

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 661-333-1181 fax: 661-587-0659

## Step 2

**SELECT THE TYPE OF BILLING YOU WANT** – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

## Step 3

### **SEND THE COMPLETED APPLICATION TO:**

Ginn Insurance Services  
9805 Vanessa Ave.  
Bakersfield, CA 93312

### **Please make your check payable to: Anthem Blue Cross**

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at:** 661-333-1181

Thank you for choosing...





# TONIK<sup>®</sup> Individual Enrollment Application

The TONIK plan is offered by Anthem Blue Cross Life and Health Insurance Company. Independent licensee of the Blue Cross Association.  
 © ANTHEM is a registered trademark. © The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Applicant's Social Security or ID No.									

Promotion Code				

**ALL INFORMATION YOU PROVIDE MUST BE ACCURATE.**

## 1. Applicant Information (Please print)

Applicant's Last Name	First Name	M.I.
Home Address (Must be complete: P.O. Box not acceptable)		
City	State	ZIP Code

## Reason for Application (Check one)

New enrollment(s)       Change of Coverage

To change existing Blue Cross plan, please enter ID No:

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Applicant's Social Security or ID No.	Home Phone No.	Daytime Phone No.	FAX No.
Billing Address ( <i>If different than above</i> ) or P.O. Box    Personal Mail Box (PMB) No.			
City	State	ZIP Code	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
E-mail Address		Spouse's Social Security or ID No.	
		If possible, do you want e-mail notification? <input type="checkbox"/> Yes <input type="checkbox"/> No	
When Information is sent to you, we may be able to send it in a language other than English. What language would you prefer? ( <i>Optional</i> )			
<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Korean	<input type="checkbox"/> Chinese
<input type="checkbox"/> Farsi	<input type="checkbox"/> Arabic	<input type="checkbox"/> Armenian	<input type="checkbox"/> Russian
<input type="checkbox"/> Korean	<input type="checkbox"/> Japanese	<input type="checkbox"/> Tagalog	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Other _____	<input type="checkbox"/> Khmer	<input type="checkbox"/> Hmong	

<input type="checkbox"/> Male	Birthdate (mm/dd/yyyy)	Age	Height	Weight
<input type="checkbox"/> Female				

## 2. Plan Selection

<b>Medical/Dental/Vision</b> <input type="checkbox"/> 1500 (DN13) <input type="checkbox"/> 3000 (DN14) <input type="checkbox"/> 5000 (DN15)	<b>Enhanced Dental</b> <input type="checkbox"/> PPO Dental (DR53)
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Applicant's Social Security or ID No.							

**3. Term Life Insurance Coverage Selection and Beneficiary**

Insured	Birthdate (mm/dd/yyyy)	Amount of Benefit	Beneficiary Name	Beneficiary Social Security No.	Relationship	Allocation	% Allocation
		<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$100,000				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	%
						<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	%

**Note:** Amounts greater than or equal to \$50,000 are not available to applicants under the age of 19. If selected by an approved applicant under the age of 19, the selection will default to \$30,000.

**Note:** If a beneficiary is not listed and Policy is issued, death benefits will be paid according to the Beneficiary Provision in the Policy.

**See section 6 (Application, Conditions and Agreements) for additional terms.**

Please check box if the proposed life insurance coverage will replace existing life insurance coverage from a company other than Anthem Blue Cross Life and Health Insurance Company.

**4. Prior Insurance History and HIPAA Eligibility – Please answer ALL of the following questions.**

**Anthem Blue Cross Life and Health Insurance Company credits prior coverage toward the preexisting period for those applicants who apply and are accepted for coverage and request an effective date within 63 days after termination of qualifying prior coverage as required by law. To obtain credit toward the preexisting period, please complete the following.**

- A. Do you currently have health care coverage? .....  Yes  No
- B. Have you had coverage in the last 63 days? .....  Yes  No

If you answered "Yes" to A or B above, please provide the following information:

Certificate/Policyholder No.	Plan Name	State	Most recent coverage start date
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You must discontinue your current coverage if this application is accepted.

- C. HIPAA Coverage** – If I do not qualify for this plan, I would like to be considered for coverage under HIPAA. HIPAA does require eligibility. I understand that no underwriting is required and rates may be higher than for the Individual Plans. If I qualify, please offer the HIPAA coverage and send complete details regarding my options and rates. ....  Yes  No

5. Health History

Applicant's Social Security or ID No.									

**5A. Health History Questionnaire – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.**  
**Give COMPLETE details of any “Yes” answers in Section 5B on the following page.**

<p><b>1.</b> Have you had a physical exam, any diagnostic test or screening test such as blood tests, x-rays, CAT scan, MRI, mammogram etc within the past 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>2.</b> Have you discussed with a health care provider or been advised to have testing, treatment, therapy or surgery that has not yet been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>3.</b> Have you been prescribed or taken any prescribed medication within the past 12 months except for birth control or short term (10 day) antibiotics? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>4.</b> Has it been more than 40 days since your last menstrual period? (<i>no male answer required</i>): <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>5.</b> Have you been diagnosed, treated for, evaluated for or experienced any genital/gynecological/reproductive problem(s) including infertility within the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>6.</b> Have you been evaluated for, treated or experienced breast cyst or lumps within the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>7.</b> Are you an expectant parent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>8.</b> Have you been diagnosed and/or treated for any Sexually Transmitted Disease (STD) within the past 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>9.</b> Have you been diagnosed and/or treated for any mental, emotional or behavioral disorder, including anorexia, attention deficit disorder and/or depression within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>10.</b> Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>11.</b> Have you been treated, diagnosed, or evaluated for symptoms related to alcoholism and/or use or abuse of alcohol within the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>12.</b> Have you been advised to decrease alcohol consumption, or been aware of any symptoms related to alcoholism such as blackouts, DT's, abnormal liver function test in the past 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>13.</b> Have you ever used illicit IV Drugs, OR in the last 5 years taken illegal drugs or been treated for drug abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>14.</b> Have you been diagnosed, treated, evaluated for or experienced any of the following within the last six months?</p> <p>a. Receive allergy injections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Increased heart rate <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Irregular heart beat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Heartburn (recurrent) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. High cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Paralysis <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>h. Abnormal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i. Recurrent diarrhea and/or excessive vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>j. Unexplained weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>k. Loss of consciousness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>l. Blood and/or sugar in urine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>m. Persistent and/or intense pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>15.</b> Do you have any implants or prosthesis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>16.</b> Have you ever consulted a health care provider, been diagnosed, had treatment, or had treatment recommended for any of the following within the last 10 years?</p> <p>a. AIDS/ARC; Evaluated for or recommended Antiviral treatment <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Heart/circulatory/bleeding disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Diabetes or other endocrine (glandular) disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Kidney/gall bladder/stomach/intestinal disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Hepatitis or other liver disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Hernia/hemorrhoid/rectal disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Muscle/bone/tendon joint injuries or disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h. Multiple Sclerosis, migraine headaches, Parkinson's disease or other brain/nervous disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i. Congenital heart or other birth defects/congenital disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>j. Respiratory disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>17.</b> Have you ever had or been diagnosed with or treated for cancer or a malignant tumor? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>18.</b> Have you been diagnosed, had symptoms or received treatment for any condition(s) not listed elsewhere on this application? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>19.</b> Have you been hospitalized or treated in the emergency room within the last 12 months except for pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>20.</b> In the last 12 months, have you considered or are you considering any hospitalization, medical or surgical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>21.</b> Have you smoked cigarettes, cigars, or pipes, or used chewing tobacco within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p><b>I HAVE PERSONALLY REVIEWED AND ANSWERED ALL HEALTH QUESTIONS CORRECTLY</b></p>	
<p>Applicant's Signature</p> <p>X</p>	<p>Date</p>

**5B. Professional Services**

Give COMPLETE details in all sections below of any "Yes" answers to the questions in Section 5A.

Question #	Name of Hospital, Clinic and/or Person Providing Care	Phone No. ( )
Date of Treatment ( <i>Month/Year</i> )	Date Ended ( <i>Month/Year</i> )	<input type="checkbox"/> Still under treatment
Name of Condition/Illness		
Treatment Rendered ( <i>i.e., X-ray, lab, surgical procedure, prescribed medications, etc.</i> )		
Results		

Question #	Name of Hospital, Clinic and/or Person Providing Care	Phone No. ( )
Date of Treatment ( <i>Month/Year</i> )	Date Ended ( <i>Month/Year</i> )	<input type="checkbox"/> Still under treatment
Name of Condition/Illness		
Treatment Rendered ( <i>i.e., X-ray, lab, surgical procedure, prescribed medications, etc.</i> )		
Results		

Question #	Name of Hospital, Clinic and/or Person Providing Care	Phone No. ( )
Date of Treatment ( <i>Month/Year</i> )	Date Ended ( <i>Month/Year</i> )	<input type="checkbox"/> Still under treatment
Name of Condition/Illness		
Treatment Rendered ( <i>i.e., X-ray, lab, surgical procedure, prescribed medications, etc.</i> )		
Results		

Question #	Name of Hospital, Clinic and/or Person Providing Care	Phone No. ( )
Date of Treatment ( <i>Month/Year</i> )	Date Ended ( <i>Month/Year</i> )	<input type="checkbox"/> Still under treatment
Name of Condition/Illness		
Treatment Rendered ( <i>i.e., X-ray, lab, surgical procedure, prescribed medications, etc.</i> )		
Results		

6. Application Understandings, Conditions and Agreement

It is important that you carefully read and fully understand the following. All Applicants age 18 and over must personally read, agree to and sign the following.

Applicant's Social Security or ID No.

I, the undersigned, understand that under the Anthem Blue Cross Life and Health plan in which I am enrolling, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use a network hospital or physician.

Effective Date

REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED.

- If Anthem Blue Cross Life and Health Insurance Company ("Anthem") approves my application, please assign an effective date of ... The effective date must be after the signature date but not greater than 75 days from the signature date on this application. If Anthem approves my application, please assign an effective date of the first day after Anthem approval.

Please note: If you are changing coverage, your effective date will always be the first of the month following approval.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

CURRENT HEALTH COVERAGE: If you currently have health coverage, Anthem strongly recommends that you maintain your current coverage and request an effective date of 60 to 75 days from the date of application. This will help ensure that your application is processed before you surrender your present insurance.

Agreement

By applying for coverage, I, the undersigned, agree to the following:

- Anthem Blue Cross Life and Health Insurance Company ("Anthem") may decline my application. No coverage comes into effect until Anthem approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Anthem at its discretion (except for HIPAA). Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Anthem nor any affiliated company shall have any liability to me or anyone else listed on it, except for the obligation to return the money submitted with this application. If this application is not accepted, I will not be entitled to benefits or coverage from Anthem. The selling agent has no authority to promise me coverage or to modify Anthem underwriting policy or the terms of any Anthem coverage. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.) In no event shall Anthem or any affiliated company have any liability to the applicant if the application is not approved, except for the obligation to return the money submitted with this application if this application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by the Medical Underwriting Department of Anthem. I understand Anthem may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.

Term Life Insurance Coverage

I am applying for the benefits provided by the policy indicated in section 2. I understand that receipt of money with this application does not create coverage. Coverage will come into effect only on approval by Anthem Blue Cross Life and Health Insurance Company.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes a claim containing any false, incomplete or misleading information to obtain the proceeds of an insurance policy is guilty of a felony.

Note: Life insurance is to be underwritten by Anthem Blue Cross Life and Health Insurance Company. Initials

Rescission of Membership

I have provided true and complete answers to all questions in this application, and understand that all answers are important and will be considered in the acceptance or denial of this application. I understand that all information I know, that is responsive to a question on this application, must be provided in my answers. If I misstate or omit any such information, Anthem Blue Cross Life and Health Insurance Company ("Anthem") may rescind my coverage. I understand this means that Anthem will revoke my membership as if it never existed.

Also, if I have any medical signs, symptoms, or treatment after completing this application but before coverage is effective, I will immediately tell Anthem. I understand that Anthem may deny or rescind my coverage if I do not disclose this information.

All of my dependants listed on this application who are over the age of 18 years have read this application and have provided complete and accurate information for this application. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about all applicants, including my children under the age of 18, listed on the application is true and complete. I understand and agree that no one listed on this application will be eligible for coverage if false or incomplete information is provided, and that Anthem may rescind coverage if it discovers that in applying for coverage I misstated or omitted any information I know that is responsive to any question in this application. Initials

I have personally read and attest to the completeness and validity of the information provided on this application. If I am accepted, this application will become part of the contract between Anthem and me. I and any enrolled family members agree to abide by the terms of that contract. Initials

REQUIREMENT FOR BINDING ARBITRATION

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT BLUE CROSS REQUIRES BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO CLAIMS OF MEDICAL MALPRACTICE IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. This means that you and Blue Cross are waiving their right to a jury trial for both medical malpractice claims, and any other disputes. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration." Both parties also agree to give up any right to pursue on a class basis any claim or controversy of any type against the other. Initials

Signature (Required) - IMPORTANT: ALL APPLICANTS OVER AGE 18 MUST PERSONALLY READ, AGREE TO, SIGN AND DATE.

\*\*NOTICE\*\* BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ALL DISPUTES AGAINST ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY WHERE THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS AND ANY OTHER DISPUTES.

Applicant/Parent or Legal Guardian Today's Date

If an Applicant does not read English, the translator must sign and submit a Statement of Accountability for translating this entire application (see Section 8).



**8. Statement of Accountability - To be completed when the applicant cannot complete the application.**

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

- Agent assisted application
- Applicant does not read English                       Applicant does not speak English                       Applicant does not write English
- Other (explain): \_\_\_\_\_

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: \_\_\_\_\_

I also translated and fully explained the "Application Conditions and Agreement."

\_\_\_\_\_  
Signature of Translator (Required)

\_\_\_\_\_  
Today's Date (Required)

**TO BE COMPLETED BY YOUR ANTHEM BLUE CROSS-APPOINTED AGENT**

1. Are you aware of any information not disclosed on this application relating to the health, habits or reputation of any person listed on this application which might have a bearing on the risk? .....  Yes  No  
If yes, please attach explanation.
2. Did you see the proposed subscriber at the time this application was executed? .....  Yes  No  
If no, please explain: \_\_\_\_\_
3. I verify that this application was completed by the applicant unless the Statement of Accountability was completed.

<b>Signature of Agent (Required)</b>	<b>Date (Required)</b>
X	

4. **Total funds collected:** \$ \_\_\_\_\_

Name of Agent (Print Name)		Agent's Street Address	Suite No./Personal Mail Box (PMB) No.
Agent ID No.	Sub-Agent ID No.	City/State/ZIP Code	Location No.
Phone No. (    )	FAX No. (    )	E-mail address	