

### Application Instructions for Anthem Blue Cross and Blue Shield

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Jamie Stein, HealthNH.com for review along with the completed application. If you do not have access to a fax machine, send the completed application to Jamie Stein, HealthNH.com along with the required first month's payment.

### HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Make youngest spouse applicant for lowest price.
- Sign and date the application.

### IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Mail completed applications to:

**Jamie Stein, HealthNH.com**  
**Attn: New Enrollment**  
**379 Amherst Street**  
**Suite 340**  
**Nashua, NH 03063**

Jamie Stein, HealthNH.com will review your application for completeness and accuracy before we submit it to Anthem Blue Cross and Blue Shield for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at (603) 791-4585 or e-mail us at [jamie@healthNH.com](mailto:jamie@healthNH.com).



**FAX COVER LETTER**

(Please ignore this form if you do not have access to a fax machine.)

**\*\*Please FAX this cover letter with the completed application to:**

**Jamie Stein, HealthNH.com**

**FAX# 1-866-730-4025**

Dear Jamie Stein, HealthNH.com,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name \_\_\_\_\_

E-mail \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Please contact me at this phone number \_\_\_\_\_ after you have reviewed my application for completeness and accuracy.

I will contact Jamie Stein, HealthNH.com at (603) 791-4585 to verify receipt of my application.

**\*\*I understand that Jamie Stein, HealthNH.com will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original, signed application and premium payment must still be mailed to Jamie Stein, HealthNH.com. :

**Jamie Stein, HealthNH.com  
Attn: New Enrollment  
379 Amherst Street  
Suite 340  
Nashua, NH 03063**

I will send the original, signed application and premium payment, as soon as I have been contacted by Jamie Stein, HealthNH.com with confirmation that my application has been received by fax and reviewed for completeness.



# Anthem Individual Enrollment/Change Application

3000 Goffs Falls Road  
Manchester, NH 03111-0001  
www.anthem.com

New Enrollment : 1-800-382-4832  
Current Members : 1-800-225-2666

To Be Completed By Producer	
Producer Name	Jamie Stein
Vendor Code #	N1875
Producer Signature	
Producer Phone #	603 791-4585
For Office Use Only	
Effective Date	
Firm Division No.	
U/W Rate Decision	

## Remember to Complete All Sections of this Application

PLEASE USE BLACK OR BLUE INK ONLY

<b>1. Applicant Information</b>	Please check appropriate item: <input type="checkbox"/> New Enrollment <input type="checkbox"/> Change <input type="checkbox"/> Add/Remove Dependent
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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 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.**

NAME (LAST/FIRST/MIDDLE INITIAL)		HOME ADDRESS (NUMBER AND STREET)	
<input type="checkbox"/> Male <input type="checkbox"/> Female	DATE OF BIRTH MO. DAY YR.	SOCIAL SECURITY NUMBER	CITY/STATE/ZIP CODE
TELEPHONE NUMBERS HOME: WORK:		BILLING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)	
EMAIL ADDRESS		CITY/STATE/ZIP CODE	

<b>2. Membership Choice</b>	CHOOSE ONE MEMBERSHIP TYPE: <input type="checkbox"/> SINGLE <input type="checkbox"/> TWO PERSON <input type="checkbox"/> FAMILY <input type="checkbox"/> PARENT/CHILD(REN)
NOTE: FOR DOMESTIC PARTNERS INCLUDE "STATEMENT OF DOMESTIC PARTNERSHIP"	

**3. Plan Choice** (Please select one deductible option. The Two Person/Family Deductibles are greater than the Individual Deductible. Blue Direct deductibles are for in-network. There are additional deductibles for out-of-network.)

<b>Blue Direct (PPO)</b> <input type="checkbox"/> Blue Direct \$1,000/3,000 <input type="checkbox"/> Blue Direct \$2,000/6,000 <input type="checkbox"/> Blue Direct \$5,000/15,000	<b>OR</b>	<b>Anthem Lumenos Health Savings Account (H.S.A.)</b> <input type="checkbox"/> \$1,250/\$2,500 deductible (100% In network) <input type="checkbox"/> \$2,500/\$5,000 deductible (100% In network) <input type="checkbox"/> \$2,500/\$5,000 deductible (80% In network) <input type="checkbox"/> \$5,000/\$10,000 deductible (100% In network)	<b>Anthem Consumer-Driven Plan</b> <i>For Health Savings Accounts, complete the following:</i> <input type="checkbox"/> Yes, I would like to establish an H.S.A. with Anthem's banking partner. SSN required see Section 1. <input type="checkbox"/> No, I do not want to establish an H.S.A. with Anthem's banking partner.	<b>Anthem Lumenos Health Incentive Account Plus (H.I.A.)</b> <input type="checkbox"/> \$2,500/\$5,000 deductible (80% In network) <b>\$200/\$400 Funding (Individual/Family)</b> <b>Anthem Lumenos Health Incentive Account (H.I.A.)</b> <input type="checkbox"/> \$1,500/\$3,000 deductible (80% In network) <input type="checkbox"/> \$2,500/\$5,000 deductible (80% In network)
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Would you like to add Maternity Coverage?  Yes  No

<b>4. Dependent Information</b>		Add	Delete	Social Security Number	Sex	Date of Birth (mm/dd/yy)	Relationship to Applicant	BELOW PLEASE INDICATE NAME OF ACCREDITED SCHOOL FOR FULL TIME STUDENTS (AGE 19-23)	
NAME (LAST/FIRST/MIDDLE INITIAL)					<input type="checkbox"/> M <input type="checkbox"/> F				
Spouse									
<b>NOTE: IF ELECTING DEPENDENT COVERAGE, PLEASE LIST ALL ELIGIBLE CHILDREN.</b> You must complete a Certification for a Mentally or Physically Incapacitated Dependent Child form if your child is disabled, incapable of self-support, and over the age of 19. The form must also be completed by your physician.									
Dependent 1					<input type="checkbox"/> M <input type="checkbox"/> F				
Dependent 2					<input type="checkbox"/> M <input type="checkbox"/> F				
Dependent 3					<input type="checkbox"/> M <input type="checkbox"/> F				

## 5. Prior and Other Insurance Information — Please answer ALL of the following questions.

(1) Anthem Blue Cross and Blue Shield (Anthem) credits prior coverage toward the preexisting period of applicants who apply within 63 days after termination of qualifying prior coverage as required by law. In order to ensure that appropriate credit toward the preexisting period is obtained, please complete the following:

(a) Have you had coverage within 63 days of the date of application?  Yes  No  
If yes, Name and address of Insurer \_\_\_\_\_  
Policy Number \_\_\_\_\_ Name of insured \_\_\_\_\_ Date of Birth \_\_\_\_\_  Single  Two Person  Family

(b) Will medical coverage you are now electing replace another health insurance?  Yes  No  
If yes, Name and address of Insurer \_\_\_\_\_  
Group No. \_\_\_\_\_ Effective Date of Policy \_\_\_\_\_ End Date of Policy \_\_\_\_\_

(2) Are you or any of your dependents eligible for Medicare or Medicaid?  Yes  No

(3) (a) Are you or any family member on this application eligible for Anthem group coverage?  Yes  No  
(b) If yes, does employer contribute towards premium of dependent coverage?  Yes  No

**Please note: If you currently have coverage, do not cancel prior to your acceptance into our plan.**

<b>6. Billing Choice (Please Check One)</b>	<input type="checkbox"/> Quarterly Paper Bill <input type="checkbox"/> Electronic Fund Transfer - complete section 7 and attach a voided check or savings account deposit slip. <input type="checkbox"/> Monthly Paper Bill
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**7. Electronic Fund Transfer Authorization (EFT)** (Complete if you want your payments deducted directly from your checking or savings account.)

I hereby authorize Anthem to initiate a withdrawal (on or about the 5th 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 savings account deposit slip)

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

**8. Statement Of Preferred / Standard Rate Acknowledgement**

If preferred rates are not applicable but all eligibility requirements are met, Anthem will offer me, or any member to be covered under this policy a standard rate. If a standard rate is determined by underwriting, or if one or more of the individuals listed on my application do not meet the basic eligibility criteria, please indicate below how you would like us to proceed.

Please continue with the enrollment process, subject to rate classification and eligible applicants. I understand that a lower rate may be available from the state's high-risk pool. If a lower rate is available, my producer or a representative from Anthem will contact me to discuss my options. Upon acceptance of the standard rate, I understand that I will receive a premium invoice from Anthem for the additional amount due.

If Anthem's standard rate is lower than the state's high-risk pool, I authorize Anthem to proceed with my enrollment and forward my membership materials to me.

Before continuing the enrollment process, please contact me either through my producer or directly for authorization to continue at the standard rate.

Do not continue the enrollment process at the standard rate.

**9. Statement Of Premium Payment Acknowledgement**

I understand that coverage most often becomes effective for eligible members on the first day of the month after submission of enrollment forms, provided that the Enrollment and Change Form and Health Statement form are completed accurately and in full, signed, dated and received by Anthem by the last day of the month prior to the effective date (unless the applicant requests a future effective date).

I understand that the submission of my enrollment forms are not a guarantee of coverage. Anthem will make the final determination about eligibility and rate classification by reviewing the information I submit.

Anthem may request further information about eligibility. If Anthem determines that I am not eligible for membership, I will be notified of the finding, coverage will not become effective.

If Anthem requests further information about eligibility and/or health status, my effective date of coverage may be delayed until Anthem receives all of the information requested. I will be notified of the effective date and any changes in premium offerings that may have occurred during the period of delay. If I do not respond to Anthem's request for further information within 24 days, coverage will not become effective.

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE**

*(Only applies if this is a replacement policy)*

According to the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Anthem. For your own information and protection, certain facts should be pointed out to you, which could affect your rights to coverage under the new policy.

- (a) Health conditions which you may presently have, (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in a claim for benefits being denied or reduced under the new policy, whereas the same claim might have been payable under your present policy. Or, even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
- (b) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (c) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
- (d) Finally, before you terminate your present policy, be certain that your application for the new policy has been accepted by the replacing company.

**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.**

I hereby authorize Anthem to institute the action indicated above. I understand that my Health Statement form is part of this application. To the best of my knowledge and belief, all of the information I provide is accurate and true. I will submit documentation of such to Anthem upon request. I understand that any significant misrepresentation or omission may cause Anthem to terminate or void my coverage, in accordance with New Hampshire law.

<b>10. Applicant's Signature</b> (If applicant is under 18, parent or guardian signature required.) _____	Date / /
<b>Spouse's Signature</b> _____	Date / /



Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of New Hampshire, Inc.  
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## NEW HAMPSHIRE INDIVIDUAL MARKETS HEALTH STATEMENT

### APPLICANT AND FAMILY INFORMATION

**PLEASE USE BLACK OR BLUE INK ONLY**

**PART A**

**COMPLETE FOR ALL FAMILY MEMBERS APPLYING FOR COVERAGE:**

FIRST NAME	INITIAL	LAST NAME	HEIGHT	WEIGHT	DATE OF BIRTH	SEX M/F
			APPLICANT	/	/ /	
			SPOUSE	/	/ /	
			/		/ /	
			/		/ /	
			/		/ /	
			/		/ /	

**PART B**

HAS ANYONE HAD HEALTH OR LIFE INSURANCE MODIFIED, POSTPONED OR RATED? YES  NO   
 IF YES, PLEASE SUBMIT DETAILS \_\_\_\_\_

**PART C**

- Are you or any person to be insured – YES  NO
1. currently disabled or unable to perform their normal activities?
  2. been hospitalized, had surgery or been advised to have surgery within the past five years for any reason?
  3. currently pregnant or an expectant parent?
  4. currently taking any medication? If yes, please specify medication and condition for which it is used: \_\_\_\_\_
  5. have any conditions or symptoms for which a physician or other medical care provider has not been consulted?
  6. had medical expenses in excess of \$5,000 in the last 12 months?
  7. been convicted of driving under the influence of drugs or alcohol within the last 36 months?
  8. smoked or used tobacco products in the last 12 months?

**PART D**

- Have you or any person 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**) YES  NO
1. 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?
  2. Cancer, tumor or lymph node enlargement? (Indicate type of cancer and location \_\_\_\_\_)
  3. Sexually transmitted disease?
  4. Mental, emotional, behavioral or nervous condition or disorder of any kind?
  5. Brain disorder, neurologic problems, seizure disorder, any disorder of the central nervous system, stroke or paralysis?
  6. Alcohol or drug use, abuse and/or dependency?
  7. Medical diagnosis of AIDS (Acquired Immuno Deficiency Syndrome) or ARC (AIDS Related Complex)?
  8. Any disorder of the male/female reproductive organs including infertility and complications of pregnancy?
  9. Back, neck, bone, joint problems, Lupus, arthritis or autoimmune disorder?
  10. Diabetes? If so, specify date of diagnosis, type of treatment, amount of medications (if any): \_\_\_\_\_
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11. Any disorder of the stomach, intestines, gallbladder or esophagus?
  12. Any disorder of the lungs or respiratory system or Tuberculosis?
  13. Any disorder of the kidneys, bladder or urinary tract?
  14. Any disorder of the liver or pancreas?
  15. Any disorder of the endocrine system or glands?

