



## ***Indiana/Kentucky/Ohio***

### **Under 65 Underwriting, Medical Conditions & rating guide, Height & Weight build charts and Medical questions**

The Individual Business Unit at Anthem Blue Cross and Blue Shield offers a diverse suite of individual health care coverage products exclusively to direct-pay consumers. This manual provides guidelines intended to help writing agents solicit, write, and submit applications for individual health coverage in Indiana, Kentucky, and Ohio.

It is important to remember that these guidelines are for informational purposes only, and should not be interpreted as a guarantee of underwriting action on any specific case. The agent and applicant should be aware that the final decision regarding all underwriting actions—including insurability, rating, and effective date assignment will always be determined by the Medical Underwriting department following a thorough assessment of each applicant's morbidity risk. Various sources of information are used for assessing this risk; however, the most important source is the application. Therefore, it is important to make sure each application is complete and accurate.

*The information contained in this manual is intended for internal use only and may not be copied or distributed in any manner. The benefit descriptions are intended to be a brief overview of some benefits available to Anthem members.*

### ***Mission and Philosophy***

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Our mission is to improve the lives of the people we serve and the health of our communities. At Anthem, we believe health care coverage should actually help people stay healthy. That's why we go beyond simply providing coverage. We help support and encourage our members' wellness by:

- Offering large provider networks that include many of the best physicians, specialists, and hospitals in each area we serve.
- Encouraging members to have important preventive and health maintenance screenings.
- Including coverage for preventive and health maintenance care in many plan options.
- Providing programs to help members proactively manage chronic health conditions.

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# UNDER 65 UNDERWRITING GUIDELINES

## ***Adding Benefits (Upgrades)***

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Members can upgrade or downgrade benefits twice per year: once at renewal and once more within 12 months. To add benefits (upgrades) a fully completed application or a Change Of Coverage application must be sent to Underwriting. Coverage will begin according to the regulations set forth under the Effective Date Assignment section of this guide.

**Note: Effective dates on benefit changes must be the same day of the month as the renewal date.**

**Agent Tips** - Members may qualify for a better rate tier if they were:

1. Previously issued as tobacco users and is now 12 months tobacco free.
2. Previously issued at a higher tier due to build, but have maintained a lower weight for 12 months.
3. Previously issued at a higher rate due to a medical condition that has now been resolved or has not required treatment for a specified period of time.

**Note: See the Application Chart in the Miscellaneous Forms section of this manual to see what form is needed for making changes.**

## ***Adding Dependent***

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Any current member may add a dependent at any time (see Effective Date section). A current member may add a “newly acquired” dependent due to birth, adoption, marriage, or legal guardianship within 31 days of the qualifying event (i.e., date of birth, date of adoption, date of marriage, or date of legal guardianship placement) and receive the date of the qualifying event as the effective date if notification is received by Anthem within 31 days of the qualifying event (see below).

### ***Newborns or Newly Adopted Children***

Coverage is guarantee issue for the first 31 days for dependents who are newborns and newly adopted children of the primary policyholder or spouse/domestic partner. In order to continue coverage past the 31<sup>st</sup> day, the policyholder must direct Anthem to add the dependent either by calling Customer Service or submitting the request in writing. The newborn will be added at the existing family risk tier. In the case of newly adopted children, a copy of the document awarding the policyholder or spouse/domestic partner court-appointed custody must be provided or an affidavit attesting to the adoption must be completed and accompany the application.

If notification is not received within 31 days, coverage will not be extended beyond the 31<sup>st</sup> day. To obtain coverage after the 31<sup>st</sup> day, a new application, indicating “add dependent(s) to current coverage,” must be submitted and full underwriting will be required. Coverage will begin according to the regulations set forth under the Effective Date Assignment section of this guide. When completing the application, please take the following steps:

- In Section A, check the box: “add dependent (s) to current coverage” and provide the current policy number
- Provide the member’s name, social security number, and address in Section B
- Section D must be completed
- Complete Section K – answer all medical questions for all members being added

Adding a newborn to a 'child only' policy requires submitting an application to Underwriting. In this case, unlike adding a newborn to an existing family policy, the first 31 days are not free. If approved, the newborn will receive the next available effective date following receipt of the application.

### **Other Dependents**

Adding a dependent other than a newborn or newly adopted child (e.g., dependents as a result of marriage) requires a new application. The dependent is subject to full medical underwriting and the effective date will be assigned according to the regulations set forth under the Effective Date Assignment section of this guide.

For dependents added as the result of marriage, the application must be received within 31 days of the qualifying event (i.e., date of marriage) in order for coverage to be effective as of the date of the qualifying event. The dependents will be subject to full underwriting. The addition of dependents as a result of marriage may result in a new policy risk tier.

For dependents added as a result of court-appointed legal guardianship (if the legal guardian is someone other than the natural parent of the child(ren), proof of the guardianship will be required, (i.e., court-appointed custody and affidavit) and must be submitted with the application. If the application and required proof are submitted within the first 31 days of guardianship placement, adding the dependent is guarantee issue, and the dependent will be added at the existing policy risk tier. Full medical underwriting will be required if the application is submitted more than 31 days after the qualifying event.

**Note: The affidavit required for adoptions and court-appointed guardianships can be found in the Miscellaneous Forms section of this manual.**

**Note: See the Application Chart in the Miscellaneous Forms section of this manual to see what form is needed for adding dependents.**

### **Address and Billing Changes**

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Members may make address and billing changes ~~and automatic bank draft changes~~ verbally by contacting Customer Service. To request automatic bank draft, members may call customer service and request the "Automatic Bank Draft Authorization Agreement" form. Members can also make these changes by submitting a written request or by contacting their agent. If their agent is submitting the change to Anthem, the agent must submit the changes in writing by fax or email. Automatic deductions will begin on the next billing period after the receipt date of the request to use bank draft.

### **Age Determination**

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In Kentucky, the applicant's age on the effective date of coverage will determine the correct rate. In Indiana and Ohio, the applicant's age on the first of the month of the effective date of coverage will determine the correct rate. If the effective date is changed, the rate could also change. Premium due to age increases will be effective at the member's annual renewal of the policy.

### **Agent Checklist for New Business Applications**

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1. All sections of the application must be completed in full.

2. Each response on the application should be printed legibly using ink. Any cross-out, alteration, change or correction must be clearly marked and initialed by the applicant.
3. List applicant's home and business phone numbers if applicable.
4. Be sure that all medical care received during the period of time specified in the application is fully recorded for each person listed in the application.
5. Complete all necessary Medical Questionnaires for Under 65 applications. For Medicare-eligible applications, complete all necessary questions, including the Medical Questionnaire, if applicable.
6. Make sure the applicant (and spouse/domestic partner when appropriate) reviews, signs and dates the completed application.
7. Your name, tax identification number, and broker code (on your sticker assigned by your general agent) must be clearly identified on the application.
8. Obtain the premium based upon premium payment method requested. Cash and post-dated checks are not acceptable. Checks should be made payable to "Anthem Blue Cross and Blue Shield." **Please advise the applicant that checks will be converted to an electronic transaction. The electronic transaction will be processed and the applicant's account charged only if the application is approved. If the application is denied or withdrawn, the electronic transaction will not be processed. In both cases, the paper check is destroyed.**
9. Before submission, check the application for completeness. Incomplete applications will delay the processing of your customer's application and may be returned.
10. The street address must be listed on the application. Do not use a PO Box only.

## ***Appeals***

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All applicants who receive an adverse underwriting decision for a request for individual coverage will receive written notification of our decision. Every applicant who receives an adverse underwriting decision has the right to appeal the decision.

The applicant has the opportunity when they are given written notification of an adverse decision to submit a written appeal. This written request may be from the applicant or a person acting on behalf of the applicant such as a health care provider, broker or family member. All responses to appeal requests will be directed and sent to the applicant.

The purpose of an appeal is to provide additional information that was not available during the initial review or to provide corrections to the information that was provided. To expedite the appeal process the applicants should submit supporting information from their provider with the written appeal. If supporting information is not submitted with the written appeal it will be requested if necessary during the appeal review. The original application is only good for 75 days, so a new application may be needed in order to process an appeal request if the original application becomes outdated.

## ***Attending Physician's Statement (APS)***

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Medical records and an APS may be requested by Underwriting to supplement the information on the application. An APS may be requested if the application indicates a condition that requires more detailed information or if medical conditions are not fully explained on the application and/or medical questionnaires. An APS may also be requested based on internal claims information.

A **mandatory APS** will be requested if an applicant is over age 55 and **is not** replacing prior coverage and has been to a doctor in the last two years. Underwriting will send the request to the applicant and notify the agent if medical records are needed. It is the applicant's responsibility to have these records sent to Anthem. The applicant is also responsible for any costs incurred in obtaining medical records.

## ***Billing and Payment Options***

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The first month's initial premium is not **required** with the application, but it is encouraged. Once the underwriting process is complete and the applicant's final rate has been determined, any remaining balance due will be included in the next month's bill.

Billing Options: Members may choose paper billing or automatic bank drafts either monthly, quarterly, semi-annually, or annually.

### Payment Options:

Initial payments can be made by credit card (MasterCard, Visa, Discover, or American Express), a one-time automatic bank draft, or by check.

Subsequent/Ongoing payments can be made by automatic bank draft, paper check, or over the phone by calling Customer Service for a one-time credit card or bank draft. Members may also issue an electronic check through their bank's website.

## ***Cancellation***

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All new policies may be cancelled by the applicant, back to the effective date of coverage, if the cancellation request is submitted within 30 days after the applicant receives the contract or certificate, or accesses it online, whichever is earlier. If no claims have been submitted, Anthem will refund all premiums to the applicant.

A policy (excluding short term) will be automatically cancelled when the member transfers to another Anthem Individual plan. The cancellation will be effective at midnight on the day prior to the effective date of the new coverage.

**Note:** *Individual policies are not automatically cancelled when transferring to or from an Anthem Group plan. In this case, the member must request cancellation of the Individual coverage. If a member moves out of state, medical and dental coverage can be transferred to another Blue plan; however Life coverage (if any) will continue.*

All other cancellation requests must be received 30 days in advance of the cancellation date. If proper notification is not given, the member will be asked to pay the final month's bill or have the policy lapse for nonpayment if payment is not made. Customer Service will accept cancellation requests verbally over the phone; the customer can also submit a written request to cancel coverage.

Members with multiple policies (i.e., medical, dental, and/or life coverage) must specify which policies are to be cancelled. The other policies will remain effective. If the member does not specify which policies should be cancelled, all active coverage will be cancelled.

**Life Policies only:** Life coverage will be automatically cancelled on the last day of the month in which a covered member turns age 65. Eligible spouses/domestic partners and dependents under age 65 may continue their coverage under the Life Insurance policy.

**For Short Term cancellation policy, see Short Term section.**

**Note:** See "Death of a Policyholder" for policies related to death cancellations.

## ***Certificate of Coverage or Policy Delivery***

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The member will receive, along with their ID cards, instructions on how to obtain their certificate of coverage or policy via the internet. The member will also receive a postcard that can be returned if a paper copy of the certificate is requested.

## ***Child Only Policy***

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Effective 9/23/2010 we are no longer offering child only policies, except in KY. This may be a temporary measure. This applies to anyone under the age of 19.

KY Child Only policies will be offered through an Open Enrollment period each January. Applicants can apply outside of the Open Enrollment period, but there must be a HIPAA qualifying event. The only product available is Smart Sense \$2500 deductible as a single policy per child under the age of 19.

## ***Completion of the Application***

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The most important source of underwriting information is the application. The underwriting process can often be completed with a simple review of the application. Each question on the application must be *specifically* answered by each applicant and all responses must be accurately and completely recorded on the application. All applications must be completed in **ink** or online and the writing agent must verify that the applicant answered the questions, and signed and dated the application. The applicant must initial any erasures or corrections. All "YES" answers to medical questions **must be fully explained** along with the name, address and telephone number of all doctors consulted by the applicant.

## ***Conditional Coverage***

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Coverage does not become effective until Underwriting approves the application. Therefore, an applicant's current coverage should not be cancelled until they receive an approval from Anthem Blue Cross and Blue Shield.

**Note:** See *Effective Date Assignment* section for information on available effective dates.

## ***Counter Offers and Issue Letters***

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Anthem Blue Cross and Blue Shield may decline one family member, but offer coverage to others. Or, the applicant may be extended a counter offer for coverage that may include a different plan, or higher deductible level. Counter offer letters will be mailed to the applicant for approval and signature. The agent will also be copied on the letter. The applicant must sign and return the counter offer letter to the Underwriting Department within 15 business days of the date on the letter. Some applicants may also accept the counter offer using voice signature capability. The applicant will be instructed in the letter to call a specific telephone number to accept the offer. Only applicants who receive this number in their letter have the option to use the voice signature. Applicants who wish to downgrade benefits or request a future effective date can indicate this on the counter offer letter and return it in writing to the Underwriting Department.

Effective December 2006, we will not issue counter offer letters on single option counter offers where an increased risk tier is being approved. Instead, we will automatically enroll applicants based on their assigned rating tier. Applicants will receive an issue letter explaining our underwriting decision and

informing them of the new premium amount. The agent will also be copied on the letter. Since the premium will be higher than originally quoted, we will issue a paper billing statement for the first month's premium, along with ID cards. Applicants will not have to do anything to accept the coverage, other than pay the premium.

### ***Death of a Certificate Holder***

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Written or telephone notification to Anthem Blue Cross and Blue Shield is required after the death of a policyholder. Termination of the policy will be effective the day after the policyholder's death; this is to ensure eligible benefits are paid up to the date of death and any unused premiums will be refunded. If Anthem Blue Cross and Blue Shield are notified of the death of the policyholder after 91 days following the date of death, a copy of the death certificate will be required for a refund of any unused premiums.

### ***Declination***

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If a health condition(s) or other underwriting criteria makes it impossible for coverage to be offered on any basis, the application is declined, any initial payment submitted with the application will not be processed. If the initial payment is submitted via check, the original check will be destroyed and will not be returned to the applicant. If a money order is submitted, a refund check will be sent to the applicant. The applicant will receive a letter from Anthem Blue Cross and Blue Shield advising them of the reason for declination. Agents are sent a copy of the declination letter as well.

### ***Reducing Benefits (Downgrades)***

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Any reduction of benefits (including an increase in the deductible level or removal of an optional rider) is considered a 'downgrade' in benefits. Policyholders can upgrade or downgrade benefits twice per year: once at renewal and once more within 12 months. Policyholders can make changes by calling their agent, contacting Customer Service, or completing a Downgrade/Policy Change Form. The change will be effective on the first day of the month after notification is received by Anthem Blue Cross and Blue Shield, or on a specified future date if requested by the policyholder. **Note: Effective dates on benefit changes must be the same day of the month as the renewal date.**

An automated Product Change Options Tool is available on the Individual Producer's Website under Rating Tools.

**Note:** *The Downgrade/Policy Change Form can be found in the Miscellaneous section of this manual as well as on the Individual Producer Site.*

### ***Dental Coverage***

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Dental Blue®, Dental Blue Basic and Dental Blue Essential (100 or 200) are dental PPO products, available as a stand-alone product in addition to medical coverage. These products provide coverage for Diagnostic and Preventive Care, as well as Basic and Major Dental Care.

**Note:** Please refer to the **UNDER 65 PRODUCTS, Specialty Products** section for product details.

The applicant must be covered for dental before a spouse/domestic partner or any dependents can be eligible for dental coverage. If dental coverage is requested for children, all of the dependents must be covered and a premium will be charged for each child.

Each member with active dental coverage will be charged a premium.

Members who cancel their medical coverage may keep dental coverage active, if they wish. For combined billing, dental must have the same renewal date as Medical. If both medical and dental coverage is requested, one application should be submitted for both plans rather than submitting separate medical and dental applications.

## ***Dependent Coverage***

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Eligible dependents of the policyholder or spouse/domestic partner include married or unmarried children up to the end of the calendar month in which they turn 26 (OH is age 28), regardless of student or tax status. This applies to Kentucky and Ohio. For Indiana, the following applies: An eligible dependent may be your children (married or unmarried), your spouse or domestic partner's unmarried children, an unmarried child subject to legal guardianship, or other\* eligible dependents who depend on you for 50% of their financial support including your spouse or domestic partner's married children, your grandchildren (married or unmarried), a married child subject to legal guardianship or other blood relative (married or unmarried) to the end of the calendar month in which they turn 26.\*Requires submission of completed Affidavit of Dependency for Indiana Individual Policies. Premium is charged for up to 3 dependent children on a medical policy. On the application, the primary applicant will be asked to list all dependents beginning with the eldest.

## ***Dependents Who Reach Age Limitation***

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A covered dependent that loses eligibility upon attaining the maximum age is automatically enrolled in their own policy with the same benefits as they had on their parent's policy when available. Dependents can contact their agent about other plan options. Pre-existing credit and credit for any deductible amount met under the original plan will be applied to the new plan.

If the application is received after the 31-day period, the applicant will be subject to Medical Underwriting approval. Coverage will begin according to the regulations set forth under the Effective Date Assignment section of this guide.

## ***Divorce***

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When a covered person (including a dependent) loses coverage due to divorce, he or she may apply for his or her own coverage. A new application must be completed and received within 31 days of losing eligibility. If the application is received within the 31-day period, the applicant will be guaranteed the same plan (or similar plan if the same plan is no longer offered), with no lapse in coverage. Pre-existing credit and credit for any deductible amount met under the original plan will be applied to the new plan.

If the application is received after the 31-day period, the applicant will be subject to medical underwriting approval. Coverage will begin according to the regulations set forth under the Effective Date Assignment section of this guide.

## ***Domestic Partners***

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Domestic partners of the same or opposite sex are eligible for coverage if: he or she has been the sole domestic partner of the primary applicant for 12 months or more; he or she is mentally competent; he or she is not related to the primary applicant in any way (including by blood or adoption) that would prohibit marriage under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with the primary applicant. A Domestic

Partner shall be treated the same as a Spouse, and a Domestic Partner's unmarried Child, adopted Child, or Child for whom a Domestic Partner has legal guardianship shall be treated the same as any other Child. A Domestic Partner's or a Domestic Partner's Child Coverage ends on the date of dissolution of the Domestic Partnership.

## ***Dual Coverage***

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If an Anthem Blue Cross and Blue Shield individual member has health coverage under another policy once his/her Anthem individual policy is effective, and the member stated that no other health coverage would be in effect on the effective date of the Anthem policy, Anthem reserves the right to terminate the Anthem coverage. Rescission of the Anthem individual coverage will be retroactive up to 90 days or the policy effective date, at Anthem's discretion.

## ***Effective Date Assignment***

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Effective Date Assignment on Individual applications effective May 1, 2010 (Long term applications only).

### **Indiana and Ohio**

For applicants that are replacing coverage, the earliest effective date will remain the day after Anthem receives the application.

If the applicant **does not specify a requested effective date**, the **day Anthem approves the application** will be assigned.

For applicants that are not replacing coverage, the earliest effective date will be 10 days after the application is received by Anthem. (This does not apply to short term policies)

If an application has been closed and reopened:

In the case where they had other coverage within 63 days, the earliest effective date will be the day Anthem approves the application

### **Overall limitations to effective date policy:**

The effective date cannot be more than **75 days after the applicant's signature date**.

The application must be received within **20 days of the signature date**. Applications received after 20 days from signature date will be required to have the signature date updated and the health history questions confirmed accurate.

The earliest effective date for ALL family members when BOTH a replacing and a non-replacing applicant are on the same application will be 10 days after the application is received by Anthem.

In general, since multiple effective dates cannot be assigned to the same policy, the most conservative effective date rule would apply to the entire policy. This excludes reopened applications; they would receive the 'day of approval' as the earliest effective date.

Applications received 11-20 days after the signature date will be subject to a telephone interview to confirm information is still accurate

### **Kentucky**

For applicants that are replacing coverage, the earliest effective date will remain the 1st or 15th of the month after Anthem receives the application.

If the applicant **does not specify a requested effective date**, the 1st or the 15th of the month after **Anthem approves the application** will be assigned.

For applicants that are not replacing coverage, the earliest effective date will be the 1st or the 15th of the month that is at least 10 days after the application is received by Anthem.

If an application has been closed and reopened:

The earliest effective date will be the 1st or the 15th of the month after Anthem approves the application

The application must be received within **20 days of the signature date**. Applications received after 20 days from signature date will be required to have the signature date updated and the health history questions confirmed accurate.

Applications received 11-20 days after the signature date will be subject to a telephone interview to confirm the information is still accurate.

#### **Overall limitations to effective date policy:**

The effective date cannot be more than **75 days after their signature date**.

#### **Additional clarification on changes:**

The earliest effective date for ALL family members when BOTH a replacing and a non-replacing applicant are on the same application will be the 1st or the 15th of the month that is at least 10 days after the application is received by Anthem.

\* Short term policies can have any day effective date and are not limited to the 1<sup>st</sup> and the 15<sup>th</sup>. They will be assigned effective dates 10 days after received date if applicants have not had other coverage in the last 63 days.

## ***Eligibility***

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Applicants who meet the following criteria are eligible to apply for individual coverage:

- Cannot be eligible for Medicare.
- Must be between the ages of “newborn” and age 64. (Must be under age 65)
- Must be a resident of the state in which they are applying for coverage.
- Cannot be currently pregnant or an expectant parent.
- Must be a legal U.S. resident
- Cannot be on active military duty with any branch of the Armed Services.

*If an existing member moves out of state, he or she may lose eligibility and coverage may be terminated.*

## ***Foreign Exchange Students***

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Anthem will offer coverage to Foreign Exchange Students enrolled in the foreign exchange student program and pass medical underwriting. If the foreign exchange student has not resided in the U.S. for at least 3 months, they must have a physician complete our Medical History Form. The foreign exchange student cannot travel outside of the U.S. for more than 30 consecutive days during the term of the policy. **Note: The Medical History Form can be found in the Miscellaneous Forms section of this manual.**

## ***High Deductibles***

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For certain conditions listed in the agent guide, there may be a lower risk tier available for members/applicants who currently have the specified condition. Anthem may allow a lower risk tier when a certain deductible option is selected by the member. Please see the specific health condition in the agent guide for the deductible options.

## ***ID Cards***

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New members will receive ID cards approximately 7 to 10 days after enrollment, along with instructions on how to obtain a certificate of coverage. New members will also receive a separate Welcome letter shortly thereafter.

## ***Life Coverage***

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Health coverage applicants may apply for the Blue Preferred Choice Term Life coverage. New applicants must meet Anthem's medical underwriting guidelines to qualify. Term Life coverage is not offered as a standalone product.

The benefit options are: \$15,000, \$25,000, and \$50,000. The \$50,000 option is not available to applicants under the age of 19. If the \$50,000 option is selected by an approved applicant under the age of 19, coverage will default to \$25,000. Applicants under the age of one year are not eligible for Life Insurance.

The primary subscriber must carry Life coverage before a spouse/domestic partner or any dependents can be eligible for Life coverage. If Term Life coverage is selected for dependent children, **all** of the dependent children must be insured for the same benefit amount.

Active Term Life coverage will be automatically cancelled on the last day of the month of the covered member's 65<sup>th</sup> birthday. Spouses/domestic partners and dependents may continue Term Life coverage, if eligible.

## ***List Bill***

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### **Criteria for List Billing**

- The List Bill Arrangement is intended for a group of individual policies to be paid by a single payer as a convenience. It is not intended for use by families.
- A List Bill Arrangement must contain two or more subscribers to be eligible for or to maintain List Bill Arrangement status.
- 100% of premiums must be paid by the policyholder. There cannot be any employer contributions to or reimbursements of the premium payment.

### **Applying for Coverage**

- The Request for List Bill Arrangement form must be completed by noting all subscribers to be enrolled under the List Bill Arrangement.
- Each subscriber must complete an individual application for coverage and the Permission to Provide List Bill Arrangement form.
- The Permission to Provide List Bill Arrangement form must be signed by the applicant. If the applicant is a minor, it must be signed by a parent or guardian.
- The subscriber's name (even if he or she is a minor) must be on the Request for List Bill Arrangement form and the Permission to Provide List Bill Arrangement form.
- A completed copy of the Request for List Bill Arrangement form must be signed by the List Bill Administrator or the Third Party (employer) and submitted with the applications.
- All subscriber must request the same billing due date and bill cycle (monthly, quarterly, semi-annual, annually), although effective dates may be different.
- Do not submit payment with these applications. A bill will be sent after the applications are processed.
- List Bill applications sent with missing or incomplete forms will be pended until all completed forms are received.

### **Adding to an Existing List Bill**

- To add an applicant to an existing List Billed account, the applicant must complete an individual application for coverage and attach a Permission to Provide List Bill Arrangement form (Disclaimer), and a copy of the Request for List Bill Arrangement form (which should include the new member), and send the completed forms to their agent.
- The Request for List Bill Arrangement form must include the Parent Group Number that can be found on the monthly bill summary. Please note that the billing date for this new member will be the same as the other Group members. (i.e.: 1st or the 15th of the month).
- To add existing subscribers to a List Billing Arrangement, Permission to Provide List Bill Arrangement form must be signed by each subscriber. The forms must be sent with a copy of the Request for List Billing Arrangement form (with all new members' names listed).
- In order to add a dependent to an existing individual policy, the policyholder must submit an application to Anthem via his or her agent. (same effective date: 1st or the 15th of the month).

### **Cancellation of List Bill Affiliation**

- Cancellation of a List Bill account must be received by Anthem in writing from the List Bill Administrator or the List Bill Administrators authorized agent 30 days prior to the cancellation date requested.
- Upon cancellation of a List Billed account, all individual policyholders billed within that account will begin receiving monthly billings at their home address. Any refund that is due will be issued to the policyholder. The check will be made out to the policyholder; however it will be mailed to the List Bill address.
- If the List Bill Administrator requests that a subscriber be removed from the List Bill Arrangement, that subscriber will be moved as of the date through which premiums are paid and will begin receiving monthly bills at his or her home address.
- Each subscriber must be advised that his or her individual policy does not terminate if employment ends provided the premiums are paid.

## Marriage

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Current members who wish to add a spouse due to marriage must submit a new application. The spouse is subject to full medical underwriting. Both the current member and the spouse must sign the application. The new application must be received by Anthem Blue Cross and Blue Shield within 31 days of marriage in order for coverage to begin on the date of marriage. If the application is after 31 days of marriage, coverage will begin according to the regulations set forth under the Effective Date Assignment section of this guide.

## Medical Questionnaires

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Medical questionnaires should be used to supplement “yes” answers indicated on the application. Questionnaires should be completed, signed and dated by the applicant; however, an agent may obtain the applicant’s information over the telephone, sign and date the questionnaire, and indicate with whom they spoke. In most cases, an Attending Physician’s Statement (APS) is not necessary if a questionnaire is fully completed and submitted. Agents may obtain the questionnaires listed below in the Medical Questionnaire section of this manual or from the Individual Producer website:

Abnormal Pap Smear  
Alcohol & Drug  
Arthritis  
Asthma/Allergy  
Attention Deficit Disorder  
Back/Spinal  
Colitis/Irritable Bowel  
Diabetes



Digestive  
Ear/Otitis  
Endometriosis  
Fibromyalgia  
Gout  
Heart Murmur/MVP  
Hypertension



Kidney/Urinary  
Mental Health  
Migraine  
Seizure/Epilepsy  
Thyroid  
Tumor/Cyst  
Ulcer

## Member Self Serve

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Members have the ability to manage their health benefits any time, day or night, through the Anthem website at [www.anthem.com](http://www.anthem.com). Members under the age of 18 cannot be viewed or registered in Member Self Serve. Members should select the member tab, and enter their home state. Members who log in to MyAnthem<sup>SM</sup> and select *MyServices* will be able to:

- find a doctor or hospital
- order a new ID card
- view benefits
- check a claim status
- check the formulary

## Non U.S. Citizen Eligibility

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A non U.S. citizen must reside in the U.S. for a minimum of 3 months. For non U.S. citizens that have not resided in the U.S. for at least 3 months, they will be required to have a paramed exam completed if age 55 and over. A medical history form will be required for anyone under age 55.. The effective date cannot be prior to the day after Anthem receives the paramed exam results.

## **PARAMEDICAL EXAMS**

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A paramedical exam will be requested by Underwriting to assess the current health status of individual applicants age 55 or older who have not been seen by a physician in the last 24 months. These exams are at no cost to the applicant and will help us improve our underwriting process by making sure we have the most up-to-date medical information from all applicants.

Paramedical exams will be similar to a routine physical. A medical history will be gathered, and the certified paramedical professional will complete a review of the applicant's health (general health, neurological, musculoskeletal, etc.), vital signs will be taken, a urine specimen will be requested and blood will be drawn to check blood chemistry and lipids. There will also be a drug screen. The exam should take approximately 30 minutes to an hour.

Anthem's paramedical exam vendor will contact the applicant within 24 hours of Anthem requesting the exam. The vendor will attempt to contact the applicant by phone. Applicants will be given the option of scheduling the exam in their homes, in-office or at a clinic. A copy of the lab results will be sent to the applicant by the lab.

## ***Plan Transfers***

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If a current Anthem Blue Cross and Blue Shield member moves outside the state of residence in which the policy is held, the Blue Cross and Blue Shield Association, an association of independently licensed Blue Cross and Blue Shield plans, requires the member to transfer to a local plan in the new state of residence. It is the policyholder's responsibility to apply for a new policy within that state. A letter will be sent to the member requesting permission to send a letter to the other plan.

Medical and dental coverage's may be transferred to another Blue plan; however, Term Life coverage can remain active with Anthem unless the policyholder requests cancellation.

Dental policies will be cancelled and transferred to the new local plan.

## ***Pregnancy***

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Coverage is NOT available to any applicant or spouse/domestic partner if either is currently pregnant, whether they are to be covered on the policy or not, ***IF*** they are an expectant parent. However, children of the expectant parent(s), or sibling of an expectant minor, may be written independently.

## ***Premium Requirements***

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The first month's premium may accompany the application. Initial payments can be made via credit card (MasterCard, Visa, Discover, or American Express), check or authorization for a one-time bank draft.

If the initial premium is submitted via check, we will convert that check to a one-time bank draft/electronic transaction and destroy the original check; however the premium amount will not be deducted from the applicant's bank account unless and until the application is approved. If the application is declined, the applicant will receive a declination letter indicating the reason coverage was denied.

For subsequent premium payments, applicants have two billing options – (1) automatic bank draft and (2) paper billing. Members can choose to be billed monthly, quarterly, semi-annually or annually. If premiums will be paid by a third-party administrator, a list bill arrangement may be a third billing option. See the List Bill Section of this manual for additional information.

**Automatic Bank Draft:** Premium payments will be automatically deducted from a checking or savings account. Applicants requesting Automatic Bank Draft must complete and sign the Automatic Bank Draft Authorization section included on the application. If premium payments will be deducted from a savings account the member should contact their financial institution and validate the routing number (different from checking account). Members can also request Automatic Bank Draft for an existing policy by calling Customer Service and request the “Automatic Bank Draft Authorization Agreement” form.

Although every effort is made to set up Automatic Bank Draft payments with the appropriate financial institution as quickly as possible, processing delays sometimes occur. If Automatic Bank Draft is requested on a new application and a processing delay prevents Anthem from collecting any initial premium(s), the initial Automatic Bank Draft payment, once established, will include the current premium and any back premiums owed as a result of the delay. In this event, members will receive a letter notifying them of the total initial Bank Draft amount, and giving them the option of canceling the withdrawal. Members who request Automatic Bank Draft on an existing policy may receive a direct bill at their home address if the policy is not paid up through the current billing period at the time the Automatic Bank Draft becomes effective.

**Bill Direct:** Billed at the member’s home address monthly, quarterly, semi-annually or annually unless a separate billing address is provided.

**List Bill:** If an individual applicant will be making premium payments through his or her employer (via payroll deduction) Anthem can arrange to bill the employer directly each month via a list bill. The List Bill option requires 2 or more employees to be set up. **See the List Bill section of this manual for additional information.**

### **Short-Term**

**Advance Payment:** Full premium for the entire term of coverage in the form of check, money order or credit card.

**Automatic Bank Draft for Monthly Billing:** \$10 additional monthly fee will be assessed (Short-Term product only).

**Monthly Billing:** \$10 additional monthly fee will be assessed (Short-Term product only). (At least one month’s premium is required with the application)

**\*\*The effective date policy for Short Term applications is the same as for regular applications. Please refer to the Effective Date section of this manual.**

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## **Pre-Existing Conditions**

### **KENTUCKY LANGUAGE**

A pre-existing condition is defined as a condition (mental or physical) that was present and for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the Enrollment Date. Pregnancy that exists on the effective date is considered a pre-existing condition. Domestic violence is not considered a pre-existing condition. Genetic information may not be used as a condition in the absence of a diagnosis.

Pre-existing conditions are only covered after the coverage has been in force for 12 consecutive months following the effective date of coverage. Credit for a prior carrier's coverage may be given, if that coverage was continuous to a date not more than 63 days prior to Anthem's receipt date of a completed application.

### ***INDIANA LANGUAGE***

A pre-existing condition is defined as an illness, injury or condition which within the 12-month period, depending on the policy prior to the effective date, manifested itself in such a manner as would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment for which medical advice, diagnosis, care or treatment was recommended or received. Pregnancy, in addition, which exists on the effective date, is also considered a pre-existing condition.

Pre-existing conditions are only covered after the coverage has been in force for 12 consecutive months, following the effective date of coverage. Credit for a prior carrier's pre-existing period may be given, if that coverage was continuous to a date not more than 63 days prior to Anthems' receipt date of a completed application.

### ***OHIO LANGUAGE***

A pre-existing condition is defined as an illness, injury or condition which within six months prior to the effective date manifested itself in such a manner as would cause an ordinary prudent person to seek medical advice, diagnosis, care or treatment or for which medical advice, diagnosis, care or treatment was recommended or received. Pregnancy, which exists on the effective date, is also considered a pre-existing condition.

Pre-existing conditions are only covered after the coverage has been in force 12 consecutive months, following the effective date of coverage. Credit for a prior carrier's pre-existing period may be given, if that coverage was continuous to a date not more than 63 days prior to Anthem's receipt date of a completed application.

### ***Tri-State***

Prior coverage can be from a group, individual or short-term contract, (Medicaid qualifies as prior coverage) but it must be a major medical type policy. To apply for pre-existing credit, the applicant must complete the section for prior coverage information on the application. Credit is not available if the prior coverage was an indemnity plan, hospital only plan or supplemental policy.

### ***Short-Term***

A pre-existing condition is an illness, injury or condition, which within 24 months prior to the effective date, manifested itself in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment or for which a medical advice, diagnosis, care or treatment was recommended or received. Pregnancy, which exists on the effective date, is also considered a pre-existing condition. Pre-existing conditions are not covered for the term of the certificate. If you become pregnant during the term of coverage, the plan only covers complications. **Credit for a prior carrier's pre-existing period will not be given.**

### ***Reinstatements***

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If a current member allows his/her contract to terminate and wishes reinstatement, he/she will automatically be eligible if the request for reinstatement is received within 60 days of the paid to date and premium to pay up to date.

If a member does not fall within above guidelines, a new application for coverage must be completed and Medical Underwriting will apply. If approved, a new effective date for coverage will be established.

## **Renewals/Rate Increases**

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Members are typically notified at least 30 days in advance of any intended rate increases. Approximately 15 days prior to the customer notification, agents will have access to a listing of their members who will be affected by the rate increase. Renewals occur approximately 12 months from the policy effective date. Renewal dates for all members will be the first of the month in which the policies were originally effective. For example, a policy with a July 15<sup>th</sup> effective date will have a July 1<sup>st</sup> annual renewal date. On the renewal date, the policyholder will receive applicable age and product rate changes.

*(KY only)* All policyholders' rates are **guaranteed** for 12 months starting from their effective date. Rate renewals will occur each month as policies exhaust their 12-month rate guarantee. (Changes made outside of renewal could potentially change members' renewal month.)

## **Short-Term Coverage**

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Short-term coverage can be selected in monthly increments up to a maximum of six months. Short-Term coverage is not renewable; however, individuals may purchase a second Short-Term policy, if they are able to answer "NO" to the current medical questions on the application. A new application must be completed and sent to Anthem for approval, along with the appropriate premium.

At least six (6) months must lapse after the end of the second contract term before the applicant can purchase another Short-Term plan. Any condition that occurred during an earlier contract term will be treated as a pre-existing condition under subsequent contracts. *Please refer to the pre-existing condition section for additional information.*

Short-Term policies can be cancelled if the policyholder requests cancellation 30 days prior to the desired cancellation date.

Short term policies cannot be rated. They are either Accept or Decline  
**Credit for a prior carrier's pre-existing period will not be given.**

Counter offers may be issued if one individual is declined on a family or couple contract.

## **Signature Requirements**

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The primary applicant (and spouse/domestic partner or dependent child(ren) age 18 or over, if applying), must sign and date the application. The parent/guardian of a dependent child applying must sign and date the application, if the dependent child(ren) is age 18 or over. Failure to obtain any of the above signatures will result in the return of the application. The application will expire 75 days from the signature date if health coverage has not been approved by the end of the 75-day period.

## **Small Group Requirements (Indiana Only)**

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Coverage is not available to any person in an employer setting if two or more employees of an employer who meets the criteria of IC 27-8-15-1 as a small employer will be reimbursing or paying for any part of the premium for the policy. A small employer is classified as any person, firm, corporation, limited liability company, partnership or association actively engaged in business, which employs at least two but not more than 50, eligible employees during at least 50% of the working days of the employer during the preceding calendar year. The majority of those employed during that time work in

Indiana. Companies that are affiliated or that are eligible to file a combined tax return for purposes of taxation are considered to be one employer.

### ***Surviving Spouse/Domestic Partner/Dependents***

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If a covered spouse or domestic partner or dependents (if any) lose coverage due to the death of the primary policyholder, the spouse or domestic partner may continue the contract in his/her name. Anthem must receive notification within 31 days following the primary policyholder's date of death.

If notification is received after the 31-day period, a new application must be submitted and the applicant will be subject to Medical Underwriting approval. If approved, coverage will begin on the next date after the application is received, or a later date if requested.

### ***Telephone Interviews***

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The applicant should be aware that the Underwriting Department may conduct a telephone interview to verify information on the application, or to obtain additional details or missing information for the purpose of underwriting.

### ***Tier Rating***

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Anthem offers tier-rated coverage on all non-Medicare Supplement and non-short term products. Super Preferred, Preferred 1, Preferred 2, Preferred 3, Standard 1, Standard 2, Standard 3, Modified 1 and Modified 2 rates are available based upon health status and tobacco usage. Generally, underwriting will permit tobacco users any plan at a risk tier of Standard 1 with no other ratable health history in Indiana and Ohio. (For Kentucky, the tobacco user must be under the age of 30 to be Standard 1. Age 30 and over tobacco users are Standard 3.). Approval and final rate tier placement is always determined by Medical Underwriting. Any changes to the rate quoted by the applicant's agent will be communicated to the applicant and agent by the Underwriting Department. This will be a counteroffer letter, which must be signed by the applicant and returned to the Underwriting Department within 15 business days of the date on the letter, or an Issue Letter which does not have to be signed and returned.

In order to qualify for the Super Preferred risk tier, the applicant and/or spouse/domestic partner must complete the Healthy Lifestyle section on the application. The Super Preferred rate is only available for an applicant who is at least 19 years of age and spouse/domestic partner who is at least 18 years of age or older. Children are not eligible. The applicant(s) must be able to answer "yes" to all the questions for Ohio and Indiana and Kentucky questions 1, 2 and 4 must be yes and question 3 must be no. They must also fall within the restricted super preferred range on the build chart. (*This chart can be found in the height/weight section of this manual.*) The Healthy Lifestyle questions are in addition to the other medical questions on the application. The Super Preferred Rate is a quotable rate. **The tiers equate as follows:**

<b>Tier</b>	<b>Factor</b>	<b>Rate decrease/ Rate up</b>
Super Preferred (Lumenos plans)	0.516	-7%
Super Preferred (All other plans)	0.544	-5%
Preferred 1	0.573	base rate
Preferred 2	0.610	6.5%
Preferred 3	0.650	13.5%
Standard 1	0.688	20%
Standard 2	0.757	30%
Standard 3	0.802	40%

Modified 1	0.917	60%
Modified 2	1.031	80%
Modified 3 ( Available for TAA only)	1.433	150%
Modified 4(available in OH Only)	1.500	162%
Modified 5(available in IN Only)	2.292	300%

Please indicate on the application the tier you have quoted for all applicants dependents.

### ***Tobacco/Non-Tobacco Use Rate***

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Preferred rates may be available to any applicant, spouse/domestic partner or dependent that has not used ANY form of tobacco products within the past twelve (12) months.

Generally, tobacco users (applicant and spouse/domestic partner) with no other ratable health history are eligible for any plan at a risk of Standard 1 in Indiana and Ohio. In Kentucky, the tobacco user must be under the age of 30 to be Standard 1. Age 30 and over tobacco users are Standard 3.

*Note: Please refer to the section titled Tier Rating for all other rating tiers.*

### ***Underwriting Opinion Form***

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The Underwriting Opinion Form is designed to be used when agents face a difficult question that may not be addressed in the Medical Condition Guide or if there is uncertainty as to whether we would consider the application or decline coverage.

Underwriting will make a determination based only on the information provided on this form, and then return the form to the agent. If an application is submitted following the return of an Underwriting Opinion Form, please attach form to your completed application.

### ***Withdraw Application***

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To withdraw an application, Anthem Blue Cross and Blue Shield must be notified by the applicant or agent. The request can be submitted in writing, by fax, or by calling Anthem.

# MEDICAL CONDITIONS AND RATING GUIDE

## Introduction

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Medical Underwriting is the process of estimating the morbidity risk of an applicant for health coverage. Various sources are used for estimating this risk; however, the most important is the application. This guide is intended to help the writing agent solicit and write applications for coverage, and should not be interpreted as a guarantee of underwriting action on any one specific case. The agent and applicant must be aware that the final decision regarding insurability and possible effective dates is always made by the Medical Underwriting Department.

This section includes some medical conditions and the probable underwriting action for applicants with such conditions. This is not an all-inclusive list and final decisions will be determined by Medical Underwriting. Conditions are classified and rated as follows:

<b>SPRE</b>	<b>SUPER PREFERRED RATE BAND (Only available for applicant and spouse/domestic partner 18 years of age and older. The Healthy Lifestyle Questions on the application must be completed.)</b>
<b>Pref 1</b>	<b>PREFERRED ONE RATE BAND (non-tobacco use)</b>
<b>Pref 2</b>	<b>PREFERRED TWO RATE BAND</b>
<b>Pref3</b>	<b>PREFERRED THREE RATE BAND</b>
<b>Std 1</b>	<b>STANDARD ONE RATE BAND* (tobacco use)</b>
<b>Std 2</b>	<b>STANDARD TWO RATE BAND</b>
<b>Std 3</b>	<b>STANDARD THREE RATE BAND** (tobacco use)</b>
<b>Mod1</b>	<b>MODIFIED 1 RATE BAND</b>
<b>Mod 2</b>	<b>MODIFIED 2 RATE BAND</b>
<b>Mod 3</b>	<b>MODIFIED 3 RATE BAND ( MAXIMUM RATE TIER TAA ONLY)</b>
<b>MOD 4</b>	<b>MODIFIED 4 RATE BAND (AVAILABLE IN OH ONLY)</b>
<b>MOD 5</b>	<b>MODIFIED 5 RATE BAND (AVAILABLE IN INDIANA ONLY)</b>
<b>IC</b>	<b>INDIVIDUAL CONSIDERATION</b>
<b>APS</b>	<b>MEDICAL RECORDS MAY BE REQUIRED</b>
<b>DEC</b>	<b>DECLINE</b>

\*\*\*\*All conditions being treated with prescription medication are also subject to a rating increase based on the cost of the medications being used.

**\*Indiana and Ohio:** Underwriting will permit tobacco users on any plan at a risk tier of Standard 1 with no other ratable health history.

**\*Kentucky:** Underwriting will permit tobacco users on any plan at a risk tier of Standard 1 with no other ratable health history, the tobacco user must be under the age of 30.

**\*\*Kentucky:** Tobacco user age 30 and above.

## KEY POINTS TO CONSIDER

- Decisions for applicants contemplating surgery will be postponed until surgery is completed.
- Applicants with several conditions may be declined due to the combination of conditions.
- Please refer to the Build Chart for applicants, spouses/domestic partners, and all dependents to determine the “baseline” rate band **before** factoring in any medical conditions.
- The ratings on several conditions, including build, will be adjusted for age.
- Decisions for expectant parents will be postponed until after delivery.
- All ratings will depend on the benefit plan and deductible selected.
- If health information is discovered that is not on the application, it will be referenced as PHI (Protected Health Information) and cannot be released to the agent per HIPAA guidelines. Correspondence will be handled between the applicant and Underwriting.
- Prescription drug usage will be rated for dosage and cost. This could result in an offer of no prescription coverage.

Condition	Criteria	Rating Level			
		Single Member Deductible Levels			
		\$2400 Deductible or lower	\$2500-\$4900 Deductible	\$5000-\$9900 Deductible	\$10,000 Deductible or higher
<b>Acne</b> (subject to Age Adjustment)	<u>ON ACCUTANE/AMNESTEEM/CLARAVIS/SOTRET WITHIN 2 MONTHS</u>	Decline	Decline	Decline	Decline
	Ongoing treatment with acne surgery or steroid injection	Decline	Decline	Decline	Decline
	Currently treated with topical ointments or antibiotics	Std 1	Pref 1	Pref 1	Pref 1
	No SST and no Dr visit within past 90 days	Pref 1	Pref 1	Pref 1	Pref 1
<b>Acquired Immune Deficiency Syndrome or Aids Related Complex</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Alcohol / Drug Dependency</b> (subject to Age Adjustment)	Treatment within 5 years	Decline	Decline	Decline	Decline
	Treatment free for 5 years	IC/APS	IC/APS	IC/APS	IC/APS
<b>Allergy</b> (subject to Age Adjustment)	Seasonal/occasional, no medication or minimal prescription use	Pref 1	Pref 1	Pref 1	Pref 1
	Daily prescription use, or allergy shots	Std 1	Pref 1	Pref 1	Pref 1
	Daily use of steroidal bronchodilator	Std 3	Std 3	Pref 1	Pref 1
<b>Alzheimer's</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Amputation</b> (not caused by disease)	Fingers / toes	Pref 1	Pref 1	Pref 1	Pref 1
	With prosthesis	Std 1	Std 1	Std 1	Std 1
<b>Angina</b>	No Other heart related conditions	IC/APS	IC/APS	IC/APS	IC/APS
<b>Anxiety (Mental Health questionnaire)</b> (subject to Age Adjustment)	Stressful incident resolved, with < 6 month duration	Pref 1	Pref 1	Pref 1	Pref 1
	SST free 6 months	Pref 1	Pref 1	Pref 1	Pref 1
	Above criteria not met:				
	Counseling ONLY or Medication ONLY ( 2 or less)	Std 1	Pref 1	Pref 1	Pref 1
	Counseling AND Medication (or 3 or more medications)	Mod 1	Mod 1	Pref 1	Pref 1
Hospitalization or suicide attempt within 3 years	Decline	Decline	Decline	Decline	

Condition	Criteria	Rating Level			
		Single Member Deductible Levels			
		\$2400 Deductible or lower	\$2500-\$4900 Deductible	\$5000-\$9900 Deductible	\$10,000 Deductible or higher
<b>Arthritis</b> Osteoarthritis Rheumatoid (subject to Age Adjustment)	Osteoarthritis Injection therapy, narcotic or steroid use within 12 months or has required surgery or hospitalization	Decline	Decline	Decline	Decline
	On prescription medication	Std 1	Pref 1	Pref 1	Pref 1
	No prescription medication used	Pref 1	Pref 1	Pref 1	Pref 1
	Of spine: unresolved, or operated and SST within 12 months	Decline	Decline	Decline	Decline
	Rheumatoid Arthritis	Decline	Decline	Decline	Decline
<b>Ascites (all cases)</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Asthma</b> (subject to Age Adjustment)	Acute attack within 6 months or smoking within past 12 months	Decline	Decline	Decline	Decline
	Acute attack > 6 months: Age 2 and under, symptoms controlled	Mod 1	Pref 1	Pref 1	Pref 1
	Age 3 and over, meds used as needed	Std 1	Pref 1	Pref 1	Pref 1
	Age 3 and over, meds used daily	Mod 1	Mod 1	Pref 1	Pref 1
	No medication or treatment in the past 12 months	Pref 1	Pref 1	Pref 1	Pref 1
<b>Attention Deficit Disorder (ADD/ADHD)</b> (subject to Age Adjustment)	Hospitalization or suicide attempt within 3 years	Decline	Decline	Decline	Decline
	Use of 2 or more medications within 30 days	Mod 1	Mod 1	Pref 1	Pref 1
	Less than 2 medications within 30 days and counseling	Std 3	Std 3	Pref 1	Pref 1
	Less than 2 meds within 30 days and no counseling w/in 30 days	Std 1	Pref 1	Pref 1	Pref 1
	SST free 12 months	Pref 1	Pref 1	Pref 1	Pref 1
<b>Back Strain/Sprain</b>	Not related to disc or nerve: SST free 6 months	Pref 1	Pref 1	Pref 1	Pref 1
	SST within 6 months Medication only	Pref 1	Pref 1	Pref 1	Pref 1
	Chiropractic Adjustments Other	Std 1 Std 3	Std 1 Std 3	Std 1 Std 3	Std 1 Std 3
<b>Bronchitis</b> (Allergy and/or asthma questionnaire)	SST free 3 months	Pref 1	Pref 1	Pref 1	Pref 1
	SST within 3 months	Std 1	Std 1	Std 1	Std 1
	Chronic bronchitis, within the past year or smoking with past year	Decline	Decline	Decline	Decline
<b>Bursitis</b>	Single occurrence, resolved, within 12 months	Std 1	Std 1	Std 1	Std 1
	Unresolved, current symptoms or treatment	Decline	Decline	Decline	Decline

Condition	Criteria	Rating Level			
		Single Member Deductible Levels			
		\$2400 Deductible or lower	\$2500- \$4900 Deductible	\$5000- \$9900 Deductible	\$10,000 Deductible or higher
<b>Cancer</b> (Tumor Questionnaire)	Breast Cancer				
	In Situ / Stage 0-1 within 2 years	Decline	Decline	Decline	Decline
	In Situ / Stage 0-1, SST free 2 years	Std 1	Std 1	Std 1	Std 1
	No implants and no medication With implants or medication	Std 3	Std 3	Pref 1	Std 1 Pref 1
	Other stages, cancer free 10 years(from last treatment)	Std 1	Std 1	Pref 1	Pref 1
	Prostate				
	Within 5 years	Decline	Decline	Decline	Decline
	After 5 years	Std 1	Std 1	Std 1	Std 1
	Other internal cancers				
	Within 10 years(from last treatment)	Decline	Decline	Decline	Decline
	After 10 years(from last treatment)	Std 1	Std 1	Std 1	Std 1
<b>Carpel Tunnel Syndrome</b>	Unoperated				
	Mild and treated conservatively within 12 months	Std 1	Std 1	Std 1	Std 1
	SST free for 12 months (use of splint not considered treatment)	Pref 1	Pref 1	Pref 1	Pref 1
	Other than mild, with symptoms or treatment within 12 months (including physical therapy, etc.)	Decline	Decline	Decline	Decline
	Operated, resolved	Pref 1	Pref 1	Pref 1	Pref 1
<b>Cataracts</b>	Unoperated, diagnosed > 12 months, stable	Std 3	Std 3	Std 3	Pref 1
	Operated, released from care but SST within 3 months	Std 1	Pref 1	Pref 1	Pref 1
<b>Cerebral Palsy</b>	< age 20	Decline	Decline	T Decline	Decline
	> age 20	IC/APS	IC/APS	IC/APS	IC/APS
<b>Cholesterol</b> (Fasting and test result must be in past 12 months)	Total cholesterol less than or equal to 199	Pref 1	Pref 1	Pref 1	Pref 1
	Total cholesterol 200-260 on medication	Std 1	Std 1	Std 1	Std 1
	Total cholesterol 200-260 <u>NOT</u> on medication	Std 3	Std 3	Std 3	Std 3
	Total cholesterol >260	Decline	Decline	Decline	Decline
<b>Cirrhosis of the Liver</b>	Once Diagnosed	Decline	Decline	Decline	Decline
<b>Chronic Fatigue Syndrome</b>	Once diagnosed	IC	IC	IC	IC
<b>Chronic Obstructive Pulmonary Disease (COPD, Emphysema)</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Colitis</b> Ulcerative	Unoperated or surgical procedure other than IPAA	Decline	Decline	Decline	Decline
	Total Proctocolectomy with IPAA(SST within 5 years)	Decline	Decline	Decline	Decline

Condition	Criteria	Rating Level			
		Single Member Deductible Levels			
		\$2400 Deductible or lower	\$2500-\$4900 Deductible	\$5000-\$9900 Deductible	\$10,000 Deductible or higher
	Total Proctocolectomy with IPAA(SST free > 5 years and APS)	Mod 1	Mod 1	Mod 1	Mod 1
<b>Coronary Insufficiency</b>	Angina, Angioplasty, Bypass Grafting (CABG) and Myocardial Infarction (Heart Attack)				
	Currently smoking or BMI $\geq$ 28.0	Decline	Decline	Decline	Decline
	Heart attack(Myocardial Infarction)	Decline	Decline	Decline	Decline
	Stent Placement	Decline	Decline	Decline	Decline
	Angina, Angioplasty, Bypass Grafting(CABG)	Decline	Decline	Decline	Decline
<b>Coronary Occlusion</b>	See coronary insufficiency				
<b>Crohn's Disease</b>	Unoperated or operated w/ stoma (i.e. ileostomy or colostomy)	Decline	Decline	Decline	Decline
	Operated without a stoma	APS	APS	APS	APS
<b>Cystic Fibrosis</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Depression ( Not Manic or Psychotic)-Mental Health Questionnaire</b> (subject to Age Adjustment)	Stressful incident resolved, with < 6 month duration	Pref 1	Pref 1	Pref 1	Pref 1
	SST free 6 months	Pref 1	Pref 1	Pref 1	Pref 1
	Above criteria not met:				
	Counseling ONLY or Medication ONLY ( 2 or less)	Std1	Pref 1	Pref 1	Pref 1
	Counseling AND Medication (or 3 or more medications)	Mod 1	Mod 1	Pref 1	Pref 1
	Hospitalization or suicide attempt within 3 years	Decline	Decline	Decline	Decline
<b>Deviated Septum</b>	Not operated, with symptoms	Decline	Decline	Decline	Decline
	Operated, full recovery/released from care	Pref 1	Pref 1	Pref 1	Pref 1

Condition	Criteria	Rating Level			
		Single Member Deductible Levels			
		\$2400 Deductible or lower	\$2500-\$4900 Deductible	\$5000-\$9900 Deductible	\$10,000 Deductible or higher
<b>Diabetes **</b>  **To be considered for coverage, diet or oral med controlled diabetics must be in preferred range for height and weight and must not have any associated medical conditions such as high blood pressure, high cholesterol, kidney disease, circulatory disorders, neuropathy or decreased feeling, numbness or tingling in extremities, diabetic retinopathy or other vision problems. This also includes no tobacco use.	Juvenile Diabetes	Decline	Decline	Decline	Decline
	Type 1 Insulin Dependent Diabetes	Decline	Decline	Decline	Decline
	Type II:				
	Smoking within 12 months, hypertension or overweight	Decline	Decline	Decline	Decline
	Diet controlled, adult onset, excellent control **	APS- Std 1	APS- Std 1	APS- Std 1	APS- Std 1
	Diagnosed within 12 months	Decline	Decline	Decline	Decline
	Oral medication, excellent control** 1-2 years	Mod 1	Mod 1	Mod 1	Mod 1
Oral medication, excellent control** 2+ years	Std 3	Std 3	Std 3	Std 3	
Diet/Oral controlled, Fair to Poor control	Decline	Decline	Decline	Decline	
<b>Disc Disorders</b>	See Spinal Disorders				
<b>Diverticulitis or Diverticulosis</b>	Unoperated w/out hemorrhage/no IP hospital stay, SST w/in 6 mo	Decline	Decline	Decline	Decline
	Operated/Unoperated w/hemorrhage or IP hospital, SST w/in 12 months	Decline	Decline	Decline	Decline
	Operated with stoma (i.e. colostomy, ileostomy)	Decline	Decline	Decline	Decline
	All other cases (varies by SST free period)	Std 1/Std 3	Std 1/Std 3	Pref 1	Pref 1
<b>Drug Treatment</b>	See Alcohol/Drug Dependency				
<b>Emphysema</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Endometriosis</b>	Symptoms controlled effectively/no symptoms	Std 1	Std 1	Std 1	Pref 1
	Current symptoms/laser treatment	Decline	Decline	Decline	Decline
	Operated(hysterectomy) or menopausal	Pref 1	Pref 1	Pref 1	Pref 1
<b>Epilepsy ( Seizure Questionnaire)</b> (subject to Age Adjustment)	Any seizure within past 12 months	Decline	Decline	Decline	Decline
	No seizure > 1 year but < 5 years	Std 3	Std 3	Std 3	Std 3
	No seizure > 5 years	Std 1	Std 1	Std 1	Std 1
<b>Fibrocystic Breast Disease (Tumor/Cyst Questionnaire)</b>	Single cyst, unoperated, benign, no treatment required	Pref 1	Pref 1	Pref 1	Pref 1
	Single cyst, unoperated, benign, multiple episodes, treatment complete	Std 1	Pref 1	Pref 1	Pref 1
	Single cyst, Ongoing testing or treatment	Decline	Decline	Decline	Decline
	Fibrocystic breast disease, treatment within 12 months	Std 1	Pref 1	Pref 1	Pref 1

Condition	Criteria	Rating Level			
		Single Member Deductible Levels			
		\$2400 Deductible or lower	\$2500-\$4900 Deductible	\$5000-\$9900 Deductible	\$10,000 Deductible or higher
<b>Fibromyalgia</b> (subject to Age Adjustment)	No medication or symptoms within past 6 months	Pref 1	Pref 1	Pref 1	Pref 1
	Controlled on maintenance medication (non-narcotic)	Mod 1	Mod 1	Mod 1	Mod 1
	Chronic with narcotic medication or other treatment with in 30 days (other than maintenance medication)	Decline	Decline	Decline	Decline
<b>Friedreich's Ataxia</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Gallbladder Disease</b>	Not operated, with symptoms	Decline	Decline	Decline	Decline
	Operated, full recovery/released from care	Pref 1	Pref 1	Pref 1	Pref 1
<b>Gastric Bypass/Lap Band Surgery</b>	< 3 years	Decline	Decline	Decline	Decline
	> 3 years, weight stable at least 2 years, no complications (weight cannot exceed Std 1)	Std 1	Std 1	Std 1	Std 1
<b>Gastric Reflux(GERD)-</b> (subject to Age Adjustment)	No medication or OTC medication ONLY	Pref 1	Pref 1	Pref 1	Pref 1
	Prescription medication required	Std 3	Std 3	Pref 1	Pref 1
	With Implant present (i.e. ENTERYX, etc)	Decline	Decline	Decline	Decline
<b>Glaucoma</b>	Mild, controlled with follow-up visits and/or eyedrops only	Std 1	Std 1	Std 1	Std 1
	All others	Decline	Decline	Decline	Decline
<b>Gout</b>	No attack / treatment within 2 years	Pref 1	Pref 1	Pref 1	Pref 1
	Controlled with prescription medication	Std 1	Pref 1	Pref 1	Pref 1
<b>Graves Disease</b>	See Thyroid Disorders				
<b>Heart Attack (Myocardial Infarction)</b>	See Coronary Insufficiency				
<b>Heart Murmur</b>	Insignificant/asymptomatic, no treatment	Std 1	Std 1	Std 1	Std 1
	Others	IC/APS	IC/APS	IC/APS	IC/APS
<b>Heart Palpitations</b>	Symptoms controlled within 12 months	Std 1	Std 1	Std 1	Std 1
	Symptoms uncontrolled	Decline	Decline	Decline	Decline
<b>Hemophilia</b>	Once diagnosed	Decline	Decline	Decline	Decline

Condition	Criteria	Rating Level			
		Single Member Deductible Levels			
		\$2400 Deductible or lower	\$2500-\$4900 Deductible	\$5000-\$9900 Deductible	\$10,000 Deductible or higher
<b>Hemorrhoids</b>	Unoperated, treated with topical medication only or no treatment required	Pref 1	Pref 1	Pref 1	Pref 1
	Operated, full recovery	Pref 1	Pref 1	Pref 1	Pref 1
<b>Hepatitis</b>	A within 3 months	IC/APS	IC/APS	IC/APS	IC/APS
	B SST within 2 years	Decline	Decline	Decline	Decline
	C/D/E (Lifetime)	Decline	Decline	Decline	Decline
<b>Hernia</b>	Unoperated, with current symptoms, not a surgical candidate	Mod 1	Mod 1	Mod 1	Mod 1
	Operated, complete recovery	Pref 1	Pref 1	Pref 1	Pref 1
<b>Herpes, Genital</b>	Daily medication (** Pref 1 for \$1500 deductible or higher)	Std 3	Pref 1	Pref 1	Pref 1
	As needed medication or ointment (** Pref 1 for \$1500 deductible or higher)	Std 1	Pref 1	Pref 1	Pref 1
	If diagnosed with 3 or more STD's in past 5 years	Decline	Decline	Decline	Decline
<b>High Blood Pressure (Hypertension Questionnaire)</b>	Uncontrolled, Malignant Hypertension or with Diabetes or with 3 or more co-morbid	Decline	Decline	Decline	Decline
	Controlled, combined with 0-1 co-morbid conditions	Std 1	Std 1	Std 1	Std 1
	Controlled, combined with 2 co-morbid conditions	Mod 1	Mod 1	Mod 1	Mod 1
	Ongoing use of 3 or more medications(diuretic Rx ok)	Decline	Decline	Decline	Decline
<b>Hodgkin's Disease</b>	Within 10 years	Decline	Decline	Decline	Decline
	Over 10 years	Std 1	Std 1	Std 1	Std 1
<b>Huntington's Chorea</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Hypoglycemia</b>	Mild, controlled	Std 1	Std 1	Std 1	Std 1
	Severe or uncontrolled	IC/APS	IC/APS	IC/APS	IC/APS
<b>Hysterectomy</b>	Benign cause	Pref 1	Pref 1	Pref 1	Pref 1
	Due to Cancer (non metastatic) within 10 years	Decline	Decline	Decline	Decline
<b>Infertility Treatment</b>	Post-menopausal, tubal ligation or hysterectomy performed	Pref 1	Pref 1	Pref 1	Pref 1
	If above criteria does not apply: use of infertility drugs/treatment within past 2 years or multiple miscarriages within the past 2 years	Decline	Decline	Decline	Decline
<b>Interstitial Cystitis</b>	Symptoms controlled with no treatment or treated with medication only within the past 12 months	Mod 1	Mod 1	Mod 1	Pref 1
	Symptoms not controlled or treatment other than medication (nerve stimulation, bladder distention etc.)	Decline	Decline	Decline	Decline
<b>Irritable Bowel Syndrome</b>	Controlled on diet or medication for at least 6 months	Pref 1	Pref 1	Pref 1	Pref 1

Condition	Criteria	Rating Level			
		Single Member Deductible Levels			
		\$2400 Deductible or lower	\$2500-\$4900 Deductible	\$5000-\$9900 Deductible	\$10,000 Deductible or higher
	Not controlled	Std 1	Std 1	Pref 1	Pref 1
<b>Hip or Knee Replacement</b>	Done age 60-64 and over one year ago, not due to RA	Mod 1	Mod 1	Mod 1	Mod 1
	Done under age 60 or under one year ago or due to Rheumatoid Arthritis	Decline	Decline	Decline	Decline
<b>Kidney Failure or Dialysis</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Kidney Stones</b>	<b>Multiple episodes within one year</b>	Decline	Decline	Decline	Decline
	<b>Single episode in past year controlled with preventative Rx</b>	Std 1	Std 1	Std 1	Pref 1
	<b>Single Episode in past year with no preventative medication</b>	Std 3	Std 3	Std 3	Pref 1
	<b>After one year</b>	Pref 1	Pref 1	Pref 1	Pref 1
<b>Leukemia</b>	Within 10 years	Decline	Decline	Decline	Decline
	Resolved over 10 years	Std 1	Std 1	Std 1	Std 1
<b>Maintenance Medications for any condition</b>	Will be underwritten based on number of medications and costs	IC/COM	IC/COM	IC/COM	IC/COM
<b>Melanoma</b> <small>** Applies to \$1500 deductible or higher only</small>	<b>In situ/stage 1 and single occurrence:</b>				
	<b>Symptom and treatment free 5 years</b>	Pref 1	Pref 1	Pref 1	Pref 1
	<b>Symptom and treatment free 2-5 years**</b>	Std 1	Pref 1	Pref 1	Pref 1
	<b>Symptoms or treatment within 2 years</b>	Decline	Decline	Decline	Decline
	<b>All other stages or multiple occurrences:</b>				
	<b>Symptom and treatment free 10 years</b>	Std 1	Std 1	Std 1	Std 1
<b>Symptom and treatment free 5-10 years</b>	Std 3	Std 3	Std 3	Std 3	
<b>Symptoms or treatment within 5 years</b>	Decline	Decline	Decline	Decline	
<b>Meningitis</b> <small>(viral and bacterial)</small>	Bacterial, within 6 months	Decline	Decline	Decline	Decline
	Viral, within 6 months	Mod 1	Mod 1	Mod 1	Mod 1
<b>Migraines</b> <small>(subject to Age Adjustment)</small>	<b><u>2 OR MORE ER/URGENT CARE VISITS WITHIN THE PAST 12 MONTHS, OR</u></b> <b>diagnosed within the past 90 days</b>	Decline	Decline	Decline	Decline
	<b>Above criteria does not apply:</b>				
	<b>One ER/urgent care visit within 1 year</b>	Mod 1	Mod 1	Pref 1	Pref 1
	<b>Rx medication used within 6 months</b>	Std 3	Std 3	Pref 1	Pref 1
<b>No treatment within past 6 months</b>	Pref 1	Pref 1	Pref 1	Pref 1	
<b>Mitral Valve Prolapse</b> <small>(Heart Murmur/MVP Questionnaire)</small>	Unoperated, no symptoms or treatment required (except antibiotics with dental work)	Pref 1	Pref 1	Pref 1	Pref 1
	Unoperated, no symptoms within last 2 years, controlled on medication	Std 1	Std 1	Std 1	Std 1
	Unoperated, symptoms within last 2 years OR operated, within 12 months	Decline	Decline	Decline	Decline
<b>Motor or Sensory Aphasia</b>	Once diagnosed	Decline	Decline	Decline	Decline

Condition	Criteria	Rating Level			
		Single Member Deductible Levels			
		\$2400 Deductible or lower	\$2500-\$4900 Deductible	\$5000-\$9900 Deductible	\$10,000 Deductible or higher
<b>Multiple Sclerosis</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Muscular Dystrophy</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Myotonia</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Obesity</b>	(see Height/Weight Build Charts)				
<b>Obsessive Compulsive Disorder</b>	Hospitalization or substance abuse within 5 years	Decline	Decline	Decline	Decline
	Diagnosed within 2 years or unstable	Decline	Decline	Decline	Decline
	SST free 2 years	Pref 1	Pref 1	Pref 1	Pref 1
	SST within 2 years, diagnosed more than 2 years, stable	Mod 1	Mod 1	Mod 1	Mod 1
<b>Open Heart Surgery</b>	Any Condition	Decline	Decline	Decline	Decline
<b>Organ Transplant Recipient/Candidate</b>	Any condition	Decline	Decline	Decline	Decline
<b>Osteoporosis Osteopenia</b> (subject to Age Adjustment)	No history of fractures	Std 1	Pref 1	Pref 1	Pref 1
	With history of fracture, surgery advised or continuous use of narcotic medication(s)	Decline	Decline	Decline	Decline
<b>Otitis Media (Ear/Otitis Questionnaire)</b> (subject to Age Adjustment)	<u>TUBES INSERTED</u>	Pref 1	Pref 1	Pref 1	Pref 1
	<u>SINGLE EPISODE, RECOVERED</u>	Pref 1	Pref 1	Pref 1	Pref 1
	Multiple episodes within 12 months 2 – 3 episodes	Std 1	Pref 1	Pref 1	Pref 1
	4 or more episodes	Std 3	Std 3	Pref 1	Pref 1
<b>Ovarian Cyst</b>  ** Applies to \$1500 deductibles or higher only	SST free 12 months	Pref 1	Pref 1	Pref 1	Pref 1
	SST within 12 months Resolved or controlled on medication **	Std 1	Pref 1	Pref 1	Pref 1
	Cyst(s) present, but not a surgical candidate	Mod 1	Mod 1	Mod 1	Mod 1
<b>Pacemaker Implant</b>	Implant present	Decline	Decline	Decline	Decline
<b>Palpitations</b>	See Heart Palpitations				
<b>Pancreatitis</b>	SST within 12 months or recurrent/multiple episodes	Decline	Decline	Decline	Decline
	Single episode, SST free 12 months	IC/APS	IC/APS	IC/APS	IC/APS
<b>Pap Smears</b> (Cervical Dysplasia)	Class I or II - clean pap obtained afterwards	Pref 1	Pref 1	Pref 1	Pref 1
	Clean pap NOT obtained	Decline	Decline	Decline	Decline
	Class III or more	IC/Decline	IC/Decline	IC/Decline	IC/Decline
<b>Parkinson's Disease</b>	Once diagnosed	Decline	Decline	Decline	Decline

Condition	Criteria	Rating Level			
		Single Member Deductible Levels			
		\$2400 Deductible or lower	\$2500-\$4900 Deductible	\$5000-\$9900 Deductible	\$10,000 Deductible or higher
<b>Peptic Ulcer</b> (Ulcer Questionnaire)	<u>UNOPERATED, CURRENT SYMPTOMS</u>	Decline	Decline	Decline	Decline
	Unoperated, no current symptoms, current treatment	Std 3	Std 3	Pref 1	Pref 1
	Operated within one year, resolved	Std 1	Std 1	Pref 1	Pref 1
	Operated more than one year, resolved	Pref 1	Pref 1	Pref 1	Pref 1
<b>Phlebitis (DVT)</b>	<u>CURRENT SYMPTOMS OR TREATMENT</u>	Decline	Decline	Decline	Decline
	Resolved, but symptoms/treatment within 3 years	Mod 1	Mod 1	Mod 1	Mod 1
	No symptoms/treatment within past 3 years	Std 1	Std 1	Std 1	Std 1
<b>Polycystic Ovaries</b>  ** with a \$25K single deductible can be Pref 1	Both ovaries removed or menopausal	Pref 1	Pref 1	Pref 1	Pref 1
	SST free 2 years, no current treatment other than BCP **	Std 3	Std 3	Std 3	Std 3
	Within 2 years	Decline	Decline	Decline	Decline
<b>Pregnancy</b>	Currently pregnant	Decline	Decline	Decline	Decline
<b>Prostate Disorders</b>	BPH (benign prostatic hypertrophy),unoperated No symptoms, on medication	Std 1	Std 1	Pref 1	Pref 1
	Current symptoms	Decline	Decline	Decline	Decline
	BPH, operated Within 6 months	Std 3	Std 3	Pref 1	Pref 1
	After 6 months	Pref 1	Pref 1	Pref 1	Pref 1
	Prostate Disorders (Malignant) <5 years	Decline	Decline	Decline	Decline
<b>Prostatitis</b>	<u>ACUTE PROSTATITIS</u> <u>SST FREE 12 MONTHS</u>	Pref 1	Pref 1	Pref 1	Pref 1
	<u>SST WITHIN 12 MONTHS, RESOLVED, NO CURRENT TREATMENT</u>	Std 1	Std 1	Std 1	Std 1
	<u>SST WITHIN 12 MONTHS, UNRESOLVED OR CURRENT TREATMENT</u>	Decline	Decline	Decline	Decline
	Chronic Prostatitis SST free 12 months	Std 1	Std 1	Std 1	Std 1
	SST free between 1 – 12 months	IC/Mod 1	IC/Mod 1	IC/Mod 1	IC/Mod 1
	SST within 30 days	Decline	Decline	Decline	Decline
<b>Psychotic Disorders</b> (Mental Health Questionnaire) (subject to Age Adjustment)	Schizophrenia, Bipolar Disorder, Major Depression SST within 10 years or 2 or more hospitalizations	Decline	Decline	Decline	Decline
	SST free 10 years	Std 1	Std 1	Std 1	Std 1
	All other severe psychotic disorders	Decline	Decline	Decline	Decline
<b>Quadriplegia</b> (Paralysis)	All cases	Decline	Decline	Decline	Decline
<b>Rheumatoid Arthritis</b>	Once diagnosed	Decline	Decline	Decline	Decline

Condition	Criteria	Rating Level			
		Single Member Deductible Levels			
		\$2400 Deductible or lower	\$2500-\$4900 Deductible	\$5000-\$9900 Deductible	\$10,000 Deductible or higher
<b>Skin Cancer</b> (subject to Age Adjustment)	Basal cell, resolved and less than 3 excisions	Pref 1	Pref 1	Pref 1	Pref 1
	Basal cell, 3 or more excisions within 5 years	Mod 1	Mod 1	Mod 1	Mod 1
	Squamous cell Completely excised within 1 year	Mod 1	Mod 1	Mod 1	Mod 1
	From 1 to 5 years	Std 1	Std 1	Std 1	Std 1
	Over 5 years	Pref 1	Pref 1	Pref 1	Pref 1
	Malignant Melanoma				
	See Malignant Melanoma	-	-	-	-
<b>Skin Disorders</b> Psoriasis Rosacea	Psoriasis				
	Controlled with topical medication, no dermatologist visit within past 90 days	Std 1	Pref 1	Pref 1	Pref 1
	Oral medication or injections within 12 months or not stable for 2 years	Decline	Decline	Decline	Decline
	Rosacea				
	Symptoms controlled without treatment for 6 months	Pref 1	Pref 1	Pref 1	Pref 1
	Controlled medication within 6 months/no eye complications	Std 1	Pref 1	Pref 1	Pref 1
Uncontrolled or complications	Decline	Decline	Decline	Decline	
<b>Sleep Apnea</b> * Unoperated-Must have documentation from a physician that a CPAP/BiPAP is not needed. (subject to Age Adjustment)	Currently using CPAP or BiPAP	Decline	Decline	Decline	Decline
	Operated Within 6 months	Decline	Decline	Decline	Decline
	SST free 6 months and post-surgical sleep study shows resolved	Std 1	Pref 1	Pref 1	Pref 1
	*Unoperated No treatment required, no tobacco use in 12 months, Pref 1 weight	Std 1	Pref 1	Pref 1	Pref 1
	No treatment, but overweight or smoking within 12 months	Std 3	Std 3	Std 3	Std 3
<b>Spinal Disorders</b> (Back Pain Questionnaire)  ** Documented by MRI, X-ray, etc. (subject to Age Adjustment)	<u>SCOLIOSIS</u> <u>MILD CURVATURE, SST FREE 5 YEARS</u>	Pref 1		Pref 1	Pref 1
		Std 1	Pref 1	Pref 1	Pref 1
	Mild to Moderate Curvature	Mod 1	Std 1	Mod 1	Mod 1
	Severe curvature, no treatment in past year	Decline	Mod 1	Decline	Decline
	Operated within 12 months		Decline		
	Disc Disorder Multiple disc surgeries (multiple dates)	Decline	Decline	Decline	Decline
	Operated SST within 6 months	Decline	Decline	Decline	Decline
		APS	Decline	APS	APS

Condition	Criteria	Rating Level			
		Single Member Deductible Levels			
		\$2400 Deductible or lower	\$2500-\$4900 Deductible	\$5000-\$9900 Deductible	\$10,000 Deductible or higher
	SST free 6 months		APS		
	Unoperated Single disc resolved and SST free 12 months **	Std 1	Std 1	Pref 1	Pref 1
	Multiple discs, unresolved; herniation, rupture or protrusion present	Decline	Decline	Decline	Decline
<b>Stroke</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Syringomyelia</b>	Once diagnosed	Decline	Decline	Decline	Decline
<b>Temporomandibular Joint Syndrome (TMJ)</b> (Ohio and Indiana are Pref 1 due to benefit exclusion)	SST* free 2 years	Pref 1	Pref 1	Pref 1	Pref 1
	SST* free 12 months - 2 years	Std 1	Pref 1	Pref 1	Pref 1
	SST* free 6 – 12 months	Std 3	Pref 1	Pref 1	Pref 1
	SST* within 6 months	Decline	Decline	Decline	Decline
	* mouthpiece okay, will not be considered treatment				
<b>Tendinitis</b>	Current symptoms or treatment	Decline	Decline	Decline	Decline
	Resolved, SST within 1 year	Std 1	Std 1	Std 1	Std 1
	Resolved, SST free 1 year	Pref 1	Pref 1	Pref 1	Pref 1
<b>Thyroid Disorders</b>	<u>HYPERTHYROIDISM, HYPOTHYROIDISM, GOITER, GRAVES DISEASE</u> <u>CONTROLLED &gt; 3 MONTHS WITH ANNUAL OFFICE VISIT OR REPLACEMENT THERAPY</u>	Pref 1	Pref 1	Pref 1	Pref 1
	Controlled > 3 months with treatment other than replacement therapy	Std 1	Pref 1	Pref 1	Pref 1
	Diagnosed in past 3 months or not stable in the past 3 months	Decline	Decline	Decline	Decline
<b>Tonsillitis</b>	1 episode within the past 12 months	Pref 1	Pref 1	Pref 1	Pref 1
	2 episodes within the past 12 months	Std 1	Std 1	Std 1	Std 1
	3 or more episodes within the past 12 months	Mod 1	Mod 1	Mod 1	Mod 1
	Chronic Tonsillitis	Decline	Decline	Decline	Decline
<b>Varicose Veins</b>	Operated SST free 2 years	Pref 1	Pref 1	Pref 1	Pref 1
	SST within 6 months - 2 years	Std 1	Std 1	Std 1	Std 1
	SST within 6 months	Decline	Decline	Decline	Decline

Condition	Criteria	Rating Level			
		Single Member Deductible Levels			
		\$2400 Deductible or lower	\$2500-\$4900 Deductible	\$5000-\$9900 Deductible	\$10,000 Deductible or higher
	Unoperated SST free 5 years	Pref 1	Pref 1	Pref 1	Pref 1
	Single episode, treated with stocking or due to pregnancy	Std 1	Std 1	Std 1	Std 1
	Multiple episodes or SST within 30 days	Mod 1	Mod 1	Mod 1	Mod 1
<b>Wilson's Disease</b>	Once diagnosed	Decline	Decline	Decline	Decline

## UNINSURABLE CONDITIONS

Acromegaly  
Acute Poliomyelitis(current)  
Addison's Disease  
Adrenal Gland Disorders  
AIDS/AIDS Related Complex  
Alcohol/Drug Dependency

- Within 5 years of treatment

Alzheimer's Disease  
Amyloidosis  
Amyotrophic Lateral Sclerosis  
Ankylosing Spondylitis  
Ankylosis(current)  
Any condition for which testing or surgery is contemplated, recommended or scheduled and has not been completed.  
Aphasia, Motor or Sensory  
Arteritis  
Arthritis - Rheumatoid  
Ascities  
Banti's Disease (Liver Disorder)  
Biliary Atresia(current)  
Bipolar Disorder(with in 10 years)  
Brain Damage (Organic)  
Buerger's Disease (Thromboangitis Obliterans)  
Burkett's Tumor (Malignant Lymphoma)  
Cancer

- Most internal < 10 years last treatment

Cardiomyopathy  
Carpal Tunnel/unop w/symptoms  
Cerebral Palsy under age 20  
Charcot-Marie Tooth Disease  
Chronic Obstructive Pulmonary Disease (COPD/Emphysema)  
Chronic Pulmonary Heart Disease  
Cirrhosis of Liver  
Cleft Lip / Palate Uncorrected and Operated age 20 and under  
Coagulation Defects  
Collagen Diseases  
Congestive Heart Failure  
Connective Tissue Disease, Lupus  
Cooley's Anemia  
Crohn's Disease  
Cushing's Syndrome w/in 5 years  
Cystic Fibrosis  
Dermatomyositis  
Diabetes, Insulin dependent  
Drug Treatment w/in 5 years  
Eating Disorders

Emphysema  
Endocarditis  
Epilepsy / any seizure < 1 years  
Esophageal Varicies  
Friedreichs Ataxia  
Future Surgery Testing  
Gallbladder Disease / unoperated  
Gastric Bypass w/in 3 years  
Glomerulonephritis (chronic)  
Growth Deficiencies  
Heart Valve Replacement  
Hemiplegia - Hemiparesis  
Hemochromatosis  
Hemophilia  
Hepatitis, C, D, E or chronic  
HIV Infection  
Hodgkin's Disease < 10 years  
Human T-Cell Leukemia Virus  
Human T-Cell Lymphotropic Virus  
Huntington's Chorea  
Hydrocephalus  
Hydronephrosis, present or bilateral  
Infertility treatment within past 2 years  
Kidney Failure/dialysis  
Kaposi's Sarcoma  
Leukemia < 10 years  
Leukoencephalopathy  
Lispisosis (Neiman-Pick Disease)  
Lupus Erythematosis  
Marfan Syndrome  
Mediterranean Anemia (Thalassemia Major)  
Melanoma, within 1 years  
Meningitis, present  
Mitral Stenosis  
Multiple Sclerosis  
Muscular Dystrophy  
Myasthenia Gravis  
Myelopathy  
Neiman Pick Disease (Lipidosis)  
Neurofibromatosis  
Occlusion of Cerebral Arteries  
Open Heart Surgery  
Organ Transplant recipient  
Osteogenesis Imperfecta  
Ostetitis Deformans (Paget's Disease)  
Pacemaker  
Paget's Disease  
Paraplegia  
Parkinson's Disease  
Peripheral Vascular Disease  
Peroneal Peripheral Neuropathy  
Pneumoconiosis  
Pneumocystis Pneumonia / Pneumocystis carinii infections  
Polyarteritis Nodosa  
Polycystic Kidney Disease  
Polycythemia  
Polymyositis  
Porphyria

Post-Inflammatory Pulmonary Fibrosis  
Pregnancy, current  
Primary Pulmonary Hypertension  
Psoriatic Arthropathy  
Psychosis Organic Brain Syndrome  
Pulmonary Aleveolar Proteinosis  
Pulmonary Heart Disease, Chronic  
Pulmonary Embolism, current  
Quadriplegia (paralysis)  
Renal Failure  
Reyes Syndrome within one year  
Rheumatoid Arthritis  
Sarcoma, Kaposi's  
Schizophrenia(within 10 years)  
Scleroderma  
Senile, Pre-Senile Organic Syndromes  
Shunts  
Sickle Cell Anemia  
Silicosis  
Sjogren's Disease  
Spinocerebellar Disease  
Spondylitis  
Stents, heart  
Stroke  
Syringomyelia  
Tabes Dorsalis  
Tay-Sach's Disease (Cerebral Lipidosis)  
Temporal Arteritis  
TIA – Transcient Ischemic Attack  
Thalassemia, Anemia Major  
Thromboangitis  
Thrombotic  
Thrombocytopenia Purpura  
Transient Organic Psychotic Conditions  
Transplanted Organ  
Transposition of the great vessels  
Truncus Arteriosus  
Tuberculosis, within 2 years  
Tubular Necrosis  
Ulcerative Colitis  
Uremia  
Valve Replacement  
Varices, Esophageal  
Vasculitis  
Von Recklinghasusen's Disease (Neurofibromatosis)  
Wegener's Granulomatosis Syndrome  
Werlhof's Disease (Purpura, Thrombocytopenia)  
Wilson's Disease

## Medication Denials

Deny if any applicant is taking/has taken any of the following medications within the last twelve months\*:

Abacavir	Crixivan	Heparin	Mycophenolate	Stavudine
Accutane**	Cyclosporine	Hexalen	Myfortic	Stelazine
Agenerase	Cytovene	HIVID	Naltrexone	Suboxone
Aggrenox	d4T	Humira	Namenda	Subutex
Aldurazyme	Dalteparin	Hydroxychloroquine	Navane	Supartz
Alimta	Dapsone	Sulfate	Neupogen	Sustiva
Ambrisentan	Daunoxome	Imuran	Norvir	Symbyax
Amevive	Delavirdine	Indinavir	Octagam	Symlin
Amnesteem**	Didanosine	Insulin	Onxol	Synagis
Amprenavir	Dipyridamole	Interferon	Orap	Synvisc
Androgel	Disulfiram	Intron A	Orgaran	Tacrolimus
Antabuse	Doxil	Invega	Orthoclone OKT3	Tarceva
Anzemet	Duralith	Invirase	Oxycontin	Tasmar
Apokyn	Efavirenz	Iressa	Parcopa	Taxotere
Arava	Eldepryl	Jantoven	Pegasys	Thalidomide
Aricept	Eloxatin	Kaletra	Pentamidine	Thalomid
Arimidex	Emsam	LAAM	Persantine	Thioridazine
Artane	Emtriva	Lamivudine	Plaquenil	Thiothixene
Atripla	Enbrel	Lantus	Platinol	Thorazine
Avastin	Entocort	Leponex	Plenaxis	Ticlid
Avonex	Epivir	Letairis	Pletal	Ticlopidine
Azathioprine	Epogen	Levemir	PMPA	Trental
AZT	Epzicom	Levomethadyl	Pneumopent	Trifluoperazine
Baraclude	Equetro	Lexiva	Prialt	Trilafon
Betaseron	Erbitux	Lialda	Procrit	Trizivir
Bexxar	Eskalith	Lithane	Prolixin	Truvada
Bleomycin	Exelon	Lithium	Quetiapine	Tysabri
Brovana	Exubera	Lithizine	Ranexa	Valcyte
Buprenex	Fabrazyme	Lithobid	Ranolazine	Vantas
Byetta	Faslodex	Lithonate	Rebif	Velcade
Campral	Fazaclo	Lithotab	Remicade	Vidaza
Carbolith	Felbamate	Lovenox	Reminyl	Videx
Chlorpromazine	Felbatol	Loxapine	Rescriptor	Viracept
Cibalith-S	Femara	Loxitane	Retrovir	Viramune
Cisplatin	Flolan	Lymphocyte Immune	Revia	Viread
Claravis**	Fluphenazine	Globulin	Reyataz	Vistide
Clolar	Folex	MBACOD	Rheumatrex	Vitravene
Clopidogrel	Fortovase	Mellaril	Risperdal	Warfarin
Clozapine	Foscavir	Memantine	Sandimmune	Xolair***
Clozaril	Fuzeon	Meproton	Selegiline HCl	Zalcitabine
Cognex	Ganciclovir	Methadone	Serentil	Zerit
Combivir	Geodon	Methotrexate	Simponi	Ziagen
Comtan	Gleevec	Moban	Somavert	Zidovudine
Copoxone	Haldol	Mozobil	Sotret**	Zolinza
Coumadin	Haloperidol	Muromonab-CD3	Spiriva	Zyprexa

Any medication not on this list should be investigated in order to determine the underlying medical condition for which the medication was prescribed. \*\*Will consider after off medication for 2 months. \*\*\* Will consider after off medication for 6 months. This list is not an all inclusive list and by no means contains every drug that is declinable.

Rev. 04/07/11

Male BMI Reference Chart Age 16 - 64	Super Preferred		Preferred	Standard 1		Modified 1 & APS	DECLINE
	Approximate BMI: < 18.5	Approximate BMI Range: 18.5-24.9	Approximate BMI Range: 25.0-31.9	Approximate BMI Range: 32.0-34.9		Approximate BMI Range: 35.0 - 37.9	Approximate BMI: ≥ 38.0
	Wt in lbs.	Weight Range in lbs.	Weight Range in lbs.	Weight Range in lbs.		Weight Range in lbs.	Wt. in lbs.
Height (inches)	APS	LBS	LBS	LBS		LBS	LBS
4'6" (54")	< 77	77-103	104-132	133	144	145-157	158+
4'7" (55")	< 80	80-107	108-137	138	150	151-163	164+
4'8" (56")	< 83	83-111	112-142	143	155	156-169	170+
4'9" (57")	< 86	86-115	116-147	148	161	162-175	176+
4'10" (58")	< 89	89-119	120-152	153	167	168-181	182+
4'11" (59")	< 92	92-123	124-158	159	173	174-187	188+
5'0" (60")	< 95	95-127	128-163	164	178	179-194	195+
5'1" (61")	< 98	98-132	133-169	170	184	185-200	201+
5'2" (62")	< 101	101-136	137-174	175	191	192-207	208+
5'3" (63")	< 105	105-140	141-180	181	197	198-214	215+
5'4" (64")	< 108	108-145	146-186	187	203	204-221	222+
5'5" (65")	< 111	111-149	150-192	193	210	211-228	229+
5'6" (66")	< 115	115-154	155-197	198	216	217-235	236+
5'7" (67")	< 118	118-159	160-204	205	223	224-242	243+
5'8" (68")	< 122	122-164	165-210	211	229	230-249	250+
5'9" (69")	< 125	125-168	169-216	217	236	237-257	258+
5'10" (70")	< 129	129-173	174-222	223	243	244-264	265+
5'11" (71")	< 133	133-178	179-229	230	250	251-272	273+
6'0" (72")	< 137	137-183	184-235	236	257	258-279	280+
6'1" (73")	< 140	140-189	190-242	243	264	265-287	288+
6'2" (74")	< 144	144-194	195-248	249	272	273-295	296+
6'3" (75")	< 148	148-199	200-255	256	279	280-303	304+
6'4" (76")	< 152	152-204	205-262	263	287	288-311	312+
6'5" (77")	< 156	156-210	211-269	270	294	295-320	321+
6'6" (78")	< 160	160-215	216-276	277	302	303-328	329+
6'7" (79")	< 164	164-221	222-283	284	310	311-336	337+
6'8" (80")	< 168	168-227	228-290	291	318	319-345	346+
6'9" (81")	< 173	173-232	233-298	299	326	327-354	355+
6'10" (82")	< 177	177-238	239-305	306	334	335-362	363+
6'11" (83")	< 181	181-244	245-313	314	342	343-371	372+
7'0" (84")	< 186	186-250	251-320	321	350	351-380	381+
7'1" (85")	< 190	190-256	257-328	329	359	360-390	391+
7'2" (86")	< 195	195-262	263-336	337	367	368-399	400+
7'3" (87")	< 199	199-268	269-343	344	376	377-408	409+

**ENTERPRISE: Height / Weight : Females Age 16-64**

Change History: **EFFECTIVE 4/1/10**

Female BMI Reference Chart Age 16 - 64	APS	Super Preferred	Preferred	Standard 1		Modified 1 & APS		DECLINE
	Approximate BMI: < 17.5	Approximate BMI Range: 17.5-24.9	Approximate BMI Range: 25.0-30.9	Approximate BMI Range: 31.0-33.9		Approximate BMI Range: 34.0-36.9		Approximate BMI: ≥ 37.0
		Weight Range	Weight Range	Weight Range		Weight Range		Weight
	Height (inches)	LBS	LBS	LBS	LBS		LBS	LBS
4'0" (48")	< 58	58-81	82-101	102	111	112	121	122 +
4'1" (49")	< 60	60-85	86-105	106	115	116	126	127 +
4'2" (50")	< 63	63-88	89-110	111	120	121	131	132 +
4'3" (51")	< 65	65-92	93-114	115	125	126	136	137 +
4'4" (52")	< 68	68-95	96-119	120	130	131	142	143 +
4'5" (53")	< 70	70-99	100-123	124	135	136	147	148 +
4'6" (54")	< 73	73-103	104-128	129	140	141	153	154 +
4'7" (55")	< 76	76-107	108-133	134	146	147	158	159 +
4'8" (56")	< 78	78-111	112-138	139	151	152	164	165 +
4'9" (57")	< 81	81-115	116-143	144	156	157	170	171 +
4'10" (58")	< 84	84-119	120-148	149	162	163	176	177 +
4'11" (59")	< 87	87-123	124-153	154	168	169	182	183 +
5'0" (60")	< 90	90-127	128-158	159	173	174	189	190 +
5'1" (61")	< 93	93-132	133-163	164	179	180	195	196 +
5'2" (62")	< 96	96-136	137-169	170	185	186	202	203 +
5'3" (63")	< 99	99-140	141-174	175	191	192	208	209 +
5'4" (64")	< 102	102-145	146-180	181	197	198	215	216 +
5'5" (65")	< 105	105-149	150-186	187	204	205	222	223 +
5'6" (66")	< 109	109-154	155-191	192	210	211	228	229 +
5'7" (67")	< 112	112-159	160-197	198	216	217	235	236 +
5'8" (68")	< 115	115-164	165-203	204	223	224	243	244 +
5'9" (69")	< 119	119-168	169-209	210	229	230	250	251 +
5'10" (70")	< 122	122-173	174-215	216	236	237	257	258 +
5'11" (71")	< 126	126-178	179-221	222	243	244	264	265 +
6'0" (72")	< 129	129-183	184-228	229	250	251	272	273 +
6'1" (73")	< 133	133-189	190-234	235	257	258	280	281 +
6'2" (74")	< 136	136-194	195-241	242	264	265	287	288 +
6'3" (75")	< 140	140-199	200-247	248	271	272	295	296 +
6'4" (76")	< 144	144-204	205-254	255	278	279	303	304 +
6'5" (77")	< 148	148-210	211-261	262	286	287	311	312 +
6'6" (78")	< 152	152-215	216-267	268	293	294	319	320 +

AGE 6-15				
Height	Weight			
	BMI <14.0 APS	BMI 14.0-30.0 Preferred	BMI 30.1-39.9 Std 1(20%)	BMI 40.0+ Decline
3'0"	< 27	27 – 55	56 - 73	74+
3'1"	< 29	29 – 58	59 - 77	78+
3'2"	< 30	30 – 61	62 - 82	83+
3'3"	< 32	32 – 65	66 - 86	87+
3'4"	< 33	33 – 68	69 - 90	91+
3'5"	< 35	35 – 71	72 - 95	96+
3'6"	< 37	37 - 75	76 - 100	101+
3'7"	< 38	38 – 79	80 - 105	106+
3'8"	< 40	40 – 82	83 - 110	111+
3'9"	< 42	42 – 86	87 - 115	116+
3'10"	< 43	43 – 90	91 - 120	121+
3'11"	< 45	45 – 94	95 - 125	126+
4'0"	< 47	47 – 98	99 - 130	131+
4'1"	< 49	49 – 102	103 - 136	137+
4'2"	< 51	51 - 105	106 - 142	143+
4'3"	< 53	53 – 111	112 - 147	148+
4'4"	< 55	55 – 114	115 - 153	154+
4'5"	< 57	57 – 120	121 - 159	160+
4'6"	< 59	59 – 124	125 - 165	166+
4'7"	< 62	62 – 129	130 - 171	172+
4'8"	< 64	64 – 134	135 - 178	179+
4'9"	< 66	66 – 138	139 - 184	185+
4'10"	< 68	68 – 143	144 - 191	192+
4'11"	< 71	71 – 147	148 - 197	198+
5'0"	< 73	73 – 153	154 - 204	205+
5'1"	< 75	75 – 159	160 - 211	212+
5'2"	< 78	78 – 164	165 - 218	219+
5'3"	< 80	80 – 169	170 - 225	226+
5'4"	< 83	83 - 175	176 - 232	233+
5'5"	< 85	85 – 180	181 - 240	241+
5'6"	< 88	88 – 186	187 - 247	248+
5'7"	< 91	91 – 191	192 - 255	256+
5'8"	< 93	93 - 197	198 - 262	263+
5'9"	< 96	96 - 203	204 - 270	271+
5'10"	< 99	99 – 209	210 - 278	279+
5'11"	< 102	102 – 215	216 - 286	287+
6'0"	< 104	104 – 221	222 - 294	295+
6'1"	< 107	107 – 227	228 - 302	303+
6'2"	< 110	110 – 234	235 - 311	312+
6'3"	< 113	113 – 240	241 - 319	320+
6'4"	< 116	116 – 246	247 - 328	329+
6'5"	< 119	119 – 253	254 - 336	337+
6'6"	< 122	122 – 260	261 - 345	346+
6'7"	< 125	125 – 266	267 - 354	355+
6'8"	< 128	128 - 273	274 - 363	364+

Age 5 & Under (for heights not listed, use the BMI calculator above)	
Height	Weight in lbs.
	APS when BMI is less than 14.0
3'0"	25 lbs. or less
3'1"	27 lbs. or less
3'2"	28 lbs. or less
3'3"	30 lbs. or less
3'4"	31 lbs. or less
3'5"	33 lbs. or less
3'6"	35 lbs. or less
3'7"	36 lbs. or less
3'8"	38 lbs. or less
3'9"	40 lbs. or less
3'10"	41 lbs. or less
3'11"	43 lbs. or less
4'0"	45 lbs. or less
4'1"	47 lbs. or less
4'2"	49 lbs. or less
4'3"	51 lbs. or less
4'4"	53 lbs. or less
4'5"	55 lbs. or less
4'6"	57 lbs. or less
4'7"	60 lbs. or less
4'8"	62 lbs. or less
4'9"	64 lbs. or less
4'10"	66 lbs. or less

**SUBMIT THIS PAGE WITH YOUR APPLICATION**

**ABNORMAL PAP SMEAR QUESTIONNAIRE**  
**(Complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Date(s) of abnormal pap smear(s)? \_\_\_\_\_

2. Diagnosis (please try to use classifications below when possible):

- \_\_\_ Class 1: Normal cells but viral infections, bacteria or yeast
- \_\_\_ Class 2: Mild dysplasia, atypical cells, inflammation,
- \_\_\_ Class 3: Moderate dysplasia, abnormal cells, (CIN I or CIN II)
- \_\_\_ Class 4: Severe dysplasia, carcinoma in-situ, (CIN III)
- \_\_\_ Class 5: Malignant cells (Cancer)

3. Was a cervical biopsy performed? Yes \_\_\_ No \_\_\_ Results \_\_\_\_\_

4. Please indicate type of treatment(s), if any, and date:

\_\_\_ **Colposcopy** Date: \_\_\_\_\_

\_\_\_ **Laser vaporization of cervix (laser surgery)** Date: \_\_\_\_\_

\_\_\_ **Cryotherapy of cervix (freeze cervix)** Date: \_\_\_\_\_

\_\_\_ **Conization (cone, LEEP)** Date: \_\_\_\_\_

\_\_\_ **Hysterectomy** Date: \_\_\_\_\_

\_\_\_ **No treatment but repeat pap smear**

Date of repeat pap smear: \_\_\_\_\_

Results (use class): \_\_\_\_\_

Medication prescribed? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ (Date last used) \_\_\_\_\_

5. Have you had a follow up pap smear since the original diagnosis or treatment? Yes \_\_\_ No \_\_\_

If yes, when: \_\_\_\_\_

Results (use class): \_\_\_\_\_

6. Name and address of treating physician: \_\_\_\_\_

\_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

**ALCOHOL & DRUG QUESTIONNAIRE**  
(complete all questions)

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Are you currently using or have you ever used the following substances:
- |  | Yes   | No    |
|--|-------|-------|
| Alcohol (beer, wine or liquor)                               | _____ | _____ |
| Narcotics (heroin, opium, Demerol or their derivatives)      | _____ | _____ |
| Hallucinogens (LSD, PCP, DMT, STP or derivatives)            | _____ | _____ |
| Stimulants (cocaine, crack, amphetamines, antidepressants)   | _____ | _____ |
| Depressants (bromides, barbiturates or their derivatives)    | _____ | _____ |
| Tranquilizers (Valium, Librium, Haldol or their derivatives) | _____ | _____ |
| Marijuana (hash, pot, grass, tea or their derivatives)       | _____ | _____ |
| Intravenous drug use   | _____ | _____ |
| Any other substance not listed above                         | _____ | _____ |

(Please provide details to any "YES" answers below:

Type	Quantity	Frequency	From	To
_____				
_____				

2. Have you had a DUI, OUI or OWI within the last 5 years? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please provide the date, state of your driver's license and your driver's license number:  
\_\_\_\_\_

3. Have you undergone treatment for substance abuse? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide details for:

a. Type of treatment (hospitalization, medication, psychotherapy): \_\_\_\_\_  
\_\_\_\_\_

b. Date of treatment, length of treatment and date treatment ended:  
\_\_\_\_\_

c. Name, address and phone number of treating physician, counselor, and facility:  
\_\_\_\_\_  
\_\_\_\_\_

4. Have you, in the past 10 years, been a member of Alcoholics Anonymous, Narcotics Anonymous, or similar aftercare programs? Yes \_\_\_ No \_\_\_\_ . If yes, are you an active member? Yes \_\_\_ No \_\_\_\_ If an inactive member, what was the date last attended? \_\_\_\_\_

Have you used any substances since your initial treatment? Yes \_\_\_\_\_ No \_\_\_\_ If yes, please give details:  
\_\_\_\_\_

**ALCOHOL & DRUG QUESTIONNAIRE**  
**(continued)**

5. Have you had a liver function or liver enzyme test? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, please provide date and results of most recent test:

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6. Any history of:

Heart problems	Yes _____	No _____
Gastritis/ulcer	Yes _____	No _____
Depression	Yes _____	No _____
Kidney/liver disease	Yes _____	No _____

Please explain any "yes" answers: \_\_\_\_\_

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All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

**ARTHRITIS QUESTIONNAIRE**  
**(complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Type of arthritis: Rheumatoid \_\_\_\_\_ Osteoarthritis \_\_\_\_\_ Other \_\_\_\_\_ (please explain):  
\_\_\_\_\_

2. Age at time of diagnosis or first symptoms? \_\_\_\_\_ Symptoms at time of diagnosis: \_\_\_\_\_  
\_\_\_\_\_

What are your symptoms now? \_\_\_\_\_

3. Which joints have arthritis? \_\_\_\_\_ Any deformity of joints? Yes \_\_\_ No \_\_\_  
If yes, please explain: \_\_\_\_\_

4. Any work loss or restriction of activities? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide details:  
\_\_\_\_\_

5. Do you require the use of cane, crutches or a wheelchair to move about? Yes \_\_\_\_\_ No \_\_\_  
\_\_\_\_\_

6. Have you used any type of steroids, methotrexate or gold injections? Yes \_\_\_ No \_\_\_  
If yes, give dates and type of treatment: \_\_\_\_\_  
\_\_\_\_\_

List your medication(s):

<b>Name of Medication:</b>	<b>Dosage:</b>	<b>Frequency (i.e., daily, weekly)</b>
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_____	_____	_____
_____	_____	_____

7. Have you ever been hospitalized for arthritis or any related conditions? \_\_\_ Yes \_\_\_ No. If yes, provide complete details regarding dates of hospitalization(s), duration of stay and treatment received?  
\_\_\_\_\_

8. Have you had or been advised to have surgery for arthritis? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, indicate type of surgery and joints involved: \_\_\_\_\_  
\_\_\_\_\_

9. Name and address of treating physician: \_\_\_\_\_

Date last seen: \_\_\_\_\_

10. What is your current height? \_\_\_\_\_ Weight? \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date



**ATTENTION DEFICIT DISORDER QUESTIONNAIRE**  
**(complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Date first treated: \_\_\_\_\_

2. Please state the name(s), dosage(s) and frequency for taking any medications prescribed:  
\_\_\_\_\_  
\_\_\_\_\_

3. Is medication still being taken? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, when was medication discontinued? \_\_\_\_\_

4. Is medication taken throughout the year, or are there "breaks" when medication is not taken?  
Please provide details: \_\_\_\_\_

5. Have there been any behavioral problems at school, truancy, etc.? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please provide details: \_\_\_\_\_

6. Any growth problems or other mental/physical problems noted? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please provide details: \_\_\_\_\_

7. Has the individual received psychological counseling, or has counseling been recommended? Yes \_\_\_ No  
If yes, please provide details (including dates of treatment and name, address and phone number of  
counselor, physician or therapist): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Have there been any hospitalizations for this or other related conditions? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please provide details: \_\_\_\_\_  
\_\_\_\_\_

Date of confinement: \_\_\_\_\_ Length of stay: \_\_\_\_\_

Name, address and phone number of hospital where confined:  
\_\_\_\_\_  
\_\_\_\_\_

9. Are you still being treated? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, indicate date released from doctor: \_\_\_\_\_

If yes, indicate date you are to be released: \_\_\_\_\_

10. Name, address and phone number of treating physician or health care practitioner:  
\_\_\_\_\_  
\_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand  
Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

**BACK/SPINAL QUESTIONNAIRE**  
**(complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Have you ever had pain in your back, neck or shoulder? Yes \_\_\_ No \_\_\_ If yes, complete the following:
  - a. How many times: \_\_\_\_\_
  - b. Date of first episode: \_\_\_\_\_
  - c. Date of last episode: \_\_\_\_\_
  
2. What area(s) involved? (circle appropriate areas)  
Neck (cervical)                      Middle (thoracic)                      Low (lumbosacral)
  - a. Does the pain radiate? Yes \_\_\_ No \_\_\_ If yes, where? \_\_\_\_\_
  - b. Give definitive diagnosis, if known \_\_\_\_\_
  
3. Is this a disc disorder? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, indicate type:  
\_\_\_\_\_ Herniation                      \_\_\_\_\_ Rupture                      \_\_\_\_\_ Protrusion
  
4. Was this the result of an injury? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide details \_\_\_\_\_  
\_\_\_\_\_
  
5. Have you ever been diagnosed with Scoliosis? Yes \_\_\_ No \_\_\_ If yes, degree of curvature \_\_\_\_\_
  
6. Due to back pain, do you take prescription medication? Yes \_\_\_\_\_ No \_\_\_ If yes, provide the following:  

<b>Name of Medication</b>	<b>Dosage:</b>	<b>Frequency/Date last taken:</b>
_____	_____	_____

  - a. Have you ever had or been advised to have surgery/or spinal fusion? Yes \_\_\_\_\_ No \_\_\_  
If yes, provide details: \_\_\_\_\_
  - b. Have you ever had or now have chiropractic treatment or physical therapy for your back?  
Yes \_\_\_ No \_\_\_ If yes, how often? \_\_\_\_\_ Date last seen? \_\_\_\_\_
  - c. Have you ever had loss of time at work or restriction of activities? Yes \_\_\_\_\_ No \_\_\_  
If yes, how long were you off work? \_\_\_\_\_  
When did you return to work? \_\_\_\_\_
  
7. What is the current status of your back, neck or shoulder pain? \_\_\_\_\_
  
8. Name and address of treating physician: \_\_\_\_\_  
\_\_\_\_\_
  
9. What is your current height \_\_\_\_\_ Weight? \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

**COLITIS/IRRITABLE BOWEL SYNDROME QUESTIONNAIRE**  
(complete all questions)

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Was diagnosis of condition Ulcerative Colitis, Spastic Colon, Diverticulosis or Diverticulitis? Yes \_\_\_ No \_\_\_  
If yes, which condition? \_\_\_\_\_  
If no, provide exact diagnosis: \_\_\_\_\_  
What was the cause? \_\_\_\_\_

2. Date of first episode? \_\_\_\_\_ Date last treated? \_\_\_\_\_ # episodes in last year? \_\_\_\_\_

3. How many attacks/episodes/flare ups have you had since the initial diagnosis? \_\_\_\_\_  
Date of last attack/episode/flare up? \_\_\_\_\_

**(Circle the most accurate description for each column below:)**

<b>Attack Duration</b>	<b>Attack Frequency</b>	<b>Weight Loss</b>	<b>Abdominal Pain and attack</b>
Up to 4 weeks	1 per year	None	Mild
4-6 weeks	2 per year	10 lbs. or less	Moderate
Over 6 weeks	3 per year	Over 10 lbs.	Extreme

4. Have you had any of the following tests:

\_\_\_ Blood Test                      Date \_\_\_\_\_                      \_\_\_ Barium Enema                      Date \_\_\_\_\_  
\_\_\_ Colonoscopy                      Date \_\_\_\_\_                      \_\_\_ Sigmoidoscopy                      Date \_\_\_\_\_  
\_\_\_ Pathology/biopsy                      Date \_\_\_\_\_

5. Have you been hospitalized or had surgery for this or any other related condition(s)? \_\_\_ Yes \_\_\_ No

If yes, what type of surgery? \_\_\_\_\_ Date(s): \_\_\_\_\_

Please provide details: \_\_\_\_\_

6. Are you on a special diet or do you use regular medication for this condition? Yes \_\_\_\_\_ No \_\_\_

**Name of Medication:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_ **Frequency (i.e., daily, weekly)** \_\_\_\_\_

7. Have you ever taken, or been advised to take, any type of steroids (oral/suppositories) or azulfidine/sulfasalazine? \_\_\_ Yes \_\_\_ No

If yes, give name(s) of medication(s) and date(s) taken: \_\_\_\_\_

8. What is your current height? \_\_\_\_\_ Weight? \_\_\_\_\_

9. Name and address of treating physician: \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18) \_\_\_\_\_

\_\_\_\_\_ Date

## DIABETES QUESTIONNAIRE (complete all questions)

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Date diagnosed or date of first symptoms: \_\_\_\_\_ Blood sugar reading at that time? \_\_\_\_\_

2. Please indicate type of treatment: \_\_\_\_\_ Diet \_\_\_\_\_ Oral medication \_\_\_\_\_ Insulin \_\_\_\_\_

Are you compliant with dietary restrictions and recommended medications? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, explain: \_\_\_\_\_

Name of Medication	Dosage:	Frequency (i.e., daily, weekly)
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3. Have you ever been hospitalized for diabetes or any related conditions? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide complete details regarding dates of stay and treatment received: \_\_\_\_\_

4. How often does your doctor check blood sugar levels \_\_\_\_\_

How frequently do *you* test your blood sugar? \_\_\_\_\_ Usual reading? \_\_\_\_\_

5. Please provide **last 4 fasting blood sugar readings or Hgb A1C readings from your doctor and date of tests:**


6. Any history of: **(Circle one)**

Kidney disease	yes	no
Recurrent infections	yes	no
Circulatory disorders	yes	no
Leg or foot ulcers	yes	no
Insulin reactions	yes	no
Vision problems (Retinopathy)	yes	no
Decreased feeling, numbness or tingling in extremities	yes	no

Please explain any "yes" answers: \_\_\_\_\_

7. What is your current height? \_\_\_\_\_ Weight? \_\_\_\_\_

8. Name and address of treating physician: \_\_\_\_\_

9. Any other comments? \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18) \_\_\_\_\_

Date \_\_\_\_\_

**DIGESTIVE QUESTIONNAIRE**  
**(complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Exact diagnosis of condition: \_\_\_\_\_

2. Have you ever been diagnosed or treated for:

- |   |   |
|---|---|
| <input type="checkbox"/> Gastroesophageal Reflux (GERD)   | <input type="checkbox"/> Esophageal Spasm   |
| <input type="checkbox"/> Esophageal Stricture             | <input type="checkbox"/> Reflux Esophagitis |
| <input type="checkbox"/> Esophagitis                      | <input type="checkbox"/> Hiatal Hernia      |
| <input type="checkbox"/> Difficult swallowing (Dysphagia) | <input type="checkbox"/> Heartburn          |

3. Date of first episode? \_\_\_\_\_ # Episodes in last year? \_\_\_\_\_ Date of last episode? \_\_\_\_\_

4. Are you on a special diet or do you use regular medicine for the condition? Yes \_\_\_\_\_ No \_\_\_\_\_

<b>Name of Medication:</b>	<b>Dosage:</b>	<b>Frequency (i.e., daily, weekly)</b>
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_____
_____
_____

5. Have you had any special tests or X-rays? Yes \_\_\_\_\_ No \_\_\_\_\_

When? \_\_\_\_\_

Type of test? \_\_\_\_\_

Results and diagnosis? \_\_\_\_\_

6. Have you been hospitalized or had surgery for this or any other related condition? Yes \_\_\_ No \_\_\_

If yes, name of hospital: \_\_\_\_\_

Surgery date(s): \_\_\_\_\_ Hospitalization date(s): \_\_\_\_\_

Details of surgery or hospitalization: \_\_\_\_\_

\_\_\_\_\_

7. What is your current height? \_\_\_\_\_ Weight? \_\_\_\_\_

8. Name and address of treating physician: \_\_\_\_\_

\_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

**EAR/OTITIS QUESTIONNAIRE**  
**(complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Give diagnosis of ear disorder: \_\_\_\_\_

2. Date diagnosed or date of first symptoms: \_\_\_\_\_

3. How many episodes in the past 2 years? \_\_\_\_\_

Frequency of episodes? \_\_\_\_\_

4. Give details including dates of past and current treatment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

5. Is any prescription medication taken for this condition? Yes \_\_\_\_\_ No \_\_\_\_\_

<b>Name of Medication:</b>	<b>Dosage:</b>	<b>Frequency (i.e., daily, weekly)</b>
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_____	_____	_____
_____	_____	_____

6. Give name and address of treating physician: \_\_\_\_\_

\_\_\_\_\_

7. Date last seen for this condition? \_\_\_\_\_

8. Ever had or been advised to have surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide details: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

**ENDOMETRIOSIS QUESTIONNAIRE**  
**(Complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated/relationship to applicant: \_\_\_\_\_

1. Date of first episode: \_\_\_\_\_

2. # of episodes in last year: \_\_\_\_\_

3. Date of last episode: \_\_\_\_\_

4. Have you had any special test or x-rays?    Yes \_\_\_\_\_    No \_\_\_\_\_

If yes, type of test? \_\_\_\_\_

Results and diagnosis: \_\_\_\_\_

5. Have you had any surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give details: \_\_\_\_\_

6. Do you use regular medication for this condition? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of medication

Dosage

Frequency

7. Name and address of treating physician:

\_\_\_\_\_

\_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge.  
I understand that the insurer will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

**FIBROMYALGIA QUESTIONNAIRE**  
**(Complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Age at time of diagnosis or first symptoms? \_\_\_\_\_ Symptoms at time of diagnosis: \_\_\_\_\_

What are your symptoms now? \_\_\_\_\_  
Date of last symptoms? \_\_\_\_\_

2. Affected muscles/areas? \_\_\_\_\_

3. Any work loss or restriction of activities? Yes \_\_\_ No \_\_\_ If yes, provide details: \_\_\_\_\_

Have you applied for disability? Yes \_\_\_ No \_\_\_ If yes, provide details: \_\_\_\_\_

4. Do you require the use of cane, crutches or a wheelchair to move about? Yes \_\_\_ No \_\_\_

5. List your medication(s):

<b>Name of Medication:</b>	<b>Dosage:</b>	<b>Frequency (i.e., daily, weekly)</b>
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6. Have you ever been treated for depression? Yes \_\_\_ No \_\_\_ If yes, provide details including dates and medications: \_\_\_\_\_

7. Details of physical therapy and/or pain management including dates of past and current treatment: \_\_\_\_\_

8. Have you ever been hospitalized for fibromyalgia or any related conditions? Yes \_\_\_ No \_\_\_ If yes, provide complete details regarding dates of hospitalization(s), duration of stay and treatment received? \_\_\_\_\_

9. Have you had or been advised to have surgery for fibromyalgia? Yes \_\_\_ No \_\_\_ If yes, advise type of surgery: \_\_\_\_\_

10. Name and address of treating physician: \_\_\_\_\_

Date last seen: \_\_\_\_\_

11. What is your current height? \_\_\_\_\_ Weight? \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand that Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent / guardian if under 18)

\_\_\_\_\_  
Date

**GOUT QUESTIONNAIRE**  
**(complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Date diagnosed or date of first symptoms: \_\_\_\_\_

2. Number of attacks in the last year? \_\_\_\_\_

3. Date of last attack? \_\_\_\_\_

4. Give details of past and current treatment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

5. **Name of Medication:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_ **Frequency (i.e., daily, weekly)** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Do you have any history of:  
Hypertension (high blood pressure) Yes \_\_\_\_\_ No \_\_\_\_\_  
Kidney disease/Kidney Stones Yes \_\_\_\_\_ No \_\_\_\_\_

Explain any "yes" answers and provide date(s) of treatment: \_\_\_\_\_

\_\_\_\_\_

7. Name and address of treating physician: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

8. Date last seen? \_\_\_\_\_

\_\_\_\_\_

9. What is your current height? \_\_\_\_\_ Weight? \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

## HEART MURMUR/MITRAL VALVE PROLAPSE QUESTIONNAIRE (complete all questions)

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Give exact diagnosis: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

2. Description of murmur (check one):  
 functional     organic     diastolic     systolic     other (specify)

3. Have you had any of the following?

<b>Test:</b>			<b>If yes, when?</b>	<b>Results were (circle):</b>		
EKG	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal	Abnormal	Unknown
Echocardiogram (Echo)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal	Abnormal	Unknown
Doppler Test	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal	Abnormal	Unknown
Heart Catherization	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal	Abnormal	Unknown
Holter Monitor	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal	Abnormal	Unknown
Thallium	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal	Abnormal	Unknown
Stress/Treadmill	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____	Normal	Abnormal	Unknown

4. Have you ever experienced symptoms (chest pain, shortness of breath, dizziness, palpitations, irregular heartbeat)? Yes  No  If yes, please give details (**date of onset, frequency, severity, date of last symptoms**): \_\_\_\_\_

\_\_\_\_\_

5. Have you ever taken medication for this condition? Yes  No

<b>Medication:</b>	<b>Dosage:</b>	<b>Frequency (i.e., daily, weekly)</b>	<b>Date stopped (if no longer taking)</b>
_____	_____	_____	_____
_____	_____	_____	_____

6. Have you ever had surgery, or has surgery or other treatment been recommended for this or any related condition? Yes  No  If yes, give details: \_\_\_\_\_

\_\_\_\_\_

7. Has there been any hospitalization for this or any other related condition? Yes \_\_\_\_\_ No

If yes, dates of confinement(s): \_\_\_\_\_ Length of stay(s): \_\_\_\_\_

Name and address of hospital(s) where confined: \_\_\_\_\_

8. Do you have any other cardiovascular conditions? Yes \_\_\_\_\_ No  If yes, please provide complete details:

\_\_\_\_\_

9. Name and address of treating physician: \_\_\_\_\_

\_\_\_\_\_

10. What is your current height? \_\_\_\_\_ Weight? \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

## HYPERTENSION QUESTIONNAIRE (complete all questions)

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Date high blood pressure first diagnosed? \_\_\_\_\_ Blood pressure reading at that time? \_\_\_\_\_

2. Are you taking medication(s) for your blood pressure? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Medication:	Dosage:	Frequency (i.e., daily, as needed)
_____	_____	_____
_____	_____	_____

If no, did your doctor recommend discontinuation? Yes \_\_\_\_ No \_\_\_\_ Date Discontinued \_\_\_\_\_

3. How often do you see your doctor for blood pressure checkups? \_\_\_\_\_

4. Please provide your last **5 blood pressure readings from your doctor and date of readings:**

_____	_____	_____
_____	_____	_____

If you monitor your blood pressure at home, what does it normally run? \_\_\_\_\_

5. What is your current height? \_\_\_\_\_ Weight? \_\_\_\_\_

Any history of:	(Circle one)	
Circulatory Disorder	Yes	No
Kidney disease	Yes	No
Diabetes	Yes	No
Heart disorder/murmurs	Yes	No
Cerebrovascular disease (Stroke, TIA)	Yes	No
Valve problems or enlarged heart	Yes	No

Please explain any "yes" answers: \_\_\_\_\_  
\_\_\_\_\_

7. Please provide your latest cholesterol reading (if know): \_\_\_\_\_

8. Medication required? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Medication:	Dosage:	Frequency (i.e., daily, weekly)
_____	_____	_____
_____	_____	_____

9. Have you ever been hospitalized for your high blood pressure? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, name and address of hospital? \_\_\_\_\_

Date of hospitalization and treatment: \_\_\_\_\_  
\_\_\_\_\_

10. Name and address of treating physician: \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)	Date
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**KIDNEY/URINARY DISORDER QUESTIONNAIRE**  
**(complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. What kind of kidney/urinary disorder did you have? Bladder infection, reflux, cystitis, kidney stones, nephritis, prostate trouble or other? \_\_\_\_\_  
\_\_\_\_\_

2. When did you first have symptoms? \_\_\_\_\_

3. When did you last have symptoms? \_\_\_\_\_

4. How many occurrences have you had? \_\_\_\_\_

5. Name and address of hospital and treating physician? \_\_\_\_\_  
\_\_\_\_\_

6. Any surgery? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what type? \_\_\_\_\_ Date? \_\_\_\_\_

Details: \_\_\_\_\_

7. Name and address of hospital? \_\_\_\_\_  
\_\_\_\_\_

8. Do you now have, or have you ever had any heart trouble or high blood pressure?  
Yes \_\_\_\_\_ No \_\_\_\_\_ (If yes, provide dates and details): \_\_\_\_\_  
\_\_\_\_\_

9. What special studies have you had? (Provide dates and results of studies)  
\_\_\_\_\_

10. When was urine last checked? Date: \_\_\_\_\_ Why was it checked? \_\_\_\_\_  
\_\_\_\_\_

11. Name and address of treating physician: \_\_\_\_\_  
\_\_\_\_\_

12. What is your current height? \_\_\_\_\_ Weight? \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

**MENTAL HEALTH QUESTIONNAIRE**  
**(complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Clinical name (definitive diagnosis) of condition: \_\_\_\_\_

Have you been diagnosed with: \_\_\_\_\_ Depression \_\_\_\_\_ Anxiety \_\_\_\_\_ Panic Disorder  
\_\_\_\_\_ Schizophrenia \_\_\_\_\_ Obsessive Compulsive Disorder \_\_\_\_\_ Bipolar Disorder  
\_\_\_\_\_ Manic Depression

2. Did you seek treatment from a psychologist, psychiatrist, physician, LSW or other type of counselor?  
Yes \_\_\_ No \_\_\_. **If yes, circle which one was seen** and give date(s) of treatment: \_\_\_\_\_

Frequency of treatment: \_\_\_\_\_

If treatment has ended, provide date of last visit: \_\_\_\_\_

3. Was medication prescribed? Yes \_\_\_\_\_ No \_\_\_\_\_

<b>Name of Medication:</b>	<b>Dosage:</b>	<b>Frequency (i.e., daily, weekly)</b>
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\_\_\_\_\_

4. Are you still on medication? Yes \_\_\_\_\_ No \_\_\_\_\_. If no, when was medication discontinued? \_\_\_\_\_

If yes,

<b>Name of Medication:</b>	<b>Dosage:</b>	<b>Frequency (i.e., daily, weekly)</b>
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\_\_\_\_\_

5. Have you been hospitalized for this, or a similar condition? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, provide complete details regarding date(s) of hospitalization, duration of stay and name of facility: \_\_\_\_\_

\_\_\_\_\_

6. If this was a "situational" depression, please explain cause: \_\_\_\_\_

\_\_\_\_\_

7. Have you ever attempted suicide? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, please provide details:

\_\_\_\_\_

8. Any other comments? \_\_\_\_\_

\_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

**MIGRAINE QUESTIONNAIRE**  
**(complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Date of diagnosis or first symptoms: \_\_\_\_\_

2. Frequency of headaches: \_\_\_\_\_ # per week \_\_\_\_\_ # per month

3. Are headaches mild, moderate or severe? \_\_\_\_\_

Date of last headache? \_\_\_\_\_

Name and address of treating physician: \_\_\_\_\_

\_\_\_\_\_

4. Any work loss or restricted activities? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give details: \_\_\_\_\_

5. Are you taking medication for this condition? Yes \_\_\_\_\_ No \_\_\_\_\_

**Name of Medication:** \_\_\_\_\_ **Dosage:** \_\_\_\_\_ **Frequency (i.e., daily, weekly)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

6. How often do you see the doctor for this condition? \_\_\_\_\_

7. Results and dates of any special test/studies:

Dates	Name of test/study & results
_____	_____
_____	_____
_____	_____

8. Are the headaches caused by eyestrain, sinus infection, hypertension, brain tumor, aneurysm, trauma, acute febrile illness or temporal arteritis: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, provide details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date



**THYROID QUESTIONNAIRE**  
**(complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Date of first symptoms or diagnosis? \_\_\_\_\_

2. What was the original diagnosis (hypothyroid, hyperthyroid, goiter, other)? Please specify:  
\_\_\_\_\_  
\_\_\_\_\_

3. Give details of past and current treatment: \_\_\_\_\_  
\_\_\_\_\_

4. Ever had or been advised to have surgery? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, give details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Any prescription medications taken for this condition? Yes \_\_\_\_\_ No \_\_\_\_\_

<b>Name of Medication:</b>	<b>Dosage:</b>	<b>Frequency (i.e., daily, weekly)</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Name and address of treating physician: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Date of last office visit and laboratory studies? \_\_\_\_\_

Was the last thyroid level within range? Yes \_\_\_\_\_ No \_\_\_\_ If no, please indicate results of last thyroid level and date: \_\_\_\_\_

8. What is your current height? \_\_\_\_\_ Weight? \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

**TUMOR/CYST/SKIN CANCER QUESTIONNAIRE**  
**(complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Date of diagnosis or date of first indication of tumor/cyst/skin cancer: \_\_\_\_\_

What diagnosis or description was given to you by your doctor about the tumor/cyst/skin cancer?  
\_\_\_\_\_

2. Was it diagnosed as: Malignant \_\_\_\_\_ or Benign \_\_\_\_\_ (If malignant, provide details) \_\_\_\_\_

If malignant, what was the stage, grade, Clark level (Melanoma) or Gleason (Prostate) score? \_\_\_\_\_

Size of tumor/cyst/skin cancer? \_\_\_\_\_ Location? \_\_\_\_\_

Has there been any metastasis or spread to any other location(s)? Yes \_\_\_\_\_ No \_\_\_\_\_  
(If yes, provide details):  
\_\_\_\_\_

Has there been any recurrence or relapse? Yes \_\_\_\_\_ No \_\_\_\_\_. If yes, provide details:  
\_\_\_\_\_

3. Did you receive medication for the tumor/cyst/skin cancer? Yes \_\_\_ No \_\_\_\_\_. If yes, provide name and dosage of medication and date medication was taken: \_\_\_\_\_

Did you receive radiation or chemotherapy for the tumor/cyst/skin cancer? Yes \_\_\_ No \_\_\_\_\_. If yes, provide details and date(s) taken: \_\_\_\_\_

4. Have you had surgery or been advised to have surgery to remove the tumor/cyst/skin cancer?

Yes \_\_\_\_\_ No \_\_\_\_\_

If surgery done, when? \_\_\_\_\_

Have you been released from treatment? Yes \_\_\_ No \_\_\_\_\_. If yes, when? \_\_\_\_\_

5. Are further studies or future operations for the tumor/cyst/skin cancer anticipated? Yes \_\_\_ No \_\_\_\_

If yes, when? \_\_\_\_\_

6. Name and address of treating physician: \_\_\_\_\_

7. Any other comments? \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

**ULCER QUESTIONNAIRE**  
**(complete all questions)**

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated: \_\_\_\_\_ Relationship to applicant: \_\_\_\_\_

1. Please indicate type of ulcer: Gastric \_\_\_\_\_ Duodenal \_\_\_\_\_ Peptic \_\_\_\_\_ Other (specify) \_\_\_\_\_

2. Details of ulcer history:

**First episode**

**Last episode**

Date: \_\_\_\_\_

Duration: \_\_\_\_\_

Location: \_\_\_\_\_

Treatment: \_\_\_\_\_

Number of episodes/flare-ups in the last 4 years? \_\_\_\_\_ Is ulcer now present? Yes \_\_\_\_\_ No \_\_\_\_\_

3. Have you ever had any complications (such as anemia, vomiting blood, blood in stool, perforation, other)?

Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, provide date(s) of incident and details: \_\_\_\_\_

\_\_\_\_\_

4. Have you had surgery for the ulcer or is surgery anticipated in the future? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, provide complete details regarding date(s) of surgery, type of surgery and advise if any symptoms since surgery? \_\_\_\_\_

\_\_\_\_\_

5. Was medication prescribed? Yes \_\_\_\_\_ No \_\_\_\_\_

**Name of Medication:**

**Dosage:**

**Frequency (i.e., daily, weekly)**

\_\_\_\_\_

6. Are you still on medication? Yes \_\_\_\_\_ No \_\_\_\_\_. If no, when was medication discontinued? \_\_\_\_\_

7. Recent lab test or special studies (x-ray, Upper GI, other?) \_\_\_\_\_

Results of test: \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Unknown

8. Do you now use tobacco products? Yes \_\_\_\_\_ No \_\_\_\_\_

9. Name and address of treating physician: \_\_\_\_\_

\_\_\_\_\_

10. What is your current height? \_\_\_\_\_ Weight? \_\_\_\_\_

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand Anthem Blue Cross and Blue Shield will rely on these statements when determining eligibility.

\_\_\_\_\_  
Signature of person treated (or parent/guardian if under 18)

\_\_\_\_\_  
Date

# MISCELLANEOUS FORMS

## Application Chart

	FORM NEEDED	COMMENTS
Add newborn within first 31 days of life to parent(s) policy.	Downgrade/Policy Change Form	Policyholder can either call customer service and give information on child and request baby be added permanently or submit the form.
Add newborn to sibling policy at anytime after they are released from the hospital.	N/A	Cannot add siblings to existing child only policy.
Add newborn after 31 <sup>st</sup> day.	Individual Enrollment Application with a version history prior to 9/10	Is underwritable and will be given next available effective date after app is received.
Add adopted child.	Individual Enrollment Application with a version history prior to 9/10 if under age 19. If over age 19 an application with a version history of 9/10 is required.	Besides application, need Affidavit for Special Dependent or a copy of the document awarding court-appointed custody.
Add any other dependent/spouse/domestic partner.	Individual Enrollment Application	Child, Spouse or Domestic Partner under age 19 requires an application with a version history prior to 9/10. If they are 19 or older must be on an application with a version history of 9/10.
Delete dependent.	Downgrade/Policy Change Form	Policyholder can submit form or send letter to Anthem signed by subscriber. Will be deleted effective with receipt of letter.
Delete policyholder and keep coverage on spouse/domestic partner/dependents.	No form needed	Letter to Anthem signed by subscriber. Enrollment will set up coverage in spouse/domestic partner or dependent's name, if requested.
Downgrades.	Downgrade/Policy Change Form	Will accept verbally from the policyholder or agent. The policyholder can also complete the Downgrade/Policy Change Form or submit a request in writing.
Policyholders want to combine separate policies into one-Upgrade for any member on either policy.	Individual Enrollment Application with a version history of 9/10	If don't want rate review or isn't an upgrade, medical questions don't have to be answered.
Policyholders want to combine separate policies into one-Same plan or downgrade for all members.	No form needed	Request in writing with appropriate subscriber's signatures of all polices involved. Request needs to include HCID numbers; plan/deductible wanted and indicate who will remain as the subscriber.
Rate review-trying for better rate due to change in medical history, lost weight, stopped using tobacco.	Change of Coverage Application with version history of 9/10	Claims and medical history are reviewed. Rate Reviews can only be done at renewal.
Upgrades	Change of Coverage Application	

## AFFIDAVIT FOR ADOPTIONS AND COURT-APPOINTED GUARDIANSHIPS

Member's Name	Certificate No..	Group No.	(area code) Phone #
Member's Address:	Street	City, State	Zip code
Spouse/Domestic Partner Name and Address	Street	City, State	Zip code

I hereby certify that as the court-appointed custodian or guardian of the dependent child(ren) listed below, such child(ren) is/are my legal and financial responsibility and will, to the best of my knowledge, reside in my home until age 19 or until the child(ren)'s marriage, whichever comes first. (Dependent children are defined as unmarried children under 19 years of age, including legally adopted or legally placed children, who are dependent upon the subscriber for support and live with the subscriber in a regular parent-child relationship.)

NAME	DATE OF BIRTH	RELATIONSHIP

Are you legally and financially responsible for the child? YES \_\_\_ NO \_\_\_  
 Please advise the date on which you assumed financial responsibility for the child. \_\_\_\_\_  
 Is the child claimed as an eligible dependent on your State or Federal Income Tax Return? YES \_\_\_ NO \_\_\_  
 If no, please explain: \_\_\_\_\_  
 Do you live in a regular parent-child relationship with the child? YES \_\_\_ NO \_\_\_  
 Please advise the date the Petition for Adoption or Application for Appointment of Guardianship was filed. \_\_\_\_\_  
 \_\_\_\_\_  
 Was custody or guardianship awarded by a court or an authorized governmental agency? YES \_\_\_ NO \_\_\_  
 Do you intend to adopt the child? YES \_\_\_ NO \_\_\_  
 Has a court already approved the adoption? YES \_\_\_ NO \_\_\_  
 Is the child covered by Medicaid? YES \_\_\_ NO \_\_\_ If yes, give Medicaid Number: \_\_\_\_\_  
 Is the child covered by Medicare? YES \_\_\_ NO \_\_\_ If yes, give Medicare Number: \_\_\_\_\_  
 Effective dates for Medicare (if applicable): Part A \_\_\_\_\_ Part B \_\_\_\_\_  
 Are the natural parents of the above listed child(ren) living? YES \_\_\_ NO \_\_\_  
 Does either of the child's natural parents live in your household? YES \_\_\_ NO \_\_\_  
 Mother's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Mother's Current Address: \_\_\_\_\_  
 Father's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Father's Current Address: \_\_\_\_\_  
 Does either natural parent have Blue Cross and Blue Shield or Option 2000 coverage YES \_\_\_ NO \_\_\_  
 If yes, which parent? \_\_\_\_\_ Certificate No. \_\_\_\_\_ Group No. \_\_\_\_\_

**NOTE: Please submit a copy of the Petition for Adoption or Application for Appointment of Guardianship or the legal document awarding you custody or guardianship of the listed child(ren). If the child was placed for adoption, please submit a letter from the attorney handling the adoption, including the name and date of birth of the child, the name of the adoptive parent(s), and the date the child was placed.**

Custody or guardianship awarded other than by a court of law or an authorized governmental agency will not be recognized in the determination of eligibility for Blue Cross and Blue Shield coverage for the listed dependent child(ren). All information requested must be furnished before coverage for the listed child(ren) will be considered.

I AGREE TO NOTIFY ANTHEM BLUE CROSS AND BLUE SHIELD IMMEDIATELY OF ANY CHANGES, PRESENTLY UNFORSEEN BY ME, IN THE CHILD(REN)'S LIVING ARRANGEMENTS WITH ME. I UNDERSTAND THAT AN ELIGIBLE CHILD(REN) WILL BE REMOVED FROM MY MEMBERSHIP WHEN HE/SHE NO LONGER QUALIFIES AS A DEPENDENT AS DEFINED IN MY CONTRACT.

\_\_\_\_\_  
Signature of Member

\_\_\_\_\_  
DATE

**THIS FORM MUST BE NOTARIZED BY A NOTARY PUBLIC**

STATE OF \_\_\_\_\_

COUNTY OF \_\_\_\_\_

The foregoing document was subscribed and sworn to before me on the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_.

\_\_\_\_\_  
Notary Public

My commission expires: \_\_\_\_\_

The following is to be completed if the member has coverage through an employer's group plan.

\_\_\_\_\_  
Signature of Authorized Official

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Name of Company

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

AKY-136

Rev. 9/07

Rev. 04/07/11

Send to:

e-mail: uwopinionforms@wellpoint.com

# REQUEST FOR UNDERWRITING OPINION OHIO Request

Complete a separate form for each applicant/dependent

Date: \_\_\_\_\_ GA/Agent Name: \_\_\_\_\_ GA/Agent Phone #: \_\_\_\_\_

Send response to email address: \_\_\_\_\_ Client Name: \_\_\_\_\_

Client Id#: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SMOKER (Y/N): \_\_\_\_\_

Premier	Smart Sense	Blue Traditional	HSA
<input type="checkbox"/> 20% <input type="checkbox"/> 0% <input type="checkbox"/> Premier Comp Drug <input type="checkbox"/> \$15 / \$30 / \$60 / 25%	<input type="checkbox"/> Smart Sense Generic Premium Drug <input type="checkbox"/> Comp Drug Coverage	<input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3	<input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5  Other: _____ _____ _____
Deductible:	Deductible:	Deductible:	Deductible:
<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family

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## MEDICAL HISTORY – Please List ALL Medical History

Condition/ Diagnosis	Onset Date	Date last Treated	Details of symptoms, Treatment, tests performed, results	Medications (Name,dose,freq )	Current Status

**Additional Comments:**

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**“WHEN ANSWERING QUESTIONS, YOU SHOULD NOT INCLUDE ANY GENETIC INFORMATION. GENETIC INFORMATION INCLUDES FAMILY MEDICAL HISTORY AND INFORMATION RELATED TO GENETIC TESTING, GENETIC SERVICES, GENETIC COUNSELING, OR GENETIC DISEASES FOR WHICH YOU BELIEVE YOU MAY BE AT RISK.”**

**THIS UNDERWRITING OPINION IS NOT BINDING IN ANY WAY AND ANY DECISION IS BASED SOLELY ON THE INFORMATION FURNISHED ON THIS FORM. AGENTS SHOULD RETAIN A COPY OF THIS OPINION, AS UNDERWRITING WILL NOT MAINTAIN AN OPINION FILE.**

Rev. 04/07/11



Send to:

e-mail: uwopinionforms@wellpoint.com

# REQUEST FOR UNDERWRITING OPINION KENTUCKY Request

Date: \_\_\_\_\_ GA/Agent Name: \_\_\_\_\_ GA/Agent Phone #: \_\_\_\_\_

Send response to email address: \_\_\_\_\_ Client Name: \_\_\_\_\_

AGE: \_\_\_\_\_ SEX: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SMOKER (Y/N): \_\_\_\_\_

Premier	Smart Sense	HSA	Other
<input type="checkbox"/> 20% <input type="checkbox"/> 0% <input type="checkbox"/> Premier Comp Drug <input type="checkbox"/> \$15 / \$30 / \$60 / 25%	<input type="checkbox"/> Generic Premium Drug <input type="checkbox"/> Comp Drug Coverage	<input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5	<hr/> <hr/> <hr/> <hr/>
Deductible:	Deductible:	Deductible:	Deductible:
<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family



## MEDICAL HISTORY – PLEASE LIST ALL MEDICAL HISTORY

(Do **NOT** send Medical Records or MQs with Opinion Form)

Condition/ Diagnosis	Onset Date	Date last Treated	Details of symptoms, Treatment, tests performed, results	Medications (Name,dose,freq )	Current Status

**Additional Comments:**



**“WHEN ANSWERING QUESTIONS, YOU SHOULD NOT INCLUDE ANY GENETIC INFORMATION. GENETIC INFORMATION INCLUDES FAMILY MEDICAL HISTORY AND INFORMATION RELATED TO GENETIC TESTING, GENETIC SERVICES, GENETIC COUNSELING, OR GENETIC DISEASES FOR WHICH YOU BELIEVE YOU MAY BE AT RISK.”**

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Send to:

e-mail: uwopinionforms@wellpoint.com

**REQUEST FOR UNDERWRITING OPINION  
INDIANA Request**

Date: \_\_\_\_\_

Send response to email address: \_\_\_\_\_ **Client Name:** \_\_\_\_\_

This section must be completed for each applicant:

**AGE:** \_\_\_\_\_ **SEX:** \_\_\_\_\_ **HEIGHT:** \_\_\_\_\_ **WEIGHT:** \_\_\_\_\_ **SMOKER (Y/N):** \_\_\_\_\_

<i>Premier</i>	<i>Smart Sense</i>	<i>HSA</i>	<i>Other</i>
<input type="checkbox"/> 20% <input type="checkbox"/> 0% <input type="checkbox"/> Premier Comp Drug <input type="checkbox"/> \$15 / \$30 / \$60 / 25%	<input type="checkbox"/> Generic Premium Drug <input type="checkbox"/> Comp Drug Coverage	<input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4 <input type="checkbox"/> Plan 5 <input type="checkbox"/> Other _____	_____ _____ _____ _____
Deductible:	Deductible:	Deductible:	Deductible:
<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family	<input type="checkbox"/> Single <input type="checkbox"/> Family

**MEDICAL HISTORY – PLEASE LIST ALL MEDICAL HISTORY  
(Do NOT send Medical Records or MQs with Opinion Form)**

Condition/ Diagnosis	Onset Date	Date last Treated	Details of symptoms, Treatment, tests performed, results	Medications (Name,dose,freq )	Current Status

**Additional Comments:**

**“WHEN ANSWERING QUESTIONS, YOU SHOULD NOT INCLUDE ANY GENETIC INFORMATION. GENETIC INFORMATION INCLUDES FAMILY MEDICAL HISTORY AND INFORMATION RELATED TO GENETIC TESTING, GENETIC SERVICES, GENETIC COUNSELING, OR GENETIC DISEASES FOR WHICH YOU BELIEVE YOU MAY BE AT RISK.”**

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# OHIO HEALTH REINSURANCE PROGRAM OPEN ENROLLMENT "INDIVIDUAL" STATEMENT

CALENDAR YEAR: \_\_\_\_\_

TO BE COMPLETED FOR EACH INDIVIDUAL INSURED UNDER OPEN ENROLLMENT LEGISLATION

Policy Number \_\_\_\_\_ Effective Date \_\_\_\_\_

- Ohio Eligible Individual as defined by Section 3923.58(B)
- Federally Eligible Individual as defined by Section 3923.581(A)(2)

1. Is the individual employed?  YES  NO If yes, please indicate  
Type?  Full Time  Part Time  Self-employed
2. Is the individual or dependent(s) eligible for benefits through the employer's health plan?  
 YES  NO If yes, please detail why coverage is not in force. \_\_\_\_\_  
\_\_\_\_\_
3. Is the spouse/domestic partner employed?  YES  NO If yes, please indicate type:  
 Full Time  Part Time  Self-employed
4. Is the spouse/domestic partner, individual or dependent(s) eligible for benefits  
through the spouse/domestic partner's employer health plan?  YES  NO  
If yes, please detail why coverage is not in force. \_\_\_\_\_  
\_\_\_\_\_
5. Is this individual, spouse/domestic partner or dependent(s) eligible for any  
other private or public health benefits plan including Medicare or  
any state health benefits plan?  YES  NO  
If yes, please detail why coverage is not in force. \_\_\_\_\_  
\_\_\_\_\_

## **PLEASE ANSWER THE FOLLOWING QUESTIONS FOR FEDERALLY ELIGIBLE INDIVIDUALS**

6. Has this individual accumulated 18 or more months of creditable coverage and the most recent period of creditable coverage was under a group health, governmental or church plan?  
 YES  NO
7. Was the previous coverage terminated for reasons other than nonpayment of premium or fraud?  
 YES  NO
8. If the individual was eligible for COBRA or state continuation of coverage, did the individual elect this coverage and completely exhaust the coverage in accordance with the provision?  
 YES  NO

If no to questions 6, 7 or 8 please explain: \_\_\_\_\_

CARRIER Anthem Blue Cross and Blue Shield DATE \_\_\_\_\_

CONTACT NAME Melissa Wise

PHONE (502) 261-2181 FAX NUMBER (502) 261-6606

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A-2141

Rev. 4/03 (individual statement)



**Underwriting Department**  
**P.O. Box 37810**  
**Louisville KY 40233-7810**  
**866-282-2157 / fax: 800-848-2512**  
**Attention: \_\_\_\_\_**

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
**Applicant Name:** \_\_\_\_\_  
**Date Sent:** \_\_\_\_\_ **Return By:** \_\_\_\_\_

**MEDICAL HISTORY**  
**This form must be completed in its entirety.**

**Date of Exam:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please check any of the following as they apply and provide dates, hospitalization, and other pertinent details in the space provided below.**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Seizure Disorder  | <input type="checkbox"/> Mental Illness                         |
| <input type="checkbox"/> Pulmonary Disease | <input type="checkbox"/> Alcohol Abuse   | <input type="checkbox"/> Counseling                             |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> Drug Abuse  | <input type="checkbox"/> Neurological Disorder                  |
| <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Participation in a drug or alcohol rehabilitation program | <input type="checkbox"/> Other injuries, surgeries or illnesses |
| <input type="checkbox"/> Diabetes Mellitus |  |   |
| <input type="checkbox"/> AIDS/ARC          |  |   |

Explanation: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Does this patient have any future surgery or hospitalization planned? \_\_\_\_ If so, please explain: \_\_\_\_\_  
 \_\_\_\_\_

Is the patient currently on medication? \_\_\_\_ If yes, indicate name, dosage and reason for medication: \_\_\_\_\_  
 \_\_\_\_\_

**LABORATORY**

List the following laboratory results or attach a copy of the lab report(s);

Cholesterol:	Date: _____	Results: TC _____ HDL _____ LDL _____
Triglycerides:	Date: _____	Results: _____
Blood sugar:	Date: _____	Results: _____
Hematocrit or Hemoglobin Only	Date: _____	Results: _____
Serum Creatinine	Date: _____	Results: _____

**PHYSICAL EXAMINATION**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ Respiration: \_\_\_\_\_ BP: \_\_\_\_\_

Please indicate (+) if abnormal or (-) if normal as they apply and provide details in space provided.

HEENT _____	Hearing _____	Abdomen _____	Neurological _____	Heart _____
Sight _____	Skin _____	GU _____	Lungs _____	OB/GYN _____

Explanation of any abnormal findings: \_\_\_\_\_  
 \_\_\_\_\_

Name of Attending Physician (Please Print)	Degree/Licensure	Telephone
Street Address	City, State	Zip Code
Signature of Attending Physician	Provider Number	Date

## **AFFIDAVIT OF DOMESTIC PARTNERSHIP**

**NOTE:**[The definition of “Domestic Partner” for purposes of this Affidavit shall be two individuals, either of the same or opposite sex, who live together in a long-term relationship of indefinite duration with an exclusive mutual commitment in which the Domestic Partners agree to be jointly responsible for each other’s common welfare and to share financial obligations.]

We, \_\_\_\_\_ and \_\_\_\_\_ (“Domestic Partner”), after being first duly sworn depose and attest to the following:

- We are both at least eighteen (18) years of age and we are mentally competent to contract;
- Neither of us is legally married to another person, nor is either of us a member of another domestic partnership;
- We are sole Domestic Partners, and have been sole Domestic Partners for at least [twelve (12)] months] preceding the date of this Affidavit. We have been sole Domestic Partners living together continuously since \_\_\_\_\_ (month/day/year), and we intend to remain sole Domestic Partners indefinitely;
- Neither of us is related by blood or adoption closer than permitted by state law for marriage;
- We are jointly responsible for each other’s common welfare as evidenced through, for example, a joint deed, joint mortgage, joint lease, joint credit card, joint bank account, designation of Domestic Partner as beneficiary for life insurance and retirement contract, designation of Domestic Partner as primary beneficiary in the Employee’s will and/or powers of attorney authorizing each of us to act on behalf of the other;
- We understand that a Domestic Partner enrolled as a dependent ceases to be an eligible dependent on the date of the dissolution of the Domestic Partnership.

We certify, under penalty of perjury, that the foregoing is true and correct.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Domestic Partner Signature

## **Indiana, Kentucky, Ohio Important Contacts**

### **Agency Services/ Sales Support:**

#### **Individual Business**

Telephone: 1-800-742-8199  
 Email: [agency.services@anthem.com](mailto:agency.services@anthem.com)  
 Fax: 1-800-850-9888  
 Hours: 8 am-5 pm Monday-Thursday; 9 am-5 pm, Friday Eastern Time

#### **Over 65 Business**

Telephone: **1-800-633-4368**  
 Email: [seniorcentral@wellpoint.com](mailto:seniorcentral@wellpoint.com)  
 Fax: **1-805-375-6265**  
 Hours: **9 am-8 pm Monday-Thursday; 9am-3pm & 5 pm-7pm Friday Eastern Time**

### **Applications – Under 65 and Medicare Supplement (New Applications or Change of Coverage Forms):**

**Faxing Applications and Additional information to Underwriting:** 1-800-848-2512

**Email Underwriting Opinion Form Only:** [UWOpinionForms@anthem.com](mailto:UWOpinionForms@anthem.com)

#### **Mailing Applications:**

Anthem Blue Cross and Blue Shield  
 PO BOX 37810  
 Louisville, KY 40233-7810

#### **Overnight Address:**

ATTN: KY9999-LASN  
 13550 Triton Park Boulevard  
 Louisville, KY 40223

### **Customer Service: (Individual only)**

Indiana	Kentucky	Ohio
U65: 866-649-2034	U65: 866-848-1056	U65: 888-613-6097
Medicare Supp/Select: 866-649-2033	Medicare Supp/Select: 866-848-1057	Medicare Supp/Select: 866-649-2037

### **Individual Premium Payment Address:**

Indiana	Kentucky	Ohio
Anthem BCBS PO Box 105674 Atlanta, GA 30348-5674	Anthem BCBS PO Box 105675 Atlanta, GA 30348-5675	Anthem BCBS PO Box 105095 Atlanta, GA 30348-5095

### **Individual Billing Maintenance Address: (e.g., Downgrade/Policy Change Forms):**

PO Box 37730  
 Louisville, KY 40233-7730  
 Fax: 877-628-4593

**Anthem Formulary Line:** (to hear recorded updates): 1-(877) 4MULARY/ 877-468-5279

**WellPoint NextRx:** (mail service pharmacy): 1-800-962-8192

**Dental:**

Customer Service: 1-866-589-0578

Agents: 1-800-627-0004

**Supplies:**

Select "Order Material Online" from the Individual Producer Site

Refer to your Producer Manual on how to order materials via the Online Order Entry System.

**List Billing Arrangements:**

**Faxing List Bill applications and or forms:** 502-889-3210

**Mailing Applications**

Attn: List Bill Implementation Coordinator/KY0303A655

13550 Triton Park Blvd

Louisville KY 40223-7810

**Implementation Coordinator (List Bill set up and enrollment):** 502-889-2070

WellPoint NextRx is a division of WellPoint, Inc. and is also a registered service mark of WellPoint, Inc. WellPoint NextRx Services are provided by a WellPoint PBM (either NextRx Services, Inc. or NextRx, LLC, as applicable).