other government program benefits, or unable to work due to disability or receiving Workers' Compensation benefits?
☐ No ☐ Yes If yes, fill out the boxes below.

Who	Reason	Start date of benefits	End date of benefits

Step 2: What coverage would you like?

Medical Plans

Choose only one medical plan.

Anthem Bronze	Anthem Silver
☐ Pathway HMO 4950 (1X90) ☐ Pathway HMO 5000 (1G40) ☐ Pathway HMO 6700 (1X8X) ☐ Pathway HMO 6800 (1G48) ☐ Pathway HMO 6300 for HSA (1G44)	☐ Pathway HMO 1750 (1G52) ☐ Pathway HMO 2250 (1G4U) ☐ Pathway HMO 2250 (1G4K) ☐ Pathway HMO 2500 (1X9P)

Anthem Catastrophic Only available to applicants under age 30, unless otherwise qualified.

☐ Pathway HMO 7150 (1G2W)

Health Savings Account (HSA) Enrollment If you chose an HSA compatible plan, you have the option to setup a health savings account.

☐ Yes, I'd like to establish an HSA with Anthem's banking partner. (Please make sure you entered Social Security numbers in Step 1)

Current (existing) medical coverage

If you already have health care coverage, please don't cancel it until you are effective with us.

☐ One or more of the applicants currently have health care coverage (Please fill out the info below)

People with coverage (Write ALL if everyone)	Existing health care coverage company	Effective date (When coverage started)

Type of coverage	ID number(s)	Last date of coverage (If applicable)
☐ Group ☐ Individual		

Dental Plans

Dental coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a dental plan and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Dental plan option	Existing dental coverage	It's important we know.
☐ Anthem Dental Family Value (2J5C) ☐ Anthem Dental Family (2J5M) ☐ Anthem Dental Family Enhanced (1FU6) ☐ Dental Prime A (1RCC) ☐ Dental Prime B (1RCD) ☐ Dental Prime C (1RCE)	☐ I currently have dental coverage (please fill out the info below)	
	People with coverage (write ALL if everyone applying):	
	Existing dental coverage company:	Effective date (when this coverage started)
	ID Number:	Last date of coverage (if applicable)

Applicants for dental plan	Check all that apply (Primary applicant must be included)
☐ Primary applicant ☐ Spouse or domestic partner ☐ All dependent children	

Vision Plan

You must enroll in medical and/or dental coverage to be eligible for vision coverage.

Vision coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a vision plan and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Vision plan option	Applicants for vision plan	Check all that apply (Primary applicant must be included)
☐ Blue View Vision Individual (1RY8)	☐ Primary applicant ☐ Spouse or domestic partner ☐ All dependent children	

Step 3: Please read and sign

Important legal information

I understand that:

- I must send my first (initial) premium with this application, but it does not mean coverage has been approved. I'm applying for the coverage I chose on this form. To the extent permitted by law, Anthem has the right to accept or decline this application, and that there are no guarantees of any kind just because I filled out this form. If my application is denied, my bank account or credit card will not be charged.
- I'm responsible to let Anthem know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- Anthem may change check payments to electronic Automated Clearinghouse (ACH) debit transactions. If this happens, my original check will be destroyed. This charge will appear on my bank statement but my check won't be given to my financial institution or sent back to me. This charge will not enroll me in any Anthem automatic debit process and will only occur each time I send a check to Anthem. Any resubmissions due to insufficient funds may also occur electronically. All checking transactions will remain secure, and my payment by check means I agree to these terms.
- I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
- I'm applying for individual health and/or dental and/or vision coverage which is not part of any employer sponsored plan. I certify that neither I nor any dependent is being reimbursed or compensated for this coverage by any employer. I'm responsible for all of the premium payments and making sure that all premiums are paid.
- By signing below, I (primary applicant) agree to receive plan-related communications for me or those enrolled in this plan either by email or electronically. This may include my contract, evidence of coverage, billing and explanation of benefits statements, or helpful information to get the most out of my plan. I agree to provide and update Anthem with my current e-mail address. I know that at any time I can change my mind and request a free copy of these materials by mail, by contacting Anthem.
- I certify that each Social Security number listed on this application is correct.
- My domestic partner, if applicable, is only eligible for coverage if: we have chosen to share one another's lives in an intimate and committed relationship of mutual caring; we desired by our own free will to enter into a domestic partnership; the NV Secretary of State has issued a Certificate of Registered Domestic Partnership to us; we share a common residence on at least a part time basis; 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.

- I acknowledge that I have read the Important Legal Information section, and I agree to the coverage conditions. I state that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative. This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

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 if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered in this application, Anthem 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 by Anthem that was not provided to Anthem prior to the effective date of the policy, the plan may revoke coverage.

I understand that if my coverage is revoked, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for enrollment. I also understand that I may be required to pay for any claims that were paid while a member and that Anthem will refund all amounts paid by me except amounts owed to Anthem.

I have personally read and completed this application. If I am accepted, this application will become part of the contract between Anthem and me. I agree to abide by the terms of that contract.

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 AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE AFFORDABLE CARE ACT. ANTHEM AND I AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN OUR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT ANTHEM AND I ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANYOTHER ISSUES RELATED TO THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

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.
NOTICE: BY SIGNING THIS CONTRACT YOU ARE VOLUNTARILY AGREEING TO HAVE ANY DISPUTE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Please sign below

	Primary Applicant (or legal representative)	Date
	Spouse / Domestic Partner (or legal representative)	Date
	Dependent Child (age 18 or over)	Date
	Dependent Child (age 18 or over)	Date
	Dependent Child (age 18 or over)	Date

Did an agent help you? Make sure they fill out this section.

Agent (or broker) Certification	I certify to the best of my knowledge, the responses herein are accurate.			
Agent/Broker Signature				Date
Agent Name (Please print clearly)		Agent TIN / SSN (Encrypted TIN is ok)		Agency or Parent TIN/ID
Agent Address		City	State	ZIP
Agent Phone Number	Agent Fax Number	Agent Email		

Here's what's next.

1) Can you check a few items? When incorrect, they're the most frequent reasons for delays in enrollment.
   - Your name and address information should be clear and readable
   - You've included your first month's premium payment
   - Everyone 18 and older signed this form
   - If enrolling due to a qualifying event, you've completed Appendix A: Special Enrollment

2) All good? Send this to us by mail to Anthem Blue Cross and Blue Shield, P.O. Box 9041, Oxnard, CA 93031-9041 or by fax to 1 (800) 327-9255.

3) We'll be in touch in the next few weeks. If you have questions before then, call us at 1 (855) 330-1217.

Thank you!

Appendix A: Special Enrollment

If you're applying for coverage due to a qualifying event, please fill out this section along with your application.

Qualifying event date	
Date of qualifying event	For Loss of Coverage, this is the last date of existing or prior coverage. For all other events, please enter the date based on the qualifying event.

You must apply for coverage within 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
☐ 1. Marriage or Domestic Partnership Got married or in a domestic partnership that becomes eligible for coverage (see step 3 for description of eligibility)	First day of the month after we receive your complete application.
☐ 2. Birth or Adoption Had a baby, adoption of a child or placement of a child with you for adoption	Select an effective date: ☐ Same as the event date ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application* ☐ First day of month after the event date
☐ 3. Court Order or Guardianship Required by a court order to provide an eligible child(ren) coverage, including a child support order or appointment of guardianship of a child	Select an effective date: ☐ Same as the event date ☐ Based on when we receive your complete application*
☐ 4. Death Death of a family member enrolled under current coverage	Select an effective date: ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application*
☐ 5. Immigration Immigration status changed ☐ 6. Other qualifying event If you can't find your situation, contact your agent/broker or call us. We can only enroll based on events defined by state and/or federal law	Based on when we receive your complete application*
☐ 7. No qualifying event	Coverage will be effective the 1st day of the month following a 90 day waiting period.

You must apply for coverage within 60 days before or 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
8. Loss of coverage: Lost or will lose Minimum Essential Coverage: ☐ Involuntary loss of coverage (for any reason except non-payment of premium or fraud) ☐ A legal separation or divorce ☐ Moved to a new service area. Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move.	First day of the month after we receive your complete application.
☐ 9. Permanent Move Moved to U.S. from a foreign country or a U.S. territory ☐ 10. Non-calendar renewal Current policy does not renew on a calendar year basis (renews on a date other than January 1) ☐ 11. Jail or prison Released from jail or prison (incarceration)	Based on when we receive your complete application*

* If the coverage date is based on when we receive your complete application, then if we receive it:
- Between the 1st and 15th day of the month, coverage is effective the 1st day of the following month.
- Between the 16th and the last day of the month, coverage is effective the 1st day of the second following month.

Almost there! We need a bit more info.

We need supporting documentation for your qualifying event, such as a letter or official form from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected. If you're applying because you've lost your coverage, we need to know the reason why coverage was lost, and it must be included in the supporting documentation. In all instances, we might need additional documentation to confirm eligibility.

Give us or your agent a call if you have any questions.

Appendix B: Statement of Accountability

Statement of Accountability Fill out when applicant cannot complete application.

Note: Interpreter must be 18 years or older to translate the application of behalf of the applicant.

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

- ☐ 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 personal and medical history disclosed by the

- ☐ Applicant or by: _____

Language interpreted

☐ Spanish ☐ Chinese ☐ Korean ☐ Tagalog ☐ Vietnamese ☐ Other _____

I also interpreted and fully explained the “Important legal information “and the “Payment Method”.

Signature of Interpreter (required)	Date (required)
I confirm that the application was interpreted on my behalf	
Signature of Applicant (required)	Date (required)

Payment Methods for Individual Applications – Nevada

Anthem BlueCross BlueShield

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Automatic Premium Payment (complete Section A)

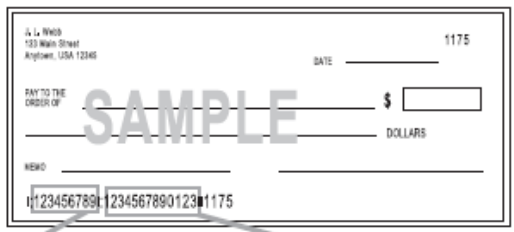
☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account

☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)



Requested Debit Day: _____ (1st to 6th 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:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield ("Anthem") to pay and charge to my account checks drawn on that account by and made payable to the order of Anthem Blue Cross and Blue Shield, 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 eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing Anthem a 30-day written notice. I agree that Anthem 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, Anthem shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Anthem's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

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

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield ("Anthem") to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review 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, moving my residence changing coverage, and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem 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, Anthem 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. **Anthem accepts Visa ☐ and MasterCard ☐.**

Card Number: _____ Expiration Date: _____

Billing address for this Credit / Debit Card: _____ City: _____ Zip Code: _____

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize Anthem either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Anthem uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-711-8949). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-711-8949). (TTY/TDD: 711)

Amharic
ይህንን ሰነድ ለመረዳት በአማራጭ ቋንቋ እርዳታ ማግኘት ከፈለጉ፣ የአባል አገልግለቶች ቁጥርን (855-711-8949) በመደወል ያለምንም ክፍያ ማግኘት ይችላሉ። (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-711-8949). (TTY/TDD: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-711-8949)請求免費協助。(TTY/TDD: 711)

Farsi
در صورتی که برای درک این سند به زبانی دیگر نیازمند کمک هستید، می‌توانید بدون هیچ هزینه اضافی این را درخواست کنید. برای این کار با مرکز خدمات اعضاء به شماره (855-711-8949) تماس بگیرید. (TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-711-8949. (TTY/TDD: 711)

German
Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (855-711-8949). (TTY/TDD: 711)

Ilokano
Nu kasapulam ti tulong tapno maawatan daytoy a dokumento iti alternatibo a lengguahe, mabalinmo a kiddawen daytoy nga awanan ti kanayunan a gastos babaen ti panagawag ti numero ti Serbisyo para ti Kameng (855-711-8949). (TTY/TDD: 711)

Japanese
この書面を他の言語で理解するための支援が必要な場合には、メンバーサービス番号（855-711-8949）に電話して支援を求めることができます。追加費用はかかりません。(TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-711-8949)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-711-8949). (TTY/TDD: 711)

Samoan
Afai e te manaomia se feesoasoani e malamalama lenei tusi i seisi gagana, e mafai ona e talosagaina e aunoa ma se totogi e ala i le vili le numera mo Sauniuniga mo lou Vaega (855-711-8949). (TTY/TDD: 711)

Tagalog
Kung kailangan ninyo ng tulong upang maunawaan ang dokumentong ito sa ibang wika, maaari ninyo itong hilingin nang walang karagdagang bayad sa pamamagitan ng pagtawag sa Member Services sa numerong (855-711-8949). (TTY/TDD: 711)

Thai
หากท่านต้องการความช่วยเหลือเพื่อทำความเข้าใจเกี่ยวกับเอกสารนี้ในภาษาอื่น ท่านอาจขอรับบริการได้โดยไม่เสียค่าใช้จ่ายเพิ่มเติมใดๆ โดยโทรไปที่หมายเลขฝ่ายบริการสมาชิก (855-711-8949) (TTY/TDD: 711)

Vietnamese
Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-711-8949). (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Information for Applications Requesting a Special Enrollment Period

Anthem BlueCross BlueShield

When applying to enroll for coverage during a Special Enrollment Period, an applicant must be eligible to enroll and provide supporting documentation of a qualifying event. Without this documentation the applicant may not be able to enroll.

Please review the list below which outlines examples of what may be used as supporting documentation. Be sure to send in a copy of the documentation supporting the qualifying event when the completed application is submitted or upload a copy of the documentation when submitting an online application.

For paper applications, please submit legible copies of everything and keep all original documents for your personal records, because no documentation will be returned. Please write the applicant's name on the top of each page of the supporting documentation.

After reviewing the information provided, we may request additional documentation to confirm eligibility. Please note that loss of health coverage due to fraud, intentional misrepresentation of a material fact or failure to pay a premium do not constitute qualifying events.

Supporting documentation by type of qualifying event
OFF Exchange for all SEP applicants for Anthem Blue Cross and Blue Shield plans in CT, IN, KY, ME, MO, NH, NV, OH or WI

Qualifying event	Description and examples of required supporting documentation
Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay a premium	**Loss of Minimum Essential Coverage due to change in employment status:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage, if available) confirming loss of coverage (date and individuals) and reason for loss of Minimum Essential Coverage (i.e., reduction in employment hours, etc.), **or** • Letter that provides notice of **offer** of COBRA or state continuation benefits. **Loss of Minimum Essential Coverage due to loss of dependent eligibility status:** **Due to death:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage, if available) confirming loss of coverage (date and individuals), and • Copy of death certificate or obituary **Due to Medicare eligibility:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage, if available) confirming loss of coverage (date and individuals), and • Copy of Medicare card or approval letter from Social Security **Due to an over-age dependent:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage, if available) confirming loss of coverage (date and individuals) **Due to legal separation, divorce, dissolution of Domestic Partnership:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card, Certificate of Creditable Coverage, if available) confirming loss of coverage (date and individuals), and • Divorce decree, legal separation agreement, or notarized/legal termination of domestic partnership **Loss of Minimum Essential Coverage due to exhaustion of COBRA or state continuation benefits:** • Letter that provides notice of termination of COBRA or state continuation benefits.

Qualifying event	Description and examples of required supporting documentation
Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay a premium	**Loss of Minimum Essential Coverage due to (permanent) move to new service area:** *Note: Applicant must have had Minimum Essential Coverage for one or more days in the 60 days prior to the permanent move, unless he or she is moving from a foreign county or a United States territory (See below).* • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming loss of coverage (date and individuals) **and** • Documentation of applicant's old address and new address (if not present on employer letter or previous carrier documentation) which may be validated by any of the following: — Recent utility bill (electric, water, phone, internet, cable) — Signed residential lease, rental agreement/contract, mortgage or nursing home/assisted living facility residency documentation — A deed showing applicant ownership of property in the new service area — New driver's license with new address in the service area — Receipt of property tax paid — Insurance documents, such as homeowner's, renter's, or life insurance policy or statement — Mail from the Department of Motor Vehicles, such as a driver's license, vehicle registration, or change of address card — State ID — Official school documents, including school enrollment, report cards, or housing documentation — Mail from a government agency to your address, such as a Social Security statement, or a notice from TANF or SNAP agency — Mail from a financial institution, such as a bank statement — U.S. Postal Service change of address confirmation letter — Pay stub showing address — Voter registration card showing name and address — Moving company contract or receipt showing address — Document from the Department of Corrections, jail, or prison indicating recent release or parole, including an order of parole, order of release, or an address certification — If you are homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify your residency. This person must prove their own residency by including one of the documents listed above. — If you are living in the home of another person, like a family member, friend, or roommate, a letter/statement from that person stating you are living with them. This person must prove their own residency by including one of the documents listed above. — Letter from a local non-profit social services provider, certified application counselor, navigator or federally qualified health center that can verify your address. If you are homeless, you can provide a letter from a government entity or not-for-profit organization, including shelters, verifying your address. — Consumers living in rural areas may provide a rural route mail delivery address. The supporting documentation needs to include the name of the applicant along with the residential address listed on the application (the new address), and documentation of the previous address, which should include the applicant's name and the residential address before the move. For **child only applications**, the name of the parent/guardian in the signature section of the application must match the name on the supporting documentation.

Qualifying event	Description and examples of required supporting documentation
Legal guardianship or court order	Legal documentation of guardianship that indicates the subscriber or the subscriber's spouse is a guardian of the applicant or court order that indicates the subscriber is required to cover the applicant. For KY only: May apply when application filed with the court for guardianship. Contact us if you are applying for a child only policy.
Gain or become a dependent through birth or adoption/ placement for adoption	**Birth:** Birth certificate **or** medical records from hospital or pediatrician which indicate the names of the parents, the name of the baby, and date of birth. *NOTE: For current Anthem members, a mother's delivery claim may be considered as proof.* **Adoption/placement for adoption:** Adoption certificate or document establishing placement of a child with applicant for adoption.
Gain a dependent through marriage or domestic partnership	Certificate of marriage, domestic partnership
Applicants moving to the U.S. from a foreign country or U.S. territory	∘ Documentation of the move (including date of move) which may be validated by a passport or VISA, **and** ∘ Documentation of the new address which may be validated by any of the following: — Recent utility bill (electric, water, phone, internet, cable) — Signed residential lease, rental agreement/contract, mortgage — A deed showing applicant ownership of property in the new service area — New driver's license with new address in the service area — Receipt of property tax paid — Insurance documents, such as homeowner's, renter's, or life insurance policy or statement — Mail from the Department of Motor Vehicles, such as a driver's license or vehicle registration — State ID — Official school documents, including school enrollment, report cards, or housing documentation — Mail from a government agency to your address, such as a Social Security statement, or a notice from TANF or SNAP agency — Mail from a financial institution, such as a bank statement — Pay stub showing address — Voter registration card showing name and address — Moving company contract or receipt showing address — If you are homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify your residency. This person must prove their own residency by including one of the documents listed above. — If you are living in the home of another person, like a family member, friend, or roommate, a letter/statement from that person stating you are living with them. This person must prove their own residency by including one of the documents listed above. — Letter from a local non-profit social services provider, certified application counselor, navigator or federally qualified health center that can verify your address. If you are homeless, you can provide a letter from a government entity or not-for-profit organization, including shelters, verifying your address. — Consumers living in rural areas may provide a rural route mail delivery address.
Release from incarceration	Papers from local, state or federal department of corrections or prisons showing the applicant's date of legal discharge.

Qualifying event	Description and examples of required supporting documentation
Child declined for Medicaid coverage	Documentation showing that the application for Medicaid coverage occurred during the annual open enrollment period and copy of Medicaid decline letter dated within 60 days.
An individual, who was not previously a citizen, a national, or a lawfully present individual, gains such status	Change in status validated by any of the following: • Valid U.S. passport or passport card. • Valid I-551, permanent resident card (issued by the Department of Homeland Security/ U.S. citizenship and immigration services). Non-expiring I-551 (issued 1977-1989) cards are acceptable. • U.S. Certificate of Naturalization (federal form N-550). • Certificate of U.S. Citizenship (federal form N-560). • Employment Authorization Document. • Unexpired foreign passport with a valid unexpired U.S. visa affixed accompanied by the approved I-94 form documenting the applicants most recent admittance into the U.S.
Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events	An official form such as a letter or other supporting documentation from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected.

If you have further questions about qualifying events or the supporting documentation that is required, please call your agent or the number the number listed for your state below:

CT 1-855-837-8537
IN 1-855-330-1093
KY 1-855-330-1095
ME 1-855-330-1097
MO 1-855-330-1099
NH 1-855-330-1102
NV 1-855-330-1217
OH 1-855-330-1106
WI 1-855-330-1215