**********NOTE**********

Anthem Enrollment Application
Regarding Sections 8 & 9

On the date you are completing this form, if your current medical coverage is still active OR will expire in the future, please complete Section 8 (Other Health Coverage). Do not leave any blank fields. If you know when your other coverage will terminate, please write that date (indicating termination date) above Effective Date.

Section 9 (Prior Health Coverage) – this section is no longer applicable. There is no pre-existing exclusion period.

The Office of Benefits cannot process your medical enrollment without this properly completed information. An incomplete form will be returned to you. If you have any questions about completing this form, call the Office of Benefits at (219) 769-9292.
8. Other Health Coverage  Please check one:  □ YES (completed below)  □ NO  

On the day your coverage begins, all family members, including yourself, who will be covered by any other health coverage.

<table>
<thead>
<tr>
<th>Policy/certificate holder’s name</th>
<th>Social Security number</th>
<th>Date of birth</th>
<th>Relationship to applicant</th>
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If you and/or your dependents are enrolled in Medicare or Medicaid, complete the following:

<table>
<thead>
<tr>
<th>Enrollee’s name(s)</th>
<th>Medicare/Medicaid ID#</th>
<th>Medicare Part A effective date</th>
<th>Medicare Part B effective date</th>
<th>ESRD onset date</th>
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Medicare Part D ID# | Medicare Part D Carrier | Medicare Part D effective date | Medicare Part D term date |
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Reason for Medicare entitlement:

□ Age  □ Disability  □ ESRD & Disability  □ End Stage Renal Disease (ESRD)

9. Prior Health Coverage  Please check one:  □ YES (completed below)  □ NO

Have you been covered by Anthem within the past two (2) years?  □ Yes  □ No

<table>
<thead>
<tr>
<th>Policy/Carrier</th>
<th>Group name/ID#</th>
<th>Date policy in effect</th>
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Have you or any dependents been covered by any other insurance within the past two (2) years?  □ Yes  □ No

Please check the type of prior coverage:

□ Employer  □ Employee/Spouse  □ Employee/Child(ren)  □ Employee/Spouse/Child(ren)

Term of this coverage:  □ Divorce  □ Legal separation  □ Death of spouse  □ COBRA coverage exhausted  □ Employment terminated  □ Group plan terminated  □ Employee/group contribution ceased  □ Other:

Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program.

2. I authorize deduction from my wages/pension, if necessary for the required premium for the coverage which I, or any dependents have applied.

3. I am applying for the coverage selected on this application. If I select a coverage, or combination of coverages, not available to me and / or a class for which I am not eligible, I agree that by my selection(s) is hereby automatically amended to be consistent with the employer’s application.

4. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application (and that Anthem Life Insurance Company may accept only certain persons or conditions for coverage) and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions. (Ohio only — unless I applied for HM0HC coverage, in which case there is no such exclusion.)

5. I am responsible for timely notifying my employer of any change that would make me or any dependent ineligible for coverage.

6. Ohio: If applying for HMO/HCN coverage, I understand that I may cancel my membership by providing written notice to Anthem within 72 hours of signing this application.

7. By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

8. THIS PARAGRAPH APPLIES ONLY TO MEMBERS OF OHIO GROUPS, AND DOES NOT APPLY TO MEMBERS OF INDIANA OR KENTUCKY GROUPS: I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may be disclosed to outside parties without my authorization. If such disclosure is permitted by both the HIPAA Privacy Regulations (45 C.F.R. Parts 160 & 164) and the Ohio Revised Code § 7953.13, I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

I acknowledge that I have read the Significant Terms, Conditions and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by Anthem in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s).

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

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

I give this authorization for and on behalf of any eligible dependents and myself if covered by the Plan. I am acting as their agent and representative.

Your health coverage will be provided by one of the following companies based upon the state in which your employer, trust or association is located:

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

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

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

Thank you for choosing Anthem Blue Cross and Blue Shield

10. Read the TERMS section carefully before signing. Please review your application for errors or omissions.

By signing this, I am indicating that I have read and understand the language in the TERMS section of this application and agree to all of its terms.

Applicant Signature

Date  /  /