Indiana Downgrade/Policy Change Form

Anthem
PO Box 37730
Louisville KY 40233-7730

This form cannot be used to:

- Add a Spouse
- Add a Dependent (except for *newborn child)
- Upgrade Product benefits
- Make changes to Life Coverage
- Add optional coverage rider

*Note—Newborns will be covered from the date of birth if notification is made within 31 days of date of birth or adoption placement.

All changes will be effective on the date requested unless otherwise notified by Anthem.

Section A – Coverage Information

Anthem individual policy coverage

Policy No._____

Your renewal month will not change.

Effective month requested:

_____

Section B – Applicant Information

Applicant Name	ID#

Section C – Change to Address or Telephone Number

Home Address (street and P.O. Box if applicable)		
City	State	Zip

Section D – Other Policy Changes

Delete Covered Members (Attach additional sheet if necessary)

Dependent Name	Relationship ☐ Spouse ☐ Child	Sex ☐ Male ☐ Female	Date of Birth	Reason
Dependent Name	Relationship ☐ Spouse ☐ Child	Sex ☐ Male ☐ Female	Date of Birth	Reason

Add Newborn Dependent (Must be added within 31 days of birth or adoption placement.)

Dependent Name	Sex ☐ Male ☐ Female	Date of Birth

Change Billing Option (If automatic bank draft is selected, please enclose required authorization form.)

☐ Direct Bill (billed at home) ☐ Automatic Bank Draft	Please change my bill frequency to: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

AUTOMATIC BANK DRAFT (automatic premium withdrawals)—your premium will be deducted on the same day of the month as your assigned effective date. (You **MUST** attach a **blank** voided check on page 2.)

I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. I understand that this authorization is in effect until I notify Anthem in writing that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals if they wish to do so.	Account holder's name (please print) **X** Account holder's signature (if other than the applicant) **X**

Cancel Coverage	**Cancel Optional Coverage**
☐ Cancel all Anthem coverage for myself and, if applicable, my spouse and dependents. ☐ Cancel Dental only ☐ Cancel Life only	☐ Maternity Rider

Section E – Change to Higher Deductible Amount

You must complete a new application to change to a lower deductible amount. This form can be used for the plans listed below.

Select ONE Plan . . .	*then select ONE Deductible and any optional Riders*			
Blue Access Value				
☐ Blue Access Value	☐ $2,000	☐ $3,000	☐ $5,000	☐ $10,000
Blue Access Economy				
☐ Blue Access Economy	☐ $500	☐ $1,000	☐ $1,500	☐ $2,500
Blue Access℠ ☐ or Blue Traditional® ☐				
☐ Plan 1 (20% coinsurance)	☐ $500	☐ $1,000	☐ $2,500	☐ $5,000
☐ Plan 2 (20% coinsurance)	☐ $250	☐ $500	☐ $1,000	☐ $2,500
☐ Plan 3 (0% coinsurance)	☐ $2,500	☐ $5,000	☐ $10,000 ($10,000 not available on Blue Traditional)	
	☐ **Maternity** rider (available with Plan 2 only)			

Select ONE Plan then select ONE Deductible and any optional Riders

Lumenos® Health Savings Account

☐ Plan 1 (0% coinsurance)
☐ $1,500/$3,000 ☐ $3,000/$6,000 ☐ $5,000/$10,000

☐ Plan 2 (20% coinsurance)
☐ $1,500/$3,000 ☐ $3,000/$6,000

☐ Yes, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please forward my information to Anthem's banking partner. (Please fill in your social security number in section B.)

☐ No, I DO NOT want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please DO NOT forward my information to Anthem's banking partner.

Lumenos® Health Incentive Account Plus

☐ Plan 1 (0% coinsurance)
☐ $2,500/$5,000 ☐ $5,000/$10,000 ☐ $10,000/$20,000

☐ Plan 2 (20% coinsurance)
☐ $2,500/$5,000

Lumenos® Health Incentive Account

☐ Plan 1 (0% coinsurance)
☐ $1,000/$2,000 ☐ $2,500/$5,000 ☐ $5,000/$10,000

☐ Plan 2 (20% coinsurance)
☐ $1,000/$2,000 ☐ $2,500/$5,000

Optional riders: ☐ Maternity

I expressly understand that this Downgrade/Policy Change Form amends the application previously submitted by me and shall become part of the terms of my policy or certificate of coverage.

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.

Signature _____ **Date** _____

Staple **blank, voided check** here

Staple **blank, voided check** here