Anthem

BLUE SHORT TERM℠

The affordable coverage you need. Just when you need it most.

PMO-208 Rev. 4/12

Anthem Blue Cross and Blue Shield: Making health care coverage easier.

At Anthem Blue Cross and Blue Shield, we're doing everything we can to make all kinds of health care coverage available to all kinds of people.

A broad range of reliable and affordable products is what you'd expect from Anthem Blue Cross and Blue Shield, a company that has been providing health care coverage and security to Missouri for over 70 years.

Day in and day out, our most important goal is treating you the way you deserve to be treated. Fairly.

We look forward to making your experience with us pleasant and rewarding.

Who needs Short Term coverage?

Recent college graduates, people between jobs, dependents, early retirees – anyone who needs temporary protection until they secure more permanent coverage. The Blue Short Term℠ plan is designed to protect you for one to six months.

No matter how healthy you are or how well you take care of yourself, unexpected health issues can arise. You don't want to get caught without health care coverage. It's just not worth the risk.

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What's Covered?

Blue Short Term offers the same level of reliable health care coverage you'd expect from the company that's been protecting people for more than 70 years.

Covered Services:

- Office visits
- Prescription drugs – up to $500
- Diagnostic services (lab and x-ray)
- Inpatient hospital and outpatient services
- Emergency room and urgent care
- Ambulance
- Home health care – up to 40 visits
- Hospice
- Human organ and tissue transplant
- Durable medical equipment - up to $2,000
- Mammograms
- Lead poison testing

Once your deductible has been reached, Blue Short Term pays 80% of covered services. You pay the remaining 20% until your total out-of-pocket expense for covered services is met. Once that limit is reached, the plan pays 100% for most covered services, up to the $2 million maximum.

Outline of Benefits

Deductible	$250 individual/$750 family $500 individual/$1,500 family $1,000 individual/$3,000 family $2,500 individual/$7,500 family $5,000 individual/$15,000 family
Out-of-Pocket Limit (including deductible)	$5,250 individual/$10,500 family $5,500 individual/$11,000 family $6,000 individual/$12,000 family $7,500 individual/$15,000 family $10,000 individual/$20,000 family
Covered Services Coinsurance	20%
Physician Office Visits	20%
Prescription Drugs	20%[1] after a separate $250 drug deductible
Plan Lifetime Maximum	$2,000,000
Benefit Period	30 to 180 days

[1]Drug coinsurance does not go towards out-of-pocket limit. $500 drug maximum per member per benefit period.

Design the plan to fit your time frame and budget.

With Blue Short Term, you get choices. Decide for yourself what fits your needs. When do you want your coverage to start? How long will you need coverage – 30, 78 days? Select the deductible that's right for you, from as low as $250 all the way up to $5,000. And with that choice, you can influence what your coverage will cost.

You even have a choice of payment options.

- Make your entire payment in advance by check or credit card.
- For a $10 monthly administration fee, you can pay monthly in two different ways:
  - Pay the first month in advance by check/credit card, then be billed monthly and pay by check.
  - Pay the first month in advance by check, and allow monthly deductions from your bank account.

Right to re-apply:

If you need additional temporary coverage when the Benefit Period ends, you may purchase coverage under another short term contract if you are still able to answer "NO" to the qualifying questions on the application for coverage. The appropriate Premium must be submitted and a new application must be completed and approved, before coverage is effective. After the second Individual Blue Short Term Contract expires, at least six months must elapse before you can purchase another short term Plan. Any condition that occurred during an earlier Benefit Period will be treated as a Pre-Existing Condition under subsequent Contracts.

Stretch your health care dollars.

With Blue Short Term, you can go to any doctor, specialist or hospital of your choice. Of course, this freedom comes with responsibility. If you seek care from a non-network provider, you may be responsible for submitting your own claims. And your share of costs may be higher. However, providers who are contracted with us will normally submit claims on your behalf.

To find your doctor or local hospital, go to Anthem.com and click on “Find a Doctor.”

Save on your prescription medications.

When your doctor prescribes medications from our formulary-the technical name for the comprehensive list of prescription medications we cover-you save money.

And now — some really important legal information you should take the time to read.

Who can apply.

Family health coverage includes you, your spouse or domestic partner and any dependent children. You must be under the age of 65, reside in the Missouri service area, be a legal resident of the U.S. and not currently pregnant. Children are covered to the end of the month in which they turn 25.

What's a preexisting condition?

Preexisting conditions are not covered under this plan. A preexisting condition is any condition that was diagnosed, treated or produced symptoms within the 24 months right before you enrolled that would have caused an ordinarily prudent person to seek medical diagnosis or treatment.

What we do not cover.

Blue Short Term plans don't provide benefits for services, supplies or charges having to do with preexisting conditions (see "What's a preexisting condition?"); preventive care (except mammograms and lead poison testing); physical therapy; occupational therapy; spinal manipulations; mental health services; substance abuse; private duty nursing; experimental or investigative treatment; dental and vision, except as spelled out in your contract; charges greater than the maximum allowable amount (charges exceeding the amount Anthem recognizes for services); care provided by a member of your family; treatment that's primarily intended to improve

your appearance; weight loss programs or treatment of obesity; hearing aids; eyeglasses or contact lenses; radial keratotomy or keratomileusis or excimer laser photo; artificial insemination, fertilization, infertility drugs or sterilization reversal; sex transformation surgery; custodial care; artificial and mechanical hearts; workers' compensation; maternity care (except for complications of pregnancy); and services we determine aren't medically necessary. These are some of the exclusions contained in the plans. Check your contract or certificate of coverage for a complete listing of benefits, exclusions and maximum payment levels.

Our appeal rights and confidentiality policy.

If we deny a claim or request for benefits completely or partially, we will notify you in writing. The notice will explain why we denied the claim/request and describe the appeals process. You can appeal decisions that deny or reduce benefits. We encourage you to file appeals right away when you first get an initial decision from us, but we require that you file within six months of getting one. You should send additional information that supports your appeal and state all the reasons why you feel the appeal request should be granted. We will review your appeal and let you know our decision in writing within 30 days of receiving your first appeal. If you remain dissatisfied with the response to the first review, you may submit any additional information, including written comments, records or documents that you want us to consider in a second level appeal.

If you are denied coverage based on medical necessity or experimental/investigative exclusions, you can request that a board-eligible or board-certified specialist review your appeal. If we deny coverage for reasons other than medical necessity or experimental/investigative reasons, you can also appeal.

Please call customer service or check your contract or certificate for more information on our internal appeal and external review processes.

Unless our notice of decision includes a different address, send requests for a review of appeal to:

Anthem Grievance Unit
P.O. Box 105568
Atlanta, GA 30348-5568

If we uphold our decision throughout the appeals process, you at any time can request a review by the Missouri Department of Insurance. In addition to the appeals processes we just described, Anthem has adopted a confidentiality policy in Missouri. This policy includes guidelines regarding the protection of confidential member information and a member's right to access and change information in Anthem's possession. The policy clearly points out when a member needs to sign a release before Anthem can disclose information to a member's provider, spouse or domestic partner or other family members.

We want you to be satisfied.

If you aren't satisfied with your Blue Short Term coverage, you can cancel it within 10 days after you receive your contract or certificate of coverage or have access to it online, whichever is earlier. If you haven't submitted any claims, you'll get a full refund of the premium you paid when coverage is cancelled within the first 10 days. You can view your contract or certificate of coverage online or receive a paper copy of it upon request as outlined in your initial membership letter.

This Blue Short Term Brochure is intended to be a brief outline of coverage and is not intended to be a legal contract. The entire provisions of benefits and exclusions are contained in the contract or certificate of coverage. In the event of a conflict between the contract or certificate of coverage and this Blue Short Term Brochure, the terms of the contract or certificate of coverage will prevail.

Short Term Rates*

AGE		$250 Deductible 20% Coinsurance		$500 Deductible 20% Coinsurance		$1,000 Deductible 20% Coinsurance		$2,500 Deductible 20% Coinsurance		$5,000 Deductible 20% Coinsurance	
		30 DAYS	DAILY RATE	30 DAYS	DAILY RATE	30 DAYS	DAILY RATE	30 DAYS	DAILY RATE	30 DAYS	DAILY RATE
<18	Male	$ 103.16	$ 3.44	$ 85.90	$ 2.87	$ 66.56	$ 2.22	$ 50.52	$ 1.69	$ 42.46	$ 1.42
	Female	$ 134.38	$ 4.48	$ 111.89	$ 3.73	$ 86.70	$ 2.89	$ 65.80	$ 2.20	$ 55.31	$ 1.85
19-29	Male	$ 108.30	$ 3.61	$ 90.18	$ 3.01	$ 69.87	$ 2.33	$ 53.03	$ 1.77	$ 44.58	$ 1.49
	Female	$ 141.04	$ 4.71	$ 117.44	$ 3.92	$ 90.99	$ 3.04	$ 69.07	$ 2.31	$ 58.05	$ 1.94
30-34	Male	$ 128.10	$ 4.27	$ 106.66	$ 3.56	$ 82.64	$ 2.76	$ 62.73	$ 2.10	$ 52.73	$ 1.76
	Female	$ 172.45	$ 5.75	$ 143.59	$ 4.79	$ 111.26	$ 3.71	$ 84.44	$ 2.82	$ 70.98	$ 2.37
35-39	Male	$ 153.99	$ 5.14	$ 128.21	$ 4.28	$ 99.35	$ 3.32	$ 75.40	$ 2.52	$ 63.38	$ 2.12
	Female	$ 200.62	$ 6.69	$ 167.04	$ 5.57	$ 129.43	$ 4.32	$ 98.24	$ 3.28	$ 82.58	$ 2.76
40-44	Male	$ 177.40	$ 5.92	$ 147.71	$ 4.93	$ 114.45	$ 3.82	$ 86.87	$ 2.90	$ 73.02	$ 2.44
	Female	$ 221.18	$ 7.38	$ 184.16	$ 6.14	$ 142.69	$ 4.76	$ 108.30	$ 3.61	$ 91.04	$ 3.04
45-49	Male	$ 218.70	$ 7.29	$ 182.10	$ 6.07	$ 141.10	$ 4.71	$ 107.09	$ 3.57	$ 90.02	$ 3.01
	Female	$ 255.06	$ 8.51	$ 212.37	$ 7.08	$ 164.55	$ 5.49	$ 124.89	$ 4.17	$ 104.98	$ 3.50
50-54	Male	$ 279.61	$ 9.33	$ 232.82	$ 7.77	$ 180.39	$ 6.02	$ 136.92	$ 4.57	$ 115.09	$ 3.84
	Female	$ 300.17	$ 10.01	$ 249.93	$ 8.34	$ 193.66	$ 6.46	$ 146.98	$ 4.90	$ 123.55	$ 4.12
55-59	Male	$ 374.40	$ 12.48	$ 311.74	$ 10.40	$ 241.55	$ 8.06	$ 183.33	$ 6.12	$ 154.11	$ 5.14
	Female	$ 367.17	$ 12.24	$ 305.72	$ 10.20	$ 236.88	$ 7.90	$ 179.79	$ 6.00	$ 151.13	$ 5.04
60-64	Male	$ 536.95	$ 17.90	$ 447.09	$ 14.91	$ 346.42	$ 11.55	$ 262.93	$ 8.77	$ 221.02	$ 7.37
	Female	$ 481.56	$ 16.06	$ 400.97	$ 13.37	$ 310.68	$ 10.36	$ 235.81	$ 7.87	$ 198.22	$ 6.61
1 Dependent Child		$ 88.89	$ 2.97	$ 74.01	$ 2.47	$ 57.35	$ 1.92	$ 43.53	$ 1.46	$ 36.59	$ 1.22
2 Dependent Children		$ 177.78	$ 5.93	$ 148.02	$ 4.94	$ 114.70	$ 3.83	$ 87.06	$ 2.91	$ 73.18	$ 2.44
3+ Dependent Children		$ 266.67	$ 8.89	$ 222.03	$ 7.41	$ 172.05	$ 5.74	$ 130.59	$ 4.36	$ 109.77	$ 3.66

Rates are effective April 1, 2012.

*Rates are for illustrative purposes only and subject to change. Some areas or age groups may have higher or lower rates. Actual rates are also based on underwriting classification. Refer to the plan for a complete list of coverage, conditions, restrictions, limitations and exclusions.

NOTE: If you need help with applying or obtaining a quote, please contact your agent.

Check the counties listed below. If your county is not included, you may need a brochure for a different area.

MISSOURI AREA FACTORS (SHORT TERM)

County	Area Factor
Audrain, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Maries, Miller, Moniteau, Montgomery, Morgan, Osage, Randolph	0.9738
Barton, Crawford, Jasper, Lawrence, Newton	0.9800
Adair, Clark, Franklin, Jefferson, Knox, Lewis, Lincoln, Linn, Macon, Marion, McDonald, Monroe, Pike, Putnam, Ralls, St. Charles, St. Louis City, St. Louis County, Schuyler, Scotland, Shelby, Sullivan, Warren, Wayne	1.0000
Barry, Cedar, Christian, Dade, Dallas, Dent, Douglas, Hickory, Howell, Laclede, Ozark, Phelps, Polk, Pulaski, Stone, Taney, Texas, Webster, Wright	1.0100
Bollinger, Butler, Cape Girardeau, Carter, Dunklin, Greene, Iron, Madison, Mississippi, New Madrid, Oregon, Pemiscot, Perry, Reynolds, Ripley, St. Francois, Ste. Genevieve, Scott, Shannon, Stoddard, Washington	1.0200

PREMIUM WORKSHEET

Use the premium worksheet to determine your total premium. For questions regarding premium calculation, contact your agent.

1. Applicant's Base Premium for the first 30 days (the amount corresponding to your age, sex, and deductible from the short term rate table)	$
2. Daily rate for primary person times the additional days coverage desired beyond the first 30 day minimum.	$
3. Spouse/Domestic Partner's Base Premium, if to be covered, (the amount corresponding to your spouse/domestic partners's age, sex, and deductible from the short term rate table)	$
4. Daily rate for Spouse/Domestic Partner, if to be covered, times the additional days coverage desired beyond the first 30 day minimum.	$
5. Child(ren)'s Base Premium if to be covered, (the amount corresponding to your number of children to be covered and deductible from the short term table)	$
6. Daily rate for Child(ren), if to be covered, times the additional days coverage desired beyond the first 30 day minimum.	$
7. Subtotal (add lines 1 through 6)	$
8. Area Factor (enter the area factor that corresponds with your county from the table on previous page)	$
9. Total Monthly Premium Due with Application (multiply line 7 by line 8)*	$

For child(ren) only policies: Use the adult premium corresponding to the child's gender and deductible. Then use the Dependent Children premium table for each additional child.

*Rates are for illustrative purposes only and subject to change. Some areas or age groups may have higher or lower rates. Actual rates are also based on underwriting classification. Refer to the plan for a complete list of coverage, conditions, restrictions, limitations and exclusions.

In Missouri (excluding 30 counties in the Kansas City area): Anthem Blue Cross and Blue Shield is the trade name for RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association.
® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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Missouri Blue Short Term℠ Individual Enrollment Application

Please print clearly in ink, or type.

Section A – Applicant Information

Last name of applicant	First name	Middle initial

Home address: Street	City	State	ZIP code

County	Home phone (include area code)	Social Security Number*

Date of birth	Age	Sex	Height (Ft./In.)	Weight (Lbs.)	Marital Status
/ /		☐ Male ☐ Female	/		☐ Single ☐ Married

Are all persons applying for coverage legal residents of the United States and residents of the state in which you are applying for coverage? **(If No, attach a copy of your green card or visa.)** ..... ☐ Yes ☐ No

Section B – Coverage Desired

Deductible level desired:
☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000

Type of coverage desired:
☐ Single ☐ Parent/Children ☐ Couple ☐ Family

Term (days):
_____ (30-180)

Effective date requested: If your application is approved, your coverage can start on any day of the month after the date we receive your application. The requested effective date is not a guarantee that the effective date will be the requested date in the event we agree to provide coverage.

Please choose the date you would like your coverage to start: _____/_____/_____ **MM/DD/YYYY**

During the term of this plan, will you or any dependent become eligible for Medicare, turn age 65, or will any dependent turn age 25 or no longer be eligible for coverage? (Dependents are eligible to the end of the calendar month in which they turn 25. When no longer eligible, dependents may apply for their own temporary coverage.) ..... ☐ Yes ☐ No

If Yes, who? _____

Section C – Dependent Information

Applicant information must be completed for all dependents (if any) for whom coverage is being requested. An eligible dependent may be your spouse, domestic partner, your unmarried children, or your spouse's or domestic partner's unmarried children (to the end of the calendar month in which they turn age 25).
(List all dependents beginning with the eldest.)

First name	Middle initial	Last name (if different from applicant)	Social Security Number*	Height Ft./In.	Weight Lbs.	Birthdate mm/dd/yyyy	Sex	Relationship to applicant
							M ☐ F ☐	
							M ☐ F ☐	
							M ☐ F ☐	
							M ☐ F ☐	

If there are additional dependents, please attach a separate page with all requested information.

**This information is used for internal purposes only and will not be disclosed.*

In Missouri (excluding 30 counties in the Kansas City area): Anthem Blue Cross and Blue Shield is the trade name for RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.
The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Section D – Other Coverage Information

Will this coverage replace a previous short-term or temporary plan? ☐ Yes ☐ No

If Yes, previous identification number: _____ **Policy expiration date:** _____

Do you or any person to be covered now have an active health coverage policy? ☐ Yes ☐ No

If Yes, expiration date (This coverage cannot be issued while any other coverage is in force.): _____

Are you currently applying for any other coverage with us? ☐ Yes ☐ No

Did you or your eligible dependents have creditable coverage within the past 63 days? ☐ Yes ☐ No

Section E – Health History Questions

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.

Is any applicant currently pregnant (includes positive pregnancy test within the last 30 days), an expectant father, or in the process of adoption or surrogate pregnancy? ☐ Yes ☐ No

If Yes, who? _____

Has any applicant been positively diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No

If Yes, provide the name of each person: _____

Has any applicant been advised by a healthcare provider to have testing, examination, evaluation, treatment, therapy, or surgery that has not yet been completed? ☐ Yes ☐ No

If Yes, who? _____

Specify condition(s): _____

Is any applicant a candidate for or recipient of an organ or bone marrow transplant? ☐ Yes ☐ No

If Yes, provide the name of each person: _____

Within the last 30 days, has any applicant been admitted to an inpatient hospital or surgical facility? ☐ Yes ☐ No

If Yes, who? _____

Specify condition(s): _____

Within the last 5 years, has any applicant been diagnosed with or received treatment for heart, lung, blood (e.g. Hemophilia, leukemia), blood vessel, kidney, liver, brain, nerve or immune system disorders, diabetes, cancer, stroke, heart attack, high blood pressure, ulcerative colitis, Crohn's Disease, or alcohol abuse or drug abuse? ☐ Yes ☐ No

If Yes, who? _____

Specify condition(s): _____

Section F – Significant Terms, Conditions and Authorizations (TERMS)

1. **I understand that it is mandatory that I notify Anthem, in writing, immediately if I (the applicant) or any other person for whom coverage is sought has a symptom of, has been advised of, or received medical treatment, advice, care or diagnosis for any illness, injury or condition after the date I sign this application but before my effective date or the date underwriting approves, whichever is later. I understand that in this situation, Anthem has the right to underwrite my application again, using the new information and that, as a result, my coverage/family members' coverage might be denied or delayed, or reformed or benefits denied due to the illness, injury or condition being treated as a preexisting condition.**
2. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
3. I understand that sending my initial premium with this application, and the receipt of my payment by Anthem, does not mean that coverage has been approved. I understand that if my application is denied, my bank account or credit card will not be charged.
4. If my request for coverage is being handled by a producer, I understand that the producer is not authorized to waive a complete answer to any question in the application, pass on insurability, make or alter any contract or waive any of Anthems' other rights or requirements.
5. I am applying for the coverage selected on this application.
6. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application and that no right whatsoever is created by this application.
7. I understand that any premium quote provided is preliminary and review of my application by medical underwriting may change the premium or result in a denial of coverage.
8. **I understand that preexisting conditions are not covered. A preexisting condition is any condition that was diagnosed or treated within 24 months prior to the effective date of coverage or produced symptoms within 24 months prior to the effective date of coverage that would have caused an ordinarily prudent person to seek medical diagnosis or treatment.**

Section F – Significant Terms, Conditions and Authorizations (TERMS) (continued)

9. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
10. I understand Anthem may convert my payments by check to an electronic Automated Clearinghouse (ACH) debit transaction. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction 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. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
11. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
12. I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
13. 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 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.
14. I authorize Anthem Blue Cross and Blue Shield, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield, to obtain any medical records or other health history information concerning me and any family member listed on my Application from any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefits plans, health insurers, medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations. I also authorize any physicians, hospitals, pharmacies, other health care providers, pharmacy benefits managers, health benefit plans, medical or pharmacy benefit administrators, Consumer Reporting Agencies, and/or insurance support organizations to furnish any medical records or health history information concerning me and any family member listed on my Application to Anthem Blue Cross and Blue Shield, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross and Blue Shield.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage.

I represent 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 material misrepresentation or omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

Any person who knowingly and with intent to defraud any insurance company, health maintenance organization, self-insured plan, or other person, files an application for insurance or a claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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.

Thank you for choosing Anthem Blue Cross and Blue Shield.

Signature of Applicant (for applicants age 18 or older) **X**	Date
Signature of Spouse or Domestic Partner (if to be covered) **X**	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) **X**	Date

Do not cancel your present health coverage until you receive written notification from Anthem Blue Cross and Blue Shield that your new coverage is in force.

Section G – Agent Certification

To be completed by your Anthem-appointed agent:

1. 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
2. **I certify to the best of my knowledge and belief, the responses herein are accurate.**

Agent's Signature **X**			Date	
Agent's Name (please print) null null		Agent Address/ Suite No. / Personal Mail Box (PMB) No.		
Agent ID No		City	State	Zip
Agent Phone No.	Agent Fax. No.	Agent Email Address		

IMPORTANT: No person, including an employee or agent of Anthem Blue Cross and Blue Shield, has the authority to change or omit any of the questions or statements on this application.

null null

Payment Methods for Individual Short Term Health Coverage
Missouri

Anthem Health. Join In.

Please complete in blue or black ink.

Applicant Name:	Primary Applicant's Social Security Number:

Monthly premium amount: $_____ Full premium amount: $_____

☐ **I want to avoid a monthly fee of $10 by paying the full premium now.**

PLEASE TELL US HOW YOU WILL PAY YOUR FULL PREMIUM:

☐ Credit/Debit Card (complete Section B)

☐ One-time Electronic Bank Payment (complete Section C)

☐ Check or Money Order attached (make payable to Anthem Blue Cross and Blue Shield)*

☐ **I understand the first month's premium is required with my application and I will be charged an additional $10 for each bill if I do not pay the full premium now.**

PLEASE TELL US HOW YOU WILL PAY YOUR FIRST PREMIUM:

☐ Automatic Bank Payment (complete Section A)
If you choose this option, you must also select the Automatic Bank Payment option for future premiums.

☐ Credit/Debit Card (complete Section B)

☐ One-time Electronic Bank Payment (complete Section C)

☐ Check or Money Order attached, including additional $10 fee (make payable to Anthem Blue Cross and Blue Shield)*

PLEASE TELL US HOW YOU WILL PAY YOUR FUTURE PREMIUMS:

☐ Automatic Bank Payment (complete Section A)

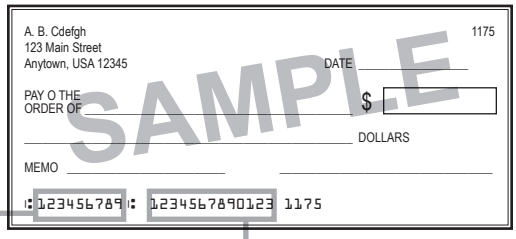
☐ Bill me for future premiums. (Bills will be sent to the address on your application unless a different address is listed below.)

Name _____ Address _____

City _____ State _____ ZIP _____

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

A. Automatic Bank Payment –
If you have selected this option for your initial payment, your bank account may be debited the applicable month's premium as soon as the day of approval. I hereby authorize Anthem to initiate a withdrawal the same day of the month as my assigned effective date from the bank account named below.



Provide your Bank Account Information here:

☐ Checking Account

☐ Savings Account **(account number will be different than that of checking account)**. Check with your financial institution to be sure automatic recurring deductions are allowed against this account.

Provide your Bank Account Information here:

9-Digit Bank Routing Number	Bank Account Number
|__|__|__|__|__|__|__|__|__|	

I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions (and corrections to premium deductions) from the bank account indicated and the designated financial institution to debit the same account. **I understand that the initial premium amount may vary as a result of change(s) during the underwriting process**. I understand that Anthem's rights with each premium deduction are the same as if I submit a check signed by me. This authorization is in effect until I provide Anthem thirty (30) days written notice that I no longer desire this service, and Anthem and the designated financial institution have the right to discontinue the premium deductions if they wish to do so. **I also understand that a service charge may be incurred for any withdrawal not honored.**

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

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

B. Credit/Debit Card – As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield to charge the credit/debit card indicated one time for the initial premium payment amount upon approval. I understand that if this option is selected, the credit/debit card indicated may be charged for the initial premium payment amount as early as the date of approval. **If the initial premium payment amount varies from the quote generated by the system or due to changes during the underwriting process, I also authorize Anthem to charge the credit/debit card indicated for the different amount.**

I agree that Anthem is fully protected in honoring any credit/debit card payments. I further agree that if any credit/debit card payment is dishonored, with or without cause, intentionally or inadvertently, Anthem is under no liability whatsoever, including any fees imposed by credit/debit card company or my bank, if my credit/debit card is rejected even though such dishonor results in termination of coverage. **We accept Visa and MasterCard.**

Type Of Card: ☐ Visa ☐ MasterCard

Card Number: |___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|

Expiration Date: |___|___|/|___|___|

Authorized Signature (as it appears on the credit/debit card) **X**	Cardholder Name (as it appears on the credit/debit card – Please PRINT)		Date
Cardholder Billing Address	City	State	ZIP

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

C. One-time Electronic Bank Payment – Please complete the information below.

Account Holder Name (Please PRINT)	9-Digit Bank Routing Number |___|___|___|___|___|___|___|___|___|	Account Number
Authorized Signature (as it appears on the financial institution's records) **X**		Date

☐ Checking Account

☐ Savings Account **(account number will be different than that of checking account).** Check with your financial institution to be sure automatic deductions are allowed against this account.

I authorize Anthem Blue Cross and Blue Shield to initiate a one-time deduction from the bank account indicated and the designated financial institution to debit the same account. If this option is selected, I understand my account may be debited the initial premium payment as early as the date of approval.

I understand that the initial premium amount may vary as a result of change(s) during the underwriting process, and I authorize Anthem to debit the bank account for the different amount.

PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.

In Missouri (excluding 30 counties in the Kansas City area): Anthem Blue Cross and Blue Shield is the trade name for RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ®ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.