

**Anthem.** 

**BLUE SHORT TERM<sup>SM</sup>**

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



P-502 Rev. 3/11

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## **Anthem Blue Cross and Blue Shield: Making healthcare coverage easier.**

At Anthem Blue Cross and Blue Shield, we're doing everything we can to make all kinds of healthcare 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 Ohio 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 healthcare coverage. It's just not worth the risk.

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Anthem 



## What's Covered?

Blue Short Term offers the same level of reliable healthcare 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 – up to \$2,500
- Home healthcare – up to 40 visits
- Hospice
- Human organ and tissue transplant – up to \$1,000,000
- Durable medical equipment – plan pays 50% of covered services after deductible

Once your deductible has been reached, Blue Short Term plan pays 80% of covered services. You pay the remaining 20% until your total out-of-pocket maximum for covered services is met. Once that limit is reached, the plan pays 100% for most covered services, up to the \$1 million maximum.

## Outline of Benefits

Deductible Single/Family	\$250 Single \$500 Family	\$500 Single \$1,000 Family	\$1,000 Single \$2,000 Family	\$2,500 Single \$5,000 Family
Out-of-Pocket Limit Single/Family Maximum	\$5,250 Single \$10,500 Family	\$5,500 Single \$11,000 Family	\$6,000 Single \$12,000 Family	\$7,500 Single \$15,000 Family
Covered Services Copayment	20%	20%	20%	20%
Rx	20% <sup>1</sup>	20% <sup>1</sup>	20% <sup>1</sup>	20% <sup>1</sup>
Office Visit	20%	20%	20%	20%
Lifetime Maximum	\$1 Million	\$1 Million	\$1 Million	\$1 Million

<sup>1</sup>Separate \$250 Rx deductible for prescription drugs. This does not go toward the out-of-pocket maximum. \$500 maximum per member per benefit period.

## **Design the plan to fit your time frame and budget.**

With Blue Short Term plan, you get choices. Decide for yourself what fits your needs. When do you want your coverage to start? How long will you need coverage – one, two, three, four, five, or six months? Select the deductible that's right for you, from as low as \$250 all the way up to \$2,500. 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.

## **Can I reapply for a short term plan?**

If you still need temporary insurance when your first Blue Short Term plan expires and you are still able to answer “no” to the questions under Part E of the application, you may reapply as often as needed (within a maximum term of 360 days) by completing a new application and sending it in with the appropriate premium. After the 360-day limit, you must wait at least six (6) months before reapplying for another short term plan.

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### **Stretch your healthcare 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](https://www.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 can apply for Blue Short Term<sup>SM</sup> coverage for yourself or with your family. Children are covered to the end of the month in which they turn 28. You must be a resident of the state in which you are applying, a legal resident of the U.S. and not currently pregnant.

### **What's a preexisting condition?**

Preexisting conditions are not covered under this plan. A preexisting condition is a condition for which medical advice, diagnosis, care or treatment was recommended or received during the 24 months right before you enrolled. Any condition that occurred in any earlier plan benefit period will be a preexisting condition under a subsequent plan benefit period.

### **Accessing Covered Services.**

Some services, or supplies, such as prescription drugs, require your doctor to receive an authorization from Anthem that defines and/or limits the conditions under which the service, or supply, will be covered to help you avoid any unnecessary out-of-pocket expenses. Other services such as organ transplants, require your physician to certify, and for us to approve the service

as medically necessary and the appropriate setting. Neither process is a guarantee of coverage.

### **What we do not cover.**

Short Term plans don't provide benefits for services, supplies or charges having to do with preexisting conditions (see "What's a preexisting condition?"); private duty nursing; maternity services; experimental or investigative treatment; mental health and substance abuse; preventive care services; well child care; 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; contraceptives; artificial and mechanical hearts; workers' compensation; 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.

Please call customer service or check your certificate of coverage 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 Blue Cross and Blue Shield  
Appeals Coordinator  
P.O. Box 33200  
Louisville, KY 40232-3200*

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.

If we uphold our decision throughout the appeals process, you can request a review by the Ohio Department of Insurance. In addition to the appeals processes we just described, Anthem has adopted a confidentiality policy in Ohio. 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 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 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 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.**

## Premium Worksheet

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

1. Applicant's Base Premium (the amount corresponding to your age, sex, and deductible from the table below)	\$
2. Spouse/Domestic Partner's Base Premium (if to be covered) (the amount corresponding to your spouse/domestic partner's age, sex, and deductible from the table below)	\$
3. Children's Base Premium (the amount corresponding to your number of children to be covered and deductible from the table at right)	\$
4. Subtotal (add lines 1 through 3)	\$
5. Area Factor (enter the area factor that corresponds with your county from the table at right)	X
6. Total Monthly Premium (multiply line 4 by line 5)	\$
7. Number of Months in Contract Term (enter 1, 2, 3, 4, 5 or 6)	X
8. Total Premium Due with Application (multiply line 6 by line 7)*	\$

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.

## Adult Monthly Rate\*

AGE	\$250 Deductible		\$500 Deductible		\$1000 Deductible		\$2500 Deductible	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
0-18	\$ 105.54	\$ 137.48	\$ 85.32	\$ 111.13	\$ 68.09	\$ 88.69	\$ 51.68	\$ 67.32
19-29	\$ 110.80	\$ 144.29	\$ 89.57	\$ 116.64	\$ 71.48	\$ 93.09	\$ 54.26	\$ 70.66
30-34	\$ 131.05	\$ 176.42	\$ 105.94	\$ 142.62	\$ 84.55	\$ 113.82	\$ 64.17	\$ 86.39
35-39	\$ 157.53	\$ 205.24	\$ 127.35	\$ 165.91	\$ 101.63	\$ 132.41	\$ 77.14	\$ 100.50
40-44	\$ 181.49	\$ 226.27	\$ 146.71	\$ 182.92	\$ 117.09	\$ 145.98	\$ 88.87	\$ 110.80
45-49	\$ 223.74	\$ 260.93	\$ 180.87	\$ 210.94	\$ 144.35	\$ 168.34	\$ 109.56	\$ 127.77
50-54	\$ 286.05	\$ 307.08	\$ 231.24	\$ 248.24	\$ 184.55	\$ 198.12	\$ 140.07	\$ 150.37
55-59	\$ 383.03	\$ 375.63	\$ 309.63	\$ 303.65	\$ 247.11	\$ 242.34	\$ 187.56	\$ 183.94
60+	\$ 594.32	\$ 492.66	\$ 444.07	\$ 398.26	\$ 354.40	\$ 317.84	\$ 268.99	\$ 241.24

Rates are effective April 1, 2011.

\*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.

## Dependent Children Monthly Rate\*

NUMBER OF CHILDREN	Deductible			
	\$ 250	\$ 500	\$ 1,000	\$ 2,500
1 Child	\$ 90.94	\$ 73.51	\$ 58.67	\$ 44.53
2 Children	\$ 181.88	\$ 147.02	\$ 117.34	\$ 89.06
3 Children	\$ 272.82	\$ 220.53	\$ 176.01	\$ 133.59

Rates are effective April 1, 2011.

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.**

AREA FACTOR	COUNTY
1.062	Ashland, Carroll, Holmes, Medina, Portage, Stark, Summit, Tuscarawas, Wayne
1.000	Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, Warren
1.106	Ashtabula, Cuyahoga, Geauga, Lake, Lorain
0.999	Crawford, Delaware, Fairfield, Franklin, Knox, Licking, Madison, Marion, Morrow, Pickaway, Richland, Union
0.943	Champaign, Clark, Darke, Greene, Logan, Miami, Montgomery, Preble, Shelby
0.997	Coshocton, Fayette, Guernsey, Hocking, Muskingum, Noble, Perry, Pike, Ross, Vinton
1.128	Allen, Auglaize, Defiance, Erie, Hancock, Hardin, Henry, Huron, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert, Williams, Wyandot
0.998	Athens, Gallia, Jackson, Lawrence, Meigs, Monroe, Morgan, Scioto, Washington
1.121	Fulton, Lucas, Wood
1.022	Belmont, Columbiana, Harrison, Jefferson, Mahoning, Trumbull

\*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.







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## Individual Application Premium Billing Page

Thank you for choosing Anthem Blue Cross and Blue Shield for your health care coverage needs. Please use the following instructions to guide you in completing the premium billing section of this application.

Please do not provide premium billing information on page 2 of the application, Section F (Automatic Bank Draft Authorization). We request that you leave this section blank. Instead, please provide this premium billing information on the last two pages of the application, Payment Methods for Individual Short Term Health Coverage.

**Agent:** Please mail this application to the following address:

**Anthem Blue Cross and Blue Shield**

**P.O. Box 37810**

**Louisville, KY 40233-7810**

**OR**

**Fax to: (800) 848-2512**

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. Independent licensee of the Blue Cross and Blue Shield Association.

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<b>Section A</b> Please print clearly in ink, or type							
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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Height (Ft. / In.)	Weight	Marital status <input type="checkbox"/> Single <input type="checkbox"/> 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?						<input type="checkbox"/> Yes <input type="checkbox"/> No (If no, attach a copy of your green card or visa.)	
Name of employer				Work phone (include area code)			

<b>Section B</b> Coverage Desired		
Deductible level desired: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500	Type of coverage desired <input type="checkbox"/> Single <input type="checkbox"/> Children <input type="checkbox"/> Parent/Children <input type="checkbox"/> Couple <input type="checkbox"/> Family	Term (months) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6
<b>Check one:</b> Coverage paid in full options: <input type="checkbox"/> Premium Check Enclosed <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express  Credit Card no. _____ Expiration date: _____  <input type="checkbox"/> Automatic Bank Draft (Complete section F.)	Monthly payment options: (\$10 monthly fee) <input type="checkbox"/> Automatic Bank Draft (Complete section F.) Premium will be deducted on the same day of the month as your assigned effective date.  <input type="checkbox"/> Bill me monthly (One month's premium must accompany this application.)	Total premium due: (Make check payable to <b>Anthem Blue Cross and Blue Shield.</b> )  \$ _____  <b>Requested future effective date:</b>

<b>Section C</b> 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 25). (List all dependents beginning with the eldest.)										
First name	Middle initial	Last name (if different from applicant)	Social Security Number	Height	Weight	Birthdate			Sex (M or F)	Relationship to applicant

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

<b>Section D</b> Other Coverage Information		
Will this coverage replace a previous short-term or temporary plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, previous identification number	Policy expiration date
Do you or any person to be covered now have an active health coverage policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, expiration date (This coverage cannot be issued while any other coverage is in force.)	
Have you or any other person to be covered ever been denied health coverage for health reasons? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, who was denied?</b>		
Are you currently applying for any other coverage with us? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Did you or your eligible dependents have creditable coverage within the past 63 days? <input type="checkbox"/> Yes <input type="checkbox"/> No		

<b>Section E</b> Other Information	
Are you, your spouse or domestic partner or any of your eligible dependents (whether or not named on this application) currently pregnant or an expectant parent (including adoptions)? <b>If Yes, who?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you, your spouse or domestic partner or any of your eligible dependents an insulin dependent diabetic?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any person named on the application currently hospitalized or in a nursing home? <b>If Yes, provide the name of each person.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last five years, have you, your spouse or domestic partner or any dependent to be covered, consulted with a health care provider for, been diagnosed with, or received treatment or medication for: heart or circulatory system disorder including heart attack or chest pain; stroke; diabetes; cancer or tumor; alcoholism or alcohol abuse; drug abuse or chemical dependency? <b>If Yes, who? Specify condition(s):</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Within the last five years, has any person to be covered ever tested positive for Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) or other immune system disorder? <b>If Yes, who?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
During the term of this plan, will you or any dependent turn age 65, or will any dependent turn age 25 or no longer be eligible for coverage? <b>If Yes, who?</b> (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.)	<input type="checkbox"/> Yes <input type="checkbox"/> No

## Section F Automatic Bank Draft Authorization

If you completed Section B and selected Automatic Bank Draft, please complete this section.

Deduct premium from:  Checking account  Savings account (Premium will be deducted on the same day of the month as your assigned effective date.)

Deduct money from my/our account for (check one):

My first and ongoing payments  My ongoing payments only (first payment made by other method)

You **MUST** attach a **blank** voided check for checking account deduction and premium will be deducted on the same day of the month as your assigned effective date. **I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the account indicated and the designated financial institution to debit the same account. I understand that this authorization is in effect until I notify Anthem in writing that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals if they wish to do so.**

Account holder's name

Applicant's Social Security Number

Account holder's signature (if other than the applicant)

## Section G Significant Terms, Conditions and Authorizations (TERMS)

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 receives medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage approval date. I understand that in this situation the new information will not be considered as a pre-existing condition. However, Anthem has the right to review my application for coverage and, if approved, to determine the appropriate premium rate.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.
2. I am applying for the coverage selected on this application.
3. 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.
4. 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.
5. I understand the pre-existing conditions in existence within 24 months immediately prior to my enrollment, for which medical advice, diagnosis, care or treatment was recommended or received, are not covered. Pregnancy is considered a pre-existing condition.
6. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
7. 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.
8. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
9. I understand I am applying for individual health coverage (Provided through a Group Trust Insurance Policy) 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.
10. THIS PARAGRAPH APPLIES ONLY TO OHIO RESIDENTS, AND DOES NOT APPLY TO INDIANA OR KENTUCKY RESIDENTS: I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my

authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 C.F.R. Parts 160 and 164) and the Ohio Revised Cod § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

11. 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.

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).

In Kentucky: 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 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.

In Ohio: Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Your health coverage will be provided by one of the following companies based upon the state where you reside:

In Indiana: Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc.

In Kentucky: Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Kentucky, Inc.

In Ohio: Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.

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)

Date

Signature of Spouse or Domestic Partner (if to be covered)

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 H Agent Certification

I hereby certify that I have asked the applicant all questions set forth above, and that I have accurately recorded the answers supplied by the applicant. Any reporting form that is required due to a positive response to this question has been completed and submitted with this application. I further certify that I have explained the exclusions and limitations of the policy.

Agent's Name (please print)

Agent's Signature

Agent Number

Agent Phone Number

Agent Fax Number

Agent Email Address

Date

**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.**

# Payment Methods for Individual Short Term Health Coverage Ohio



Please complete in blue or black ink.

Applicant Name:	Primary Applicant's Social Security Number:
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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.

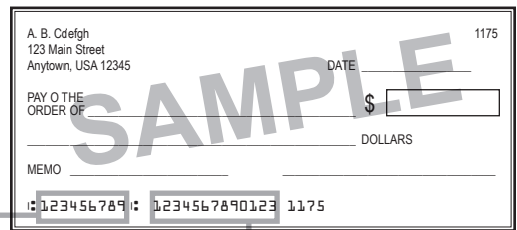
**A. Automatic Bank Payment –**  
If you have selected this option for your initial payment, your bank account may be debited the applicable month's premium as soon as the day of approval. I hereby authorize Anthem to initiate a withdrawal the same day of the month as my assigned effective date from 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
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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) <b>X</b>	Account Holder Name (Please PRINT)	Date
-----------------------------------------------------------------------------------------	------------------------------------	------

**PLEASE RETAIN A COPY OF THIS AUTHORIZATION FOR YOUR RECORDS.**

