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*The Indiana State Medical Association is dedicated to Indiana physicians and their efforts to provide the best possible health care for their patients.*

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**To: ISMA/Anthem Subscriber**

**From: ISMA Health Insurance Department**

**Date: June 10, 2010**

**Subject: Special Enrollment Opportunity for 25-26 Year Olds**

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The ISMA is offering a special enrollment opportunity to subscribers in its group health insurance program with Anthem for adding 25- to 26-year old children, effective July 1, 2010. This represents an early implementation of one of the provisions of the Patient Protection and Affordable Care Act.

Starting July 1, 2010, children can be covered as dependents through the end of the calendar year in which they attain age 26, up from age 24. Children do not have to be claimed as dependents for federal tax purposes, do not have to be students, and are eligible for coverage if married, provided they are not eligible for employer health insurance.

If you wish to add one or more dependents, please complete only the following parts of the attached Anthem Enrollment Application and submit it to the ISMA by June 30, 2010:

**Section 5:** Complete your name and social security number.

**Section 6:** Complete as questions pertain to dependent(s) being added.

**Section 7:** Complete in full.

**Section 8:** Complete as questions pertain to dependent(s) being added.

**Section 9:** Complete as questions pertain to dependent(s) being added.

**Section 10:** Sign and date.

After the application is reviewed by an Anthem underwriter, the ISMA will notify you of the impact on premiums, if any. If you accept coverage for your dependent(s), they will be added effective July 1, 2010.

If you have any questions, please call the ISMA at (800) 257-4762 or (317) 261-2060 and ask for Jolene, Donna or Tom.

# Enrollment Application



Individual

Please complete in ink and return to your employer. Use extra sheets of paper if necessary. All information given should apply to this employer. To search Blue Access<sup>SM</sup> PPO Providers, visit [www.anthem.com](http://www.anthem.com)

1. Billing Address		N/A	
		N/A	
Group #		Request. Effective Date	Applicant # / Dept. name
N/A		07/ 01 /10	
Anthem use:	Plan	Health Effective Date	Dental Effective Date
		/ /	/ /
			COB
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			Pre-ex (date)
			/ /
ISMA use:	Agent	Risk Class	Bill Cycle
			M Q S Y
			Record #
			ME #

2. Reason for Application		4. Type of Coverage/Plan	
<input type="checkbox"/> New enrollment <input type="checkbox"/> Waiver <input type="checkbox"/> Annual open enrollment <input type="checkbox"/> New hire <input type="checkbox"/> Rehire (date) / / <input checked="" type="checkbox"/> Add dependent (see section 3) <b>SPECIAL ENROLLMENT for 25-26 Year olds</b> Qualifying event _____ Event date <u>07/01/10</u>		<b>Health Coverage</b> <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + spouse <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family coverage <input type="checkbox"/> No coverage	
3. Status Change/Event		Dental Coverage	
Event date / / <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption* <input type="checkbox"/> Legal Guardianship* <input type="checkbox"/> Other _____ *Include legal documentation.		Medical Plan Name <u>N/A</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	

\* 5. Employee Information

Last name	First name, M.I.	Date of birth	Age	Sex	Social security #	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married	Height	Weight
Home address	City	State	ZIP code	County (KY residents include Municipality)				
Home telephone ( ) -	Business telephone ( ) -	eMail Address						
Are you: Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Occupation	Full time hire date	Hours working per week	Income reported by: <input type="checkbox"/> W2 <input type="checkbox"/> 1099 <input type="checkbox"/> Other: _____		

\* 6. Family Information Spouse and dependents to be covered. (Attach a separate sheet if necessary.)

1 Last name	First name, M.I.	Relationship to applicant	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)				
Date of birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security # - -	Height	Weight
Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation)				
Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)				
2 Last name	First name, M.I.	Relationship to applicant	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)				
Date of birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security # - -	Height	Weight
Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation)				
Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)				
3 Last name	First name, M.I.	Relationship to applicant	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)				
Date of birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security # - -	Height	Weight
Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation)				
Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)				
4 Last name	First name, M.I.	Relationship to applicant	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)				
Date of birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security # - -	Height	Weight
Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation)				
Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)				
5 Last name	First name, M.I.	Relationship to applicant	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other _____	Fulltime student? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is dependent's address different than applicant's address? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, provide full address)				
Date of birth / /	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Social Security # - -	Height	Weight
Eligible for federal income tax exemption? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Court ordered health care coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, include legal documentation)				
Currently hospitalized or disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, give reason)				

INSTRUCTIONS FOR THIS PAGE

Section 5: Complete your name and social security number.

Section 6: Complete as questions pertain to dependent(s) being added.

**\* 7. Other Health Coverage** *Please check one:*  YES (complete below.)  NO  
 On the day your coverage begins, list family members, including yourself, who will be covered by any other health coverage.

Provide name, phone number and address of the HMO or insurance company		Policy/certificate number		Effective date / /
Policy/certificate holder's name	Social Security number - -	Date of birth / /	Relationship to applicant	
<b>If you and/or your dependents are enrolled in Medicare Part A or Medicaid, complete the following.</b>				
Enrollee's name(s)	Medicare/Medicaid ID #	Medicare Part A effective date / /	Medicare Part B effective date / /	ESRD onset date / /
		/ /	/ /	/ /

Reason for Medicare enrollment:  
 Age  Disability  ESRD & Disability  End Stage Renal Disease (ESRD)

**\* 8. Prior Health Coverage** *Please check one:*  YES (complete below.)  NO

Have you been covered by Anthem within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No	Group name/ID #	Dates policy in effect: / / — / /
Have you and/or your dependents had prior coverage with another carrier(s) within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No	List prior carrier(s)	Dates policy in effect: / / — / /
Please check the type of prior coverage <input type="checkbox"/> Employee <input type="checkbox"/> Employee / Spouse <input type="checkbox"/> Employee / Child(ren) <input type="checkbox"/> Employee / Spouse / Child(ren)		
Termination reason: <input type="checkbox"/> Divorce/legal separation <input type="checkbox"/> Death of spouse <input type="checkbox"/> COBRA coverage exhausted <input type="checkbox"/> Employment terminated <input type="checkbox"/> Group plan terminated <input type="checkbox"/> Employer/group contribution ceased <input type="checkbox"/> Other:		

**\* 9. Medical Information**

Please note that no person will be denied health coverage on an individual basis due to the answers provided below, except for Medicare Carve-Out.

(If yes, circle condition)

- Do you or your dependents regularly take medication?..... Yes  No
- Has a physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future?..... Yes  No
- Are you or any of your dependents currently pregnant?..... Yes  No  
 If yes, name \_\_\_\_\_ due date / /
- In the last 5 years have you or any of your dependents been diagnosed or treated for any: heart/circulatory condition; cancer/tumor; disorder of the blood or immune system; stroke, aneurysm, diabetes (list age of onset below); mental/nervous disorder, depression, alcohol or drug abuse/dependency; kidney, liver or pancreas disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; or muscular dystrophy?..... Yes  No
- In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV?..... Yes  No
- Have you or any of your dependents visited the emergency room on 2 or more occurrences for the same condition in the last 12 months?..... Yes  No
- Have you or your dependents used tobacco products in the last 12 months?..... Yes  No

(If yes, circle condition)

- To the best of your knowledge, have you or any of your dependents, within the last 5 years, had a diagnosis of or treatment for the following:
  - Ulcer, hernia, diverticulitis, irritable bowel or other intestinal disorder?..... Yes  No
  - Thyroid, goiter or gallbladder disorder? ..... Yes  No
  - High blood pressure, cholesterol or triglycerides? ..... Yes  No
  - Anemia, chest pain, heart murmur or disorder of the veins/circulatory system?..... Yes  No
  - Rheumatic fever, carpal tunnel syndrome or disorder of the muscles or joints? ..... Yes  No
  - Epilepsy, convulsions, paralysis or disorder of the brain or nervous system?....  Yes  No
  - Asthma, allergies, sinus, or disorder of the respiratory system? ..... Yes  No
  - Any STD or disorder of the prostate, genital, reproductive or urinary system?..... Yes  No
  - Any disorder of the skin, ears, or eyes? ..... Yes  No
- Have you or any of your dependents, within the last 2 years, engaged in skydiving, hang gliding, underwater diving, racing (any type), rodeo, mountaineering, professional sports, piloting a plane or are any such activities contemplated? ..... Yes  No
- Are you or any of your dependents presently disabled or had a condition not identified above during the past 5 years? ..... Yes  No

Explain "YES" answers to any question. Give complete details to avoid delay. (Attach a separate sheet of paper if necessary)

Quest. #	Name of individual	Diagnosis	Treatment	Medication	Date(s) of treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)	Physician's name
					/ /				
					/ /				
					/ /				
					/ /				
					/ /				
					/ /				

Please read the TERMS on the reverse side of this page. Your Signature is required on the reverse side of this to submit this application.

INSTRUCTIONS FOR THIS PAGE

Section 7: Complete in full.

Section 8: Complete as questions pertain to dependent(s) being added.

Section 9: Complete as questions pertain to dependent(s) being added.

## 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 for 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 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 HMO/HIC coverage, in which case there is no such exclusion.)
5. I am responsible to timely notify my employer of any change that would make me or any dependent ineligible for coverage.
6. By signing this application, I agree and consent to the recording and / or monitoring of any telephone conversation between Anthem and myself.

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).

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

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

**Thank you for choosing Anthem Blue Cross and Blue Shield**

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<b>10. Read the TERMS section above carefully before signing. Please review your application for errors or omissions.</b>	
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 / /

<b>11. PLEASE READ: If you are declining coverage for yourself, spouse, or dependents, you must complete and list all below, and sign and date application.</b>	
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None <input type="checkbox"/> Other
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None <input type="checkbox"/> Other
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None <input type="checkbox"/> Other
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
Check all that apply. Waiving: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> All	
Name of person waiving	Already protected by coverage of: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> None <input type="checkbox"/> Other
Employer name	Carrier: <input type="checkbox"/> Anthem (give certificate/policy #) <input type="checkbox"/> Other carrier (give name, ID #)
<b>Check all that apply</b>	
<input type="checkbox"/> I certify that I have been given an opportunity to apply for Anthem Blue Cross and Blue Shield coverage and after careful consideration, have decided not to take advantage of this offer. In the event I wish to apply for such coverage hereafter, I may do so, subject to established procedures. If I am declining enrollment for myself or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself or my dependents in this plan, provided that enrollment is requested within 31 days after other coverage ends. My dependent(s) or I may be subject to pre-existing condition restrictions or waiting periods specified in the group certificate, if a dependent or I are late enrollees. In addition, if I have a dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 31 days after the marriage, birth, adoption or placement of adoption.	
<input type="checkbox"/> I certify that I have been given the opportunity to apply for the available group life benefits offered by my employer/group, the benefits have been explained to me, and I and / or my dependent(s) decline to participate. Neither my dependent(s) nor I were induced or pressured by my employer/group, agent or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense.	
Applicant signature	Date / /

INSTRUCTIONS FOR THIS PAGE  
Section 10: Sign and date.