

# Insurability Information Request – California



Please keep a copy of this form/notice for your records.

Medical Evidence Underwriting Unit  
LifeDisUW\_MEU@anthem.com

Group no.	Evidence required because of: <input type="checkbox"/> Over guaranteed issue amount <input type="checkbox"/> Late entrant <input type="checkbox"/> Change of benefits	This evidence is provided for: <input type="checkbox"/> An effective date under a new group <input type="checkbox"/> A post group effective date addition
-----------	--	--

## Section 1: General information

Last name	First name	M.I.	Date of birth (MMDDYYYY)					
Social Security no.	Work phone no.	Home phone no.		Email				
Employee street address		City		State	ZIP code	State of birth	Height	Weight
Request amount \$	Name of employer			Employer address				

## Section 2: Dependent information – Complete for all dependents (if any) to be covered under this program.

Last name, first name, M.I.	Sex	Date of birth (MM/DD/YYYY)	State of birth	Relationship	Height	Weight	Dependent request amount
	<input type="checkbox"/> M <input type="checkbox"/> F			<b>Spouse</b>			
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						
	<input type="checkbox"/> M <input type="checkbox"/> F						

## Section 3: Medical and activities questionnaire

**Complete the following medical questions for all persons to be covered:** For the purpose of the following questions, the term "Medical or Social Practitioner" includes but is not limited to: a doctor, nurse, psychologist, psychiatrist, social worker, chiropractor, podiatrist, therapist, pathologist, dentist, optometrist, osteopath, Christian Science practitioner, or any person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program, or a weight loss program.

<p>1. Are you or any of your dependents currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? _____ Expected due date: _____ (MMDDYYYY)</p> <p>2. Have you or any of your dependents smoked or used tobacco in the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? _____ Type: _____ Quit date (if applicable): _____ (MMDDYYYY)</p> <p>3. In the past five years, have you or any of your dependents ever:</p> <p>a. Had high blood pressure or high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, who? _____ Last three readings: _____</p> <p>b. Had heart disease, cancer, diabetes, arthritis, or asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Had counseling by a Medical or Social Practitioner for an emotional, mental or nervous condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Been treated for alcohol or chemical dependency, or been convicted for driving while intoxicated? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you or any of your dependents ever been diagnosed by, or received treatment from, a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>5. In the past three years have you or any of your dependents been prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. In the past five years have you or any of your dependents had an inpatient admission and/or outpatient surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. During the past three years, have you or any of your dependents sought medical treatment, or been advised by a Medical or Social Practitioner to seek treatment for any condition not indicated by the answers to the preceding six questions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Have you or any of your dependents ever been rated or declined for, or refused reinstatement or renewal of, life or health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of person, date and reason: _____ _____</p> <p>9. In the past three years, have you or any of your dependents been engaged in sports or hobbies such as aviation, scuba diving, sky diving, racing, or similar activities? <input type="checkbox"/> Yes <input type="checkbox"/> No Please list: _____ _____ _____</p>
---	---

**Important notice:** No person, including an employee or agent of Anthem has the authority to change or omit any of these medical questions.

**Si usted necesita ayuda un Espanol para entender este documento, comuniquese con el adminstrador de su grupo..**

Life and Disability products underwritten by Anthem Blue Cross Life and Health Insurance Company, an independent licensee of the Blue Cross Association.

Anthem is a registered trademark of Anthem Insurance Companies, Inc.

B-0711-EOI 23

### Section 3: Medical and activities questionnaire (continued)

Explain any "Yes" answers to any questions below. If additional space is necessary, attach a separate page including your signature and date.

Question no.	Name of individual	Name of illness or injury	Dates of treatment	Any remaining effects	Name of medication and dosage	Name and address of physician/hospital

### Section 4: Notice of exchange of information

To proposed Insured and other persons proposed to be Insured, if any – information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901.

### Section 5: Agreement and authorization

- I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., to Anthem Blue Cross Life and Health Insurance Company (Anthem), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to HIV virus or AIDS (excluding disclosure of HIV testing), sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that Anthem may collect personal information about me and for any dependents listed herein, from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem collects about me and for any dependents listed herein, and that I may receive a more detailed description of my rights under this law by writing to Anthem.
  - These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
  - I am responsible for the timely notification to my employer of any changes that would make me or a dependent ineligible for coverage.
  - I understand that Anthem Blue Cross Life and Health Insurance Company reserves the right to accept or decline the application and that no right whatsoever is created by this information request. I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage. I also acknowledge receipt and understanding of the Notice of Exchange of Information explained above. I represent that the answers given to all questions on this information request are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in reviewing the application for insurance. 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 information request may result in denial of benefits or rescission or cancellation of my coverage(s). This authorization, for purposes of processing this information request form, is valid from the date signed for a period of 30 months unless revoked by me in writing, which I may do at any time by contacting Anthem. A photocopy is as valid as the original.
- I give this authorization for myself and on behalf of my eligible dependents if covered by the plan, including my Spouse/Domestic Partner unless he/she signs below. I am acting as their agent and representative. Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

Applicant signature <b>X</b>	Date (MMDDYYYY)
Spouse/Domestic Partner signature (If to be covered) <b>X</b>	Date (MMDDYYYY)

This Authorization may be revoked at any time by the Applicant by sending a written revocation to us at: **Anthem, P.O. Box 4510, Woodland Hills, CA 91365**. Such revocation must be signed and dated by the Applicant and spouse, if the spouse is to be covered. Revocation of this Authorization may result in denial of coverage or denial of a claim.

### Refusal of authorization – I refuse authorization to disclose health care information. I understand that such refusal may result in denial of coverage or denial of a claim.

Applicant signature <b>X</b>	Date (MMDDYYYY)
Spouse signature (If to be covered) <b>X</b>	Date (MMDDYYYY)

**For your protection California law requires the following statement to appear on this form:** Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.