Anthem Quote Disclosure Questionnaire

Group Name _____ Effective Date _____

Signature of this form acknowledges the understanding that Anthem Blue Cross and Blue Shield uses the information provided to determine rates and eligibility for the plans selected. Anthem assumes there is no underlying arrangement subsidizing member cost shares. The employer and agent each certify that it has not funded, brokered, created or purchased, directly or indirectly, any plan that is either partially or completely subsidizing any portion of member cost shares including co-payment, deductibles and coinsurances for any non-CDHP products. All CDHP plans require full disclosure of the amount of deductible that will be funded by the employer as described below.

The foregoing information is being submitted as part of your application for insurance benefits or administrative services. In the event the information provided is incorrect or the applicant makes use of the products purchased from Anthem in a manner that is at odds with the responses given to the questions herein, Anthem reserves the right to revise or rescind any offer that was based on the incorrect information provided by the employer or agent, including, without limitation, voiding the insurance contract on the basis of false or misleading information. In addition, any agent found to have been responsible for a breach of the terms of this disclosure may be subject to disciplinary action up to and including termination of the agent's appointment.

Plan Information for Quote

Current Carrier _____

Years with Current Carrier ☐ 1 Year ☐ 2-4 Years ☐ 5+ Years

Renewal Increase % _____

Is the current carrier bill paid to date? ☐ Yes ☐ No

Will a CDHP plan be available? ☐ Yes ☐ No

If Yes, what portion of the deductible will the employer be funding? _____ %

For non-CDHP, will any portion of the deductible or copay be self funded? ☐ Yes ☐ No

Employer's Signature*	Employer's Name (Please Print)	Date
Agent's Signature	Agent's Name (Please Print)	Date

* Employers Signature only required if there is no Agent of Record

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Medical Profile (Required only for 51+ Prospect Quote)

Please answer questions to the best of your knowledge, for all eligible persons to be insured (proprietors, partners, corporate officers, employees, spouses and dependent children). Please provide details in the area provided for any question answered, "Yes".

A. Has anyone accumulated medical expenses in excess of $25,000 in the past 12 months? ☐ Yes ☐ No

B. Within the past 3 years, has anyone been hospitalized or had surgery, been diagnosed with, received medical advice for or been treated for any serious disease or disorder? ☐ Yes ☐ No

C. Are there any employees who are not actively at work performing his or her duties full time or that have missed 10 or more consecutive days of work due to illness, mental or physical disability? ☐ Yes ☐ No

Please provide details for any questions answered "Yes" in the space below.

Diagnosis	**Dates of Treatment**	**Prognosis**	**EE or Dep.**

Employer's Signature*	Employer's Name (Please Print)	Date
Agent's Signature	Agent's Name (Please Print)	Date

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