The Real Estate Agent Medical Plan

The Process: *What You Need to Do and What You Will Get*

WHAT MAKES THIS PLAN DIFFERENT?

- Six (6) Different Medical Plans From Which to Choose (see below summary)
- All Applicants are *Guaranteed Coverage* (regardless of medical history)
- Insurance provides *Group Benefits* (includes maternity, pharmacy, mental health)
- Coverage is *Guaranteed to be Renewed* (may only be canceled for non-payment)
- Coverage Includes Routine Vision Care Benefits

WHAT IS THE PROCESS?

- Interested Individuals Must Complete Applications (Employer and Enrollment)
- Employer Application (partially completed for convenience) is Required as "Group" Coverage (most often, Agent name is usually used as, "Name of Employer")
- Enrollment Application Captures Demographics and Medical Health History
- "Affidavit" of Board of Realtor Membership is Required to Obtain Quote
- Applicant Faxes / Mails Applications and Affidavit to The Scheller Bradford Group (3 forms)
- The Scheller Bradford Group Checks Forms for Completeness and Forwards to Dedicated Anthem Underwriter for risk rating and rate offers
- Anthem Underwriter Assigns "Risk Factor" and Quotes Six (6) Medical Plans
- Anthem e-Mails Quotes to The Scheller Bradford Group
- The Scheller Bradford Group Reviews Quotes and Prepares "Rate Offer Sheet"
- "Rate Offer Sheet" is Forwarded to Applicant (offer is specific to Effective Date)
- To accept offer, Plan Option Benefit and Rate Pages Must be Signed and Payment for First Month's Premium is Due (*NOTE:* chosen effective date of coverage must match effective date on benefit and rate pages, and payment check must match name of applicant on application)

Upon receipt of complete applications, the above process may be completed within seven (7) business days. A letter of acceptance ("Welcome Letter"; may serve as temporary ID) will be issued by Anthem followed by mailed member identification (ID) card(s) and web availability of certificate of coverage.

MEDICAL PLAN OPTIONS SUMMARY

PLAN 1	**Blue Access 13 Rx G:** $20 Office Visit Copay; $1,000 Individual / $3,000 Family Calendar Year Deductible; 80% Coinsurance; $4,000 Individual / $8,000 Family Out-of-Pocket Maximum; $10/$30/$60/25% to $150 max Rx Copays; $5 Routine Eye Exam with Discounts
PLAN 2	**Blue Access 17 Rx G:** $25 Office Visit Copay; $2,500 Individual / $7,500 Family Calendar Year Deductible; 80% Coinsurance; $5,000 Individual / $10,000 Family Out-of-Pocket Maximum; $10/$30/$60/25% to $150 max Rx Copays; $5 Routine Eye Exam with Discounts
PLAN 3	**Blue Access D11 Rx G:** $30 PCP/ $50 Specialist Office Visit Copay; $5,000 Individual / $10,000 Family Calendar Year Deductible; 80% Coinsurance; $10,000 Individual / $20,000 Family Out-of-Pocket Maximum; $10/$30/$60/25% to $150 max Rx Copays; $5 Routine Eye Exam with Discounts
PLAN 4	**Lumenos HDHP with HSA Option E3 Rx Z:** $3,000 Individual / $6,000 Family Plan Year Deductible ("embedded"); 100% after Deductible (exception: Preventive Care – 100% No Deductible); No Copays; "Healthy Rewards" incentives, HSA Tax Savings; $10/$30/$50/25% to $150 max Rx Copays *after Ded* to OOP max; $5 Routine Eye Exam with Vision Discounts
PLAN 5	**Lumenos HDHP with HSA Option E5 Rx Z:** $5,000 Individual / $10,000 Family Plan Year Deductible ("embedded"); 100% after Deductible (exception: Preventive Care – 100% No Deductible); No Copays; "Healthy Rewards" incentives, HSA Tax Savings; $10/$30/$50/25% to $150 max Rx Copays *after Ded* to OOP max; $5 Routine Eye Exam with Vision Discounts
PLAN 6	**Essential HS Option 4:** $20 PCP / 50% Specialist Office Visit; $5,000 Individual, $10,000 Family Calendar Year Deductible; 80% Coinsurance; $10,000 Individual / $20,000 Family Out-of-Pocket; $10 Generic Rx Copay / No Coverage Brand; $300 Annual Diagnostic Limit; No Coverage for Physical Therapy or DME; Add'l $1,000 Inpatient Copay; *Limited Coverage*

For More Information: (513)528-2400 and john.harder@schellerbradford.com

The Real Estate Agent Medical Plan

Application Instructions and Checklist

NOTE: In order to obtain rate offers, the following procedure must be followed.

Application Instructions:

1. Review e-mailed or downloaded materials: Anthem Employer Application, Anthem Employee Application, Affidavit of Board or Realtor Membership, and Medical Plan Summary.
2. By following these instructions, you will receive firm rate offers for all six (6) medical insurance plans.
3. "*Affidavit*" of Board of Realtor membership: complete form, indicating board membership affiliation.
4. "*Employer Application*" (Note: this form is set up for traditional "group" coverage; for this coverage, the individual real estate professional is the "Employer"; therefore, under Question 3., "Applicant (legal name of group)" the real estate agent's name is most often used. This name is how Anthem will identify your "group". "Tax ID/FEIN" will likely be your Social Security Number, unless you have formed a corporation (e.g., LLC). Other areas of the form have been completed for you. Under "1. Effective Date", please enter the future date which you would request that you coverage will begin (generally the first of a future month). Under "7. Signature", please sign, print your name, indicate where signed (e.g. Cincinnati or Dayton, Ohio), and date. You will see that page 2, "9. Broker Certification", has already been completed and does not require any additional information.
5. "*Enrollment Application*": while some sections have been completed for you, this form is critical to capture your demographic and health history information. We encourage your phone calls to assist in the completion of this form, if medical history is a concern. Product selection need not be completed until your purchase decision has been made. Please sign, print your name, and date the bottom of the first page.
6. Fax the three forms (six pages total) to (513) 528-6058.
7. Visit the Anthem website at www.anthem.com and review the "Blue Access" network to find participating hospital, physician, and other providers (for Vision, see "National").

CHECKLIST:

☑ "AFFIDAVIT" (one page)

☑ "Employer Application" (two pages)

☑ "Enrollment Application" (three pages)

Remember to *sign and date all forms* and **fax** to: **(513)528-6058** and *mail originals* as instructed.

Note: The Real Estate Agent Medical Plan is available to qualified members and affiliate members of Board of Realtors organizations through Anthem BC/BS as distributed by The Scheller Bradford Group. No Board of Realtors organization is a sponsor of or otherwise associated with the Plan nor does any Board of Realtors organization receive any financial benefit as a result of the Plan being offered to its membership.

THE REAL ESTATE AGENT MEDICAL PLAN

Anthem Blue Cross Blue Shield: Benefit Plan Options

Benefit Plan Comparison

Benefit / Plan	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6
Plan Name	Blue Access Option 13 with Rx G	Blue Access Option 17 with Rx G	Blue Access Option D11 with Rx G	Blue Access HDHP for HSA Lumenos E3 Z	Blue Access HDHP for HSA Lumenos E5 Z	Blue Access Limited Med Essential HS4
Office Visit	$20 copay	$25 copay	$30 copay Primary / $50 copay Specialists	100% after Deductible	100% after Deductible	$20 Primary / 50% Specialist
Deductible	$1,000 Individual / $3,000 Family Calendar Year	$2,500 Individual / $7,500 Family Calendar Year	$5,000 Individual / $10,000 Family Calendar Year	$3,000 Individual / $6,000 Family “Embedded” Plan Year	$5,000 Individual / $10,000 Family “Embedded” Plan Year	$5,000 Individual / $10,000 Family Calendar Year
Network Coinsurance	80% after Deductible	80% after Deductible	80% after Deductible	100% after Deductible	100% after Deductible	80% after Deductible
Out-of-Pocket Maximum (includes deductible)	$4,000 Individual / $8,000 Family	$5,000 Individual / $10,000 Family	$10,000 Individual / $20,000 Family	$4,000 Individual / $8,000 Family	$5,800 Individual / $11,600 Family	$10,000 Individual / $20,000Family
Other	$200 copay + 20% ER Visit; $75 UC copay	20% After Deductible ER Visit; $75 UC copay	$200 co pay + 20% ER Visit; $75 UC copay	100% (no Deductible) Preventive Care	100% (no Deductible) Preventive Care	$300/yr Diagnostic No Coverage for PT, DME
Prescription Drug (includes Mail Order)	$10/$30/$60/25% to $150 maximum Mail Order 90 day supply $10/$75/$180/ 25% to $150 maximum	$10/$30/$60/25% to $150 maximum Mail Order 90 day supply $10/$75/$180 25% to $150 maximum	$10/$30/$60/25% to $150 maximum Mail Order 90 day supply $10/$75/$180/25% to $150 maximum	Anthem Rx Discounts Apply in satisfying Deductible; $10/$30/$50/25% to $150 max *after Deductible* to OOP Max	Anthem Rx Discounts Apply in satisfying Deductible; $10/$30/$50/25% to $150 max *after Deductible* to OOP Max	$10 Generic copay *No Coverage Brand* Mail Order 90 Day Supply $10 Generic copay (*Mail Order Plans 4 and 5:* 10/$75/$150/25% to $150 max)
Lifetime Maximum	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$5,000,000	$2,000,000
Vision	$5 Exam / Yr + Discounts	$5 Exam / Yr + Discounts	$5 Exam / Yr + Discounts	$5 Exam / Yr + Discounts	$5 Exam / Yr + Discounts	$5 Exam / Yr + Discounts
Pricing Relativity	“Baseline”	~ 15% Less Than Plan 1	~ 27% Less Than Plan 1	~ 24% Less Than Plan 1	~ 36% Less Than Plan 1	~ 45% Less Than Plan 1

Employer Application

Anthem Anthem Life

Group size 2-50 eligible employees

Please complete in ink and use extra sheets of paper if necessary
For more information about Anthem, its products and services, visit **www.anthem.com.**

Anthem use:				
Group/Account #	Approved SIC	Anthem's Approved Effective Date / /	State ☐ Indiana ☐ Kentucky ☐ Ohio	Tracking ID

1. Effective date

Requested effective date: / /

2. The benefits you have selected are outlined on the attached proposal, herein incorporated by reference.

☐ Blue Access℠ (PPO) -OR-
☐ Blue Access℠ Hospital Surgical PPO
☐ Blue Preferred® Primary (HMO)
☐ Blue Priority℠ (HMO)[1]
([1]Ohio only - a health insuring corporation product or "HIC")
☐ Anthem ByDesign® (ABD) Buy-up/Health Savings Account (HSA)
☐ Blue Traditional® (Indemnity)
☐ Blue Priority Plus (POS) (Ohio only)

☐ Lumenos® Health Savings Account
☐ Lumenos® Health Reimbursement Account
☐ Lumenos® Health Incentive Account
☐ Dental Traditional (Indiana and Ohio only)
☐ Dental Blue 100
☐ Dental Blue 200
☐ Dental Blue 300
☒ Vision

☐ Basic Life
☐ Basic AD&D
☐ Dependent Life
☐ Optional Life
  ☐ EE Only
  ☐ SPS Only
  ☐ CHD Only
  ☐ SP/CHD

☐ Optional AD&D
☐ Short Term Disability
☐ Long Term Disability

3. Employer Information

Applicant (legal name of group)		Name of association (if applicable) Board of Realtors (BOR)		
Name and title of head of firm		Name and title of administrative contact		
Home office address	City	County	State	ZIP Code
eMail address		Phone number *(include area code)*	Fax number *(include area code)*	
Billing address and/or contact *(if different from above)*		Tax ID/FEIN /SSN	Number of years in business	

Type of business

Is any part of group subject to bargaining agreement? ☐ Yes ☒ No	Will bargaining agreement participants be considered eligible employees? ☐ Yes ☒ No N/A	Total # of employees residing/working outside of Home Office state N/A

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414? If yes, please give the legal names, federal tax ID no. and number of employees employed by each.
☐ Yes ☒ No

Name of current health and/or life carrier(s)	Next Renewal Date / /

If Lumenos® HSA with Incentives is selected, Employer will provide the HSA plan through a cafeteria plan. Please check the box. ☐ Yes	Do you want Anthem to facilitate opening a Health Savings Account with Mellon? ☐ Yes ☐ No

Is your group subject to COBRA? ☐ Yes ☒ No	Do you have a COBRA administrator? ☐ Yes ☒ No N/A	If no, do you want an Anthem affiliate to administer COBRA for your group? ☐ Yes ☒ No *If yes, please complete and sign the COBRA agreement.*
List employee/dependents on Continuation of Coverage/COBRA N/A	Names of persons in COBRA eligibility period N/A	

4. Medicare Secondary Payer

☒ Does **not** employ 20 or more employees (full-time, part-time, leased) under the terms of the Medicare Secondary Payer statute *(The group agrees to notify Anthem Blue Cross and Blue Shield as soon as this statement is no longer true.)*
☐ Does employ 20 or more employees (full-time, part-time, leased) under the terms of the Medicare Secondary Payer statute

5. Eligibility

Eligible full-time employees must work at least 30 (25 in OH) hours per week, must be actively at work, must have satisfied any applicable eligibility waiting period.
Eligible full-time employees do not include temporary or seasonal employees.

Number of full time employees (including those within their waiting period)	Total number of employees (including part-time)	Total number of employees not actively at work	Employees currently in their waiting period will have coverage effective:
One (1)	One (1)	None (0)	☒ On group's effective date ☐ Same waiting period that applies to new persons or on group effective date, whichever is later

New eligible enrollees will become effective on:
(IN/KY) the day after ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days of employment *or the* ***first billing date*** *after* ☐ 0 days ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days of employment
(OH) the day after ☐ 0 days ☐ 30 days ☐ 60 days or on the ☐ 91st day of employment *or the* ***first billing date*** *after* ☒ 0 days ☐ 30 days ☐ 60 days

Do any classes of employees have a different waiting period? ☐ Yes ☒ No	If yes, explain N/A

6. Contribution and Minimum Participation Requirements *Employer must have at least two employees enrolled in health to maintain coverage under this plan.*

Group contribution level for health: 50% of the single fee premium; at least 25% of total premium. For life, AD&D, STD, LTD: at least 25% of premium for each coverage except dependent life. If group contribution is 100%, 100% participation is required. Group minimum participation for Health: the greater of 75% of "Net Eligible Employees" or 50% of all eligible employees. "Net Eligible Employees" is the total number of eligible employees less those employees with other group health coverage through a spouse or as part of a collectively bargained or union plan.

Group contribution level for insurance
Health 100 % Basic Life N/A % Basic AD&D N/A % Dependent Life N/A % Optional Life N/A % Optional AD&D N/A % STD N/A % LTD N/A %
(Dental/Vision contributions should match the medical; however, when it does not, it must be at least 25 percent of the total, but not less than 50 percent of the single rate.)

Do any classes have a percentage of group contribution different than above? ☐ Yes ☒ No	If yes, explain N/A

7. Signature ***PLEASE ATTACH A CHECK FOR THE FIRST MONTH'S PREMIUM (Read the back of this form carefully before signing)***

Signature and title of authorized group representative	Print name of authorized group representative	City/state where signed	Date / /
Accepted by Anthem's Underwriting Department — Signature and title			Date / /

SG

8. Read this section carefully before signing. Please review your application for errors or omissions.

The employer and/or authorized representative hereby requests that it be approved for coverage through Anthem Blue Cross and Blue Shield and Anthem Life Insurance Company (hereinafter "Anthem" unless otherwise specified) and to be bound by Anthem's and Anthem Life's rules and regulations pertaining to coverage under the insurance contracts and policies, as adopted and/or revised from time to time. Employer understands and certifies the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and also accepts enrollment under the Anthem Life trust policy(ies), if applicable.
2. To make the coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Anthem or their designated agent(s), any information required in connection with administration of the coverage.
4. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.
5. That statement of medical history will be required of employees, and dependents when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem.
6. That approval for this coverage may cancel any prior contracts and/or coverage with Anthem effective immediately preceding the effective date of the employer's coverage.
7. To pay Anthem, by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and state-mandated continued group coverage and/or conversion process, if applicable.
8. That claims filed by or on behalf of members may, at Anthem's option, be suspended if premiums are not timely received.
9. If applicable, Employer will receive on behalf of members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.
10. The advance premium check does not create temporary or interim coverage and that receipt and deposit of that payment does not guarantee issuance of coverage. Rather, issuance of coverage is expressly conditioned on Anthem's determination that the group is an acceptable risk based on their current underwriting practices and procedures. Unless these conditions are met, there shall be no liability on the part of Anthem except to refund the payment. The employer will be responsible for returning to individual employees any part of the payment contributed by those employees.
11. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem may be different that the coverage applied for herein. In that event, Anthem shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.
12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any misstatements on employees' applications or failure to report new medical information prior to the employees' effective dates may result in a material change to the groups' coverage or premium rates as of the effective date of coverage.
13. The entire application for Group coverage has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
14. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work 30 (if employer is located in Kentucky/Indiana), 25 (if employer is located in Ohio) or more hours per week (unless otherwise approved by Anthem in writing), and meet any other eligibility requirements for coverage; employer meets the definition of small employer under applicable law of the state where it is domiciled, which is: KY - An employer who employed an average of at least two but not more than 50 employees on business days during the preceding calendar year and who employs at least two employees on the first day of the plan year. OH - An employer who employed an average of at least two but no more than 50 eligible employees on business days during the preceding calendar year and who +employs at least two employees on the first day of the plan year. All persons treated as a single employer under the US IRC of 1986 as amended, shall be considered an employer. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible employees that it is reasonably expected the employer will employ on business days in the current calendar year. IN - any person, firm, corporation, limited liability company, partnership or association actively engaged in business, who, on at least 50% of the working days of the employer during the preceding calendar year employed at least two but not more than 50 eligible full time employees, the majority of whom work in Indiana. In determining the number of eligible employees, companies that are affiliated companies or that are eligible to file a combined tax return for purposes of state taxation are considered one employer. A plan is subject to IN small group laws if either of the following conditions is met: (1) any part of the premium or benefits is paid by employer, or any covered individual is reimbursed, through wage adjustments or otherwise, by employer for any part of the premium (not including administrative expenses of administering a payroll deduction plan where employee contributes 100% of the premium without reimbursement); or (2) the employer treats the plan as part of a plan or program for purposes of the United States Internal Revenue Code of 1986, as amended.
15. The requested coverage is not in effect unless and until this application is approved by Anthem, that approval of coverage shall be evidenced by issuing Group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem.
16. The employer acknowledges that he has signed the attached benefit proposals indicating the coverages requested.
17. The broker listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.

Fraud Notice

KY - Any person who knowingly and with intent to defraud an insurance company, health maintenance organization or other person files an application for insurance or other form of health 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.

OH - Any person who, with intent to defraud or knowing that he 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.

9. Broker Certification - I hereby certify that:

1. I have reviewed the attached employee and group applications and waivers for completeness and accuracy.
2. I am not aware of any health history of any applicant that does not appear on the application.
3. I have not completed any of the information contained in the applications except with the permission of the applicant and as noted by my initials on the application.
4. I have not signed any of the applications for a group representative or individual applicant.
5. I have advised the group that a failure to provide complete and accurate information may result in a loss of coverage retroactive to the effective date of coverage or re-rating of the group's premium retroactive to the effective date and that coverage shall not be effective until Anthem Blue Cross and Blue Shield reviews and approves the application and the group receives a written notice and contract from Anthem.

Broker name: John Harder		Broker Signature: John C Harder	
Address: 463 Ohio Pike, Suite 303, Cincinnati, OH 45255			Broker ID number
Tax ID number to be paid: 31-1582334	Broker phone number: (513) 528-2400	Broker e-Mail address: john.harder@schellerbradford.com	Date: / /
Agency name *(if applicable)*: The Scheller Bradford Group		General agency broker: N/A	
Address: Same As Above		Anthem sales representative: Greg Riesenberg	

Enrollment Application

Anthem

AnthemLife

Group size 2-50 eligible employees

Please complete in black or blue ink for employee and all dependents enrolling with us and return to your employer. Use extra sheets of paper if necessary. Please provide complete details to avoid delay. If you have creditable coverage, we will give you credit for your prior coverage, and pre-existing condition limitations will be reduced or excluded for any conditions listed below. Please note that no one will be denied health coverage on an individual basis due to the answers provided below. *All information given should apply to this employer.*

1. TYPE OF COVERAGE REQUESTED: ☐ Employee Only ☐ Employee+Spouse ☐ Employee+Child(ren) ☐ Family ☐ Life Only ☐ No coverage

2. ENROLLMENT INFORMATION ☐ Single ☐ Divorced ☐ Married

Relationship	Last Name, First Name, M.I.	Social Security No. SSN required for Lumenos, Health Savings Account	Sex	Full Time Student?	Age	Date of birth	Height/ Weight	Current tobacco user?	Disabled?
Employee			☐ M ☐ F			/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
Spouse			☐ M ☐ F			/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other ____			☐ M ☐ F	☐ Yes ☐ No		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other ____			☐ M ☐ F	☐ Yes ☐ No		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No
☐ Child ☐ Other ____			☐ M ☐ F	☐ Yes ☐ No		/ /	/	☐ Yes ☐ No	☐ Yes ☐ No

Employee Home Address: Street, City, State, ZIP Code | County

Employee Home Phone ( ) | Employee Work Phone ( ) | Employee Email Address

Dependent Home Address: Street, City, State, ZIP Code (if different from employee) | Dependent Name(s)

3. MEDICAL INFORMATION ***(If yes, circle condition)***

1. Do you or your dependents regularly take medication? ☐ Yes ☐ No
2. 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
3. Are you or any of your dependents currently pregnant? ☐ Yes ☐ No
   If yes, name _____ due date ___/ ___/ ___
4. 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
5. In the past 5 years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ 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	Onset Date	Date(s) of treatment	Hospitalized? (Y/N)	Surgery? (Y/N)	Recovered? (Y/N)
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			
					/ /	/ /			

4. LIFE AND DISABILITY INSURANCE

☐ Basic Life ☐ Basic AD&D ☐ Short Term Disability
☐ Dependent Life ☐ Optional AD&D ☐ Long Term Disability
☐ Optional Life: _____ x annual earnings OR $_____
☐ Current Income: $ _____ ☐ *Hour* ☐ *Week* ☐ *Month* ☐ *Year*

☐ Anthem By Design Short Term Disability BUY-UP
☐ Anthem By Design Long Term Disability BUY-UP
☐ Anthem By Design Basic Life BUY-UP
(Complete separate election form.)

Life Class

	Last Name	First Name, M.I.	Social Security #	Relationship to applicant	Age
Primary Beneficiary			- -		
Contingent Beneficiary			- -		

5. PLEASE READ THE TERMS IN SECTION 11 CAREFULLY BEFORE SIGNING, AND REVIEW YOUR APPLICATION FOR ERRORS OR OMISSIONS.

Applicant signature | Please Print Name | Date / /

Enrollment Application

Anthem

Anthem Life

Group size 2-50 eligible employees

Name: _____ SS#: ___ - ___ - ____

6. PLEASE COMPLETE ALL INFORMATION

Reason for application:
- [x] New enrollment
- [ ] Open enrollment (N/A for Life coverage)
- [ ] Qualifying event (please complete date and reason)
  Event Date ___/___/___
  - [ ] Marriage
  - [ ] Divorce
  - [ ] Birth of Child
  - [ ] Adoption
  - [ ] Termed Employment
  - [ ] Other
- [ ] COBRA
  Event _____ Date ___/___/___
- [ ] State Continuation
- [ ] Waiver

Group Name | Group number | Sub Group Number

Group Address | Employee Hire/Rehire Date (Full time) ___/___/___

Employee status
- [x] Active
- [ ] Disabled
- [ ] Retired
- [ ] Other (please explain) _____

Hours working per Week: 25+

If not actively working, reason: N/A

Projected Return Date ___/___/___ N/A

Occupation

Annual Salary: N/A

Income reported by:
- [ ] W2
- [ ] 1099
- [ ] Other (please explain) _____

N/A

7. COVERAGE SELECTION ***(Availability dependent upon your employer's offering)***

Medical Coverage
Please check one type:
- [ ] Employee only
- [ ] Employee + spouse
- [ ] Employee + child(ren)
- [ ] Family
- [ ] No Coverage

Check the medical plan you are applying for:
- [ ] PPO
- [ ] HMO (HIC in Ohio)
- [ ] POS (Ohio only)
- [ ] Traditional
- [ ] Blue Access℠ Hospital Surgical PPO
- [ ] HDHP Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your Employer.
- [ ] HDHP/PPO
  - [ ] Core
  - [ ] Buy Up
- [ ] PPO/PPO
  - [ ] Core
  - [ ] Buy Up
- [ ] Lumenos® Health Savings Account
- [ ] Lumenos® Health Reimbursement Account
- [ ] Lumenos® Health Incentive Account

Dental Coverage:
Please check one type:
- [ ] Employee only
- [ ] Employee + spouse
- [ ] Employee + child(ren)
- [ ] Family
- [ ] No Coverage

N/A

Vision Coverage:
Please check one type:
- [ ] Employee only
- [ ] Employee + spouse
- [ ] Employee + child(ren)
- [ ] Family
- [ ] No Coverage

Same As Medical

1. If enrolling in an HMO product, please submit a PCP selection form. Anthem's PCP listings can be obtained at www.anthem.com.
2. A separate health statement is required for Life or Disability coverage in excess of Guaranteed Benefit or late enrollment.

8. WAIVER OF COVERAGE SECTION: ***(Must be completed if employee and/or dependents waive medical, vision, dental or life coverage)***

NOTE: If waiving coverage, please complete this section. Section 5 must also be signed and dated.

Medical Coverage declined for (check all that apply):
- [ ] Myself
- [ ] Spouse
- [ ] Dependent(s)

Dental Coverage declined for (check all that apply):
- [ ] Myself
- [ ] Spouse
- [ ] Dependent(s)

N/A

Vision Coverage declined for (check all that apply):
- [ ] Myself
- [ ] Spouse
- [ ] Dependent(s)

Life coverage declined for: [ ] Myself

N/A

Reason for Declining Coverage (check all that apply):
- [ ] Covered by spouse's group coverage - Carrier name and ID Number _____
- [ ] Enrolled in other Insurance provided by my employer - Carrier name and ID Number _____
- [ ] Enrolled in Individual coverage - Carrier name and ID Number _____
- [ ] Spouse covered by employer's group medical Coverage
- [ ] Medicare
- [ ] Other (Please explain) _____
- [ ] No coverage

9. PRIOR HEALTH INSURANCE INFORMATION ***Prior Health Care Coverage During the past 2 years (including Anthem):***

Insurance company name(s):	Type of prior coverage	Policy number	Effective Date	Cancel Date
	[ ] Employee Only [ ] Employee + child(ren) [ ] Employee + spouse [ ] Family		___/___/___	___/___/___

10. OTHER HEALTH INSURANCE INFORMATION

On the day your coverage begins, will you or a family member be covered by other health insurance coverage and/or Medicare? [ ] Yes [ ] No

Family Members Covered by other health coverage:	Insurance company name, address and phone number	Policy number	Effective date
			___/___/___

Policy/Certificate Holder's Name	Social Security Number	Date of birth	Relationship to applicant	Family members covered by Medicare:
		___/___/___		

Medicare ID #	Part A effective date	Part B effective date	*Medicare eligibility reason (check all that apply)*
			[ ] Age [ ] Disability [ ] ESRD: Onset Date ____

Medicare Part D ID#	Medicare Part D Carrier	Medicare Part D effective date	Medicare Part D term date
		___/___/___	___/___/___

ANTHEM USE ONLY Coordination of Benefits? [ ] Yes [ ] No Pre-ex (date)

Enrollment Application

Anthem

Anthem Life

Group size 2-50 eligible employees

11. SIGNIFICANT TERMS, CONDITIONS AND AUTHORIZATIONS (TERMS) ***Please read this section carefully before signing the application in Section 5.***

Ohio: 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.

1. I may not assign any payment under my Anthem Blue Cross and Blue Shield program unless allowable by law.
2. I understand that completion of this form does not guarantee acceptance; eligibility and enrollment criteria must be satisfied (Anthem Life Insurance Company may accept only certain persons or conditions for coverage). If accepted, my plan may exclude coverage for pre-existing conditions. (Ohio only - unless I applied for HMO/HIC coverage, in which case there is no such exclusion.)
3. I understand that Anthem imposes a pre-existing condition exclusion. The pre-existing exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period prior to enrollment. This exclusion may last up to 12 months (9 months in Indiana) from the first day of coverage, or if in a waiting period, from the first day of the waiting period. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 31 days of birth, adoption or placement for adoption.
   I understand the pre-existing exclusion waiting period is reduced by the number of days of prior creditable coverage provided there has not been a break in coverage of more than 63 days. To reduce the pre-existing exclusion waiting period, Anthem must receive a copy of the certificate of creditable coverage from the prior Health Insurance Carrier.
   To obtain a certificate of creditable coverage: 1. Contact the Human Resources area of your prior employer and request a certificate of creditable coverage or other evidence of prior coverage, 2. Contact your prior insurance carrier and request a certificate of creditable coverage or, if necessary, requests the steps to obtain a certificate of creditable coverage, or 3. Contact Anthem at the number on your new identification card for assistance in obtaining a certificate of creditable coverage from your prior insurance carrier. Make sure you provide your current mailing address. Upon receipt of your certificate of creditable coverage, forward a copy to the address on the back of your new identification card.
4. If I am declining enrollment for myself or my dependent(s) (including my spouse) because of other health insurance or group health plan coverage, I understand that I may be able to enroll myself and my dependent(s) in this plan if I or my dependent(s) lose eligibility for the other health insurance or group health plan coverage (or if the employer stops contribution towards my coverage or my dependent's other coverage).
   However, I must request enrollment within 31 days after my coverage or my dependent's other coverage ends (or after the employer stops contribution toward the other coverage). 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 dependent(s) provided that I request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.
5. Ohio: If applying for HMO/HIC coverage, I understand that I may cancel my membership by providing written notice to Anthem within 72 hours of signing this application.
6. **Ohio:** 3904.04 NOTICE OF INFORMATION PRACTICES: I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only 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 and 164) and the Ohio Revised Code § 3904.13. 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.
7. Life and disability products are underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross Blue Shield Association.

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.

I acknowledge I have read the TERMS, and I accept its provisions as a condition of coverage. I represent that all answers in sections 1 through 4 above and in Sections 6 through 10 on page 2 are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem Blue Cross and Blue Shield in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to coverage or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being rescinded or cancelled.

By signing Section 5, 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. I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative. ***Thank you for choosing Anthem Blue Cross and Blue Shield.***

AFFIDAVIT

Of Board of Realtor Membership and for Enrollment into The Real Estate Agent Medical Plan

By signing below, the signor affirms and attests to being a qualified dues paying member or affiliate member in good standing of a Board of Realtors member organization.

Member Name: _____

Board Membership: _____

_____

Member Signature

_____

Date

Membership status may be audited at any time.

John Harder
The Scheller Bradford Group
463 Ohio Pike, Suite 303
Cincinnati, OH 45255
(513)528-2400; (866)528-2403
john.harder@schellerbradford.com

Note: The Real Estate Agent Medical Plan is available to qualified members and affiliate members of Board of Realtors organizations through Anthem Blue Cross Blue Shield as distributed by The Scheller Bradford Group. No Board of Realtors organization is a sponsor of or otherwise associated with the Plan nor does any Board of Realtors organization receive any financial benefit as a result of the Plan being offered to its membership.

DO YOU HAVE EVERYTHING?

A Checklist for Your Return Envelope To Receive Your Rate Offer

To apply for coverage with Anthem, please fully complete and sign all applications and forms and return to The Scheller Bradford Group. For your convenience, application items have been completed in advance; please review for accuracy.

You *must* include the following in the envelope:

1. Employer Application

2. Enrollment Application

3. Membership Affidavit

Please be sure every highlighted section is completed; write “none” or “n/a” if necessary. Highlighted areas left blank will be returned for completion!

For faster turnaround time, you may fax the material to (513) 528-6058 or scan and email to john.harder@schellerbradford.com. Please also mail the originals as instructed below.

Have you signed and dated all three items above?

Thank you for your efficient cooperation!

Mail Originals to:

John Harder
The Scheller Bradford Group
463 Ohio Pike, Suite 303
Cincinnati, OH 45255
(513)528-2400; (866)528-2403
john.harder@schellerbradford.com