Missouri
Change of Coverage Application

Use only for upgrade of medical benefits or risk review. **This form cannot be used to add members not currently covered.**
This form cannot be used to *just* add Dental or Life—must be making Medical Coverage changes to use Sections F and G.
Please complete in blue or black ink only. Do not write in shaded areas, these are for Sales/Producer use only.

Section A – Coverage Information

Anthem individual policy coverage

Policy No. ______________________

Effective month requested: ______________________

Your renewal date will remain the same day of the month as your existing policy

Section B – Applicant Information

For Blue Preferred® HMO 90 the child must be at least 6 months or older to be listed on applicant.

Risk Tier	Last Name	First Name	MI	Social Security Number*

Home Address (street and P.O. Box if applicable)

City	State	Zip	County

Marital Status	Height (Ft. / In.)	Weight	Sex	Age	Date of Birth
☐ Single ☐ Married	/		M F		/ /

Daytime Phone Number	Evening Phone Number	E-mail (This information will not be shared with any third party.)
( )	( )	

Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? ☐ Yes ☐ No

Contraceptive Coverage Option: If your application is accepted, for most plans, benefits for contraceptive drugs and devices will be included in your health care coverage unless you check the box below. (Checking this option will not affect your premium.)

☐ For moral, ethical or religious reasons, I do not want benefits for contraceptive drugs and devices for myself or any family members.

Section C – Spouse or Domestic Partner Information

Risk Tier	Last Name	First Name	MI	Relationship
				☐ Spouse ☐ Domestic Partner

Social Security Number*	Height (Ft. / In.)	Weight	Sex	Age	Date of Birth
	/		M F		/ /

Are you a legal resident of the United States and a resident of the state in which you are applying for coverage? ☐ Yes ☐ No

Section D – Child Dependent(s) Information

(All fields required. Attach a separate sheet if necessary.)

Dependent information must be completed for all child dependents (if any) currently covered under this policy.
This form cannot be used to add members not currently covered.

Risk Tier	First, MI (last name if different)	Relationship to Applicant	Social Security Number*	Sex	Age	Date of Birth mm/dd/yyyy	Height Ft. / In.	Weight Lbs.
		Child		M F			/	
		Child		M F			/	
		Child		M F			/	
		Child		M F			/	
		Child		M F			/	

Has any person listed on this application lived (not traveled) outside the U.S. for the consecutive months? ☐ Yes ☐ No

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

Lang Insurance Service, Inc.; (636) 441-0211; www.langinsurance.com

In most of Missouri, Anthem Blue Cross and Blue Shield is the trade name of 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 Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Life and disability products are underwritten by Anthem Life Insurance Company (ALIC). Independent licensees of the Blue Cross and Blue Shield Association.
®Anthem is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Section E – Change to Higher Deductible Amount

BLUE ACCESS® CHOICE (Only available to residents of the following counties: Franklin, Jefferson, St. Charles, St. Francois, St. Louis City, St. Louis, and Warren)

Blue Access® Choice Value

Deductible (choose one)
- ☐ $2,000 ☐ $3,000
- ☐ $5,000 ☐ $10,000

Rx Options (choose one)
- ☐ $15/$30/$60/25% ($500 deductible)
- ☐ $15 Generic only ($500 maximum)
- ☐ Discount only

Blue Access® Choice Economy

Deductible (choose one)
- ☐ $1,000 ☐ $1,500
- ☐ $2,500 ☐ $5,000

Rx Options (choose one)
- ☐ $15/$30/$60/25% ($500 deductible)
- ☐ $15 Generic only ($500 maximum)
- ☐ Discount only

Blue Access® Choice 80† (deductibles–choose one)
☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $7,500

Blue Access® Choice 90† (deductibles–choose one)
☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500

Blue Access® Choice 100† (deductibles–choose one)
☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

†Blue Access® Choice 80/90/100 Rx Options/Riders (Rx default is $15 generic)
- ☐ $15/$30/$60/25% ☐ $15 Generic only
- ☐ $15/$30/$60/25% ($500 deductible) ☐ Optional Maternity Rider

BLUE ACCESS®

Blue Access® Value

Deductible (choose one)
- ☐ $2,000 ☐ $3,000
- ☐ $5,000 ☐ $10,000

Rx Options (choose one)
- ☐ $15/$30/$60/25% ($500 deductible)
- ☐ $15 Generic only ($500 maximum)
- ☐ Discount only

Blue Access® Economy

Deductible (choose one)
- ☐ $1,000 ☐ $1,500
- ☐ $2,500 ☐ $5,000

Rx Options (choose one)
- ☐ $15/$30/$60/25% ($500 deductible)
- ☐ $15 Generic only ($500 maximum)
- ☐ Discount only

Blue Access® 80† (deductibles–choose one)
☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $7,500

Blue Access® 90† (deductibles–choose one)
☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500

Blue Access® 100† (deductibles–choose one)
☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

†Blue Access® 80/90/100 Rx Options/Riders (Rx default is $15 generic)
- ☐ $15/$30/$60/25% ☐ $15 Generic only
- ☐ $15/$30/$60/25% ($500 deductible) ☐ Optional Maternity Rider

☐ **Blue Preferred® HMO 90** Select one Rx option: ☐ $15/$30/$60/25% ☐ $15 Generic only

Pick a Network for your Lumenos® Plan
☐ Blue Access ☐ Blue Access Choice

Select ONE Plan then select ONE Deductible and any optional Riders

Lumenos® Health Savings Account
- ☐ Plan 1 (0% coinsurance)
  ☐ $1,500/$3,000 ☐ $3,000/$6,000 ☐ $5,000/$10,000
- ☐ Plan 2 (20% coinsurance) ☐ $1,500/$3,000 ☐ $3,000/$6,000
- ☐ Yes, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please forward my information to Anthem's banking partner. (Please fill in your social security number in section B.)
- ☐ No, I DO NOT want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please DO NOT forward my information to Anthem's banking partner.

Optional riders: ☐ Maternity

Lumenos® Health Incentive Account Plus
- ☐ Plan 1 (0% coinsurance)
  ☐ $2,500/$5,000 ☐ $5,000/$10,000 ☐ $10,000/$20,000
- ☐ Plan 2 (20% coinsurance) ☐ $2,500/$5,000

Optional riders: ☐ Maternity

Lumenos® Health Incentive Account
- ☐ Plan 1 (0% coinsurance)
  ☐ $1,000/$2,000 ☐ $2,500/$5,000 ☐ $5,000/$10,000
- ☐ Plan 2 (20% coinsurance)
  ☐ $1,000/$2,000 ☐ $2,500/$5,000

Optional riders: ☐ Maternity

Section F – Dental Coverage (Must be making Medical Coverage changes to add/change Dental Coverage)

☐ Change plan to (at an extra cost per individual): ☐ **Dental Blue® Basic 100** ☐ **Dental Blue® Essential 100** ☐ **Dental Blue® Essential 200**

Select ONE coverage type (applies to individuals listed on this application only):
- ☐ Applicant only
- ☐ Applicant & Spouse/Domestic Partner only
- ☐ Applicant, Spouse/Domestic Partner, and all dependent children listed
- ☐ Applicant & all dependent children listed

☐ Keep existing plan

Section G – Term Life Insurance (Must be making Medical Coverage changes to add/change Life Coverage)

Blue Preferred® Term Life ☐ Yes, please continue my life coverage.

☐ Yes, in addition to my medical coverage, I wish to apply for Term Life Insurance (at an extra cost per individual).

☐ Yes, I want to change my coverage amount–see below. Provide information below.

Applicants must meet Anthem's Underwriting Guidelines to qualify for Term Life Insurance Coverage. Applicants under the age of one year are not eligible for Life Insurance. All Term Life polices terminate at age 65.

Applicants	Coverage Amount (select one)	Beneficiary**	Relationship	Beneficiary Street Address City/State/ZIP code
☐ Applicant	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		
☐ Spouse ☐ Domestic Partner	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		
☐ Child(ren)	☐ $15,000 ☐ $25,000 ☐ $50,000*	Primary:		
		Contingent:		

*The $50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to $25,000.

****If a beneficiary is not listed** and a policy is issued, death benefits will be paid in accordance with the Beneficiary Provision of the Policy.

Section H – Billing Options

Frequency (select one)

- ☐ Monthly
- ☐ Quarterly
- ☐ Semi-annually
- ☐ Annually

Initial Premium (required)

- ☐ Bank Draft (see below)
- ☐ Check Enclosed (If paying by check, make the check payable to ABCBS.)
- ☐ Credit Card (see below)

Total amount enclosed/charged $________________

Method (select one)

☐ **HOME**–Bills will be sent to your home billing address unless a separate billing address is listed below.

Name | Address (street and P.O. Box if applicable) | City | State | Zip

☐ **AUTOMATIC BANK DRAFT**(automatic premium withdrawals)–your premium will be deducted on, or about the first of each month. (You **MUST** attach a **blank** voided check)

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

- ☐ My first payment only $_________
- ☐ My first and ongoing payments
- ☐ My ongoing payments only (first payment made by other method)

I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the checking 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 (please print) X	Account holder's signature (if other than the applicant) X

Staple **blank, voided check** here

Staple **blank, voided check** here

☐ **IF PAYING BY CREDIT CARD:** *A credit card can be used only for this initial premium payment. If your application is accepted, you will be billed for future payments or you can call us to change to automatic bank withdrawal. Your credit card will not be charged unless you are approved for coverage. Please complete all the fields below.*

Credit card information –

Cardholder's Name (as shown on the credit card):

Cardholders' Address:

If applicant is using the credit card of another cardholder: *By signing this form, applicant represents and warrants that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for this payment and any charges accruing to it.*

Type of Credit Card: ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Credit Card Number: ______________________________

Expiration Date (month/year): _________ /_________

Authorization: *I authorize Anthem Blue Cross and Blue Shield to charge the credit card indicated for the amount specified in **Initial Premium**.*

Applicant's Signature: X

☐ **NEW LIST BILL**–Billing through third-party (This option must have prior approval and requires separate List Bill forms to be completed and submitted with this application).

☐ **CHANGE TO EXISTING LIST BILL** List Bill Arrangement Number: ______________________________

Section I – Health History (Attach a separate sheet if necessary.)

	YES	NO
1. Has any enrolled family member been hospitalized, seen a physician or other health care provider or taken prescription medication with the last six months? If yes, please provide name of applicant and details below.	☐	☐
2. Has any enrolled member been advised to seek treatment, have surgery or testing that has not yet been completed? If yes, please provide name of applicant and details below.	☐	☐
3. Are you or your spouse/domestic partner (whether currently enrolled or not) an expectant parent?	☐	☐
4. FEMALES ONLY – Please provide the following information (Applicable to ALL females listed on this application) Do you menstruate?	☐	☐
Has it been more than 40 days since your last menstrual period? If yes, please give reason	☐	☐
5. Has any enrolled member used tobacco products within the past 12 months? If yes, please give name	☐	☐

Section J – Significant Terms, Conditions, and Authorizations (Please read carefully.)

Please read this section carefully before signing the application.

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, or been advised of, diagnosed with or treated for any illness, injury or condition after the date I sign this application but before my *effective date*. 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 rescinded, or delayed, or reformed or benefits denied due to the illness, injury or condition being treated as a preexisting condition.** (Pre-existing condition limitation does not apply to HMO programs.)
2. 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.
3. I may not assign any payment under my Anthem program.
4. I am applying for the coverage selected on this application.
5. 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.
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 pre-existing conditions are not covered for 12 months after my enrollment. I also understand that a pre-existing condition is any condition that was diagnosed or treated within the 12 months immediately prior to my enrollment or produced symptoms within 12 months immediately prior to my enrollment that would have caused an ordinarily prudent person to seek medical diagnosis or treatment. Pregnancy is considered a pre-existing condition.** (Does not apply to HMO programs.)

Section J – Significant Terms, Conditions, and Authorizations *(continued)*

8. If the plan I purchase offers maternity coverage, and I purchase that coverage, I understand that 1) these benefits apply only to me or my covered spouse or domestic partner and not to any dependent child and 2) these benefits will not begin until after my membership has been in effect for one year. (Does not apply to Blue Preferred® HMO 90.) ***Note:*** If a female applicant/spouse or domestic partner is approved for coverage, this waiting period will be waived if she is transferring directly from group coverage through Anthem that was in effect for 12 months or more with no break in coverage.
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 payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. 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 and agree 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. If I purchase optional dental coverage, I understand that I will have a 12-month waiting period for coverage of Major services.
(For a description of Basic and Major services, please refer to your contract.)
14. By signing this application I represent that I understand that Anthem Life has the right to deny my application for Term Life Coverage, and if it does, I will be notified in writing. I understand that if Anthem Life declines this coverage, no benefits will be payable. I understand that I alone am responsible for reading and accurately completing this application, and I must communicate any changes to my status. I also understand that all other conditions of my medical application apply for the life application.
15. 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 significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

    If tobacco use question in Section I is answered "NO", I understand that the signature(s) below will attest to non-tobacco usage for the past 12 months.

    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.

Signature of Applicant *(or Custodial Parent's or Guardian's signature if applicant is under age 18)* X	Date
Signature of Spouse or Domestic Partner (if to be covered) X	Date

Section K – Agent Certification

Agent Signature X		Date
Agent Name (please print)		Agent Email Address @langinsurance.com
Agent No. MB690	Agent Phone No. (636) 441-0211	Agent Fax No. (636) 441-3123

Lang Insurance Service, Inc.; (636) 441-0211; www.langinsurance.com

In most of Missouri, Anthem Blue Cross and Blue Shield is the trade name of 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. Life and disability products are underwritten by Anthem Life Insurance Company (ALIC). Independent licensees of the Blue Cross and Blue Shield Association.
®Anthem is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.