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in less than 15 minutes!!!

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4 WAYS TO APPLY!

1) **TELEPHONE** – (toll free) 1-877-937-5506 - The **EASIEST** way to apply!

OR

2) **FAX** – (toll free) 1-877-937-9309 - Fax the attached pages and we'll call for the rest!

OR

3) **ONLINE** at www.SteveKingIns.com - Click "Apply Online Now" in the top right corner of the page.

OR

4) **REGULAR MAIL** – Mail the attached pages and we'll call for the rest! Postage paid envelope enclosed.

-
- ✓ **Please complete the following application pages 6,7, 8 and 9 of 12**
 - ✓ **Then call the office or return these pages by fax or mail and we'll obtain information from you for the rest!**



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Steven King Insurance Agency Inc.

- A top 5 Missouri Individual Blue Cross Blue Shield agent providing health insurance to 85 Missouri counties
- 2009 Premier Gold Partner
- 2007/08 Blue Cross Blue Shield Advisory Council Member
- 18 year Key Producer - 1992 to 2009

Section I – Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare? Yes No If yes, give name. _____

Did you or your eligible dependents have creditable coverage within the past 63 days? YES NO (you may be eligible for preexisting credit).

The following information must be completed in order for credit to be given. Please provide the previous 18 months of coverage.

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
---	--------------------------

Name and phone number of prior carrier(s)	Reason for cancellation
---	-------------------------

Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Effective Date of Coverage	Cancellation Date of Coverage
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Will you be canceling this coverage if approved for Anthem coverage? Yes No

Complete this section if you've had more than one carrier in the last 18 months (attach a separate sheet if necessary).

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
---	--------------------------

Name and phone number of prior carrier(s)	Reason for cancellation
---	-------------------------

Type of coverage <input type="checkbox"/> Group <input type="checkbox"/> Individual	Effective Date of Coverage	Cancellation Date of Coverage
--	----------------------------	-------------------------------

Will you be canceling this coverage if approved for Anthem coverage? Yes No

Section J – Healthy Lifestyle (optional)

You and your spouse or domestic partner may qualify for a better rate based on your lifestyle. Complete the section below if you would like to be considered for this special rate.

	Applicant		Spouse or Domestic Partner	
1. Have you been tobacco-free for the last 3 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you exercise regularly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you in excellent health with no ongoing medical conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. How many times a week do you exercise?	<input type="checkbox"/> 0-2	<input type="checkbox"/> 3-4	<input type="checkbox"/> 5-7	<input type="checkbox"/> 0-2 <input type="checkbox"/> 3-4 <input type="checkbox"/> 5-7

Section K – Health History (IMPORTANT: This section has two steps)

STEP 1: Health history questions must be answered by each/every person applying for coverage.

Health History Questionnaire — All Questions Must Be Answered Or The Application Will Be Returned.

GIVE COMPLETE DETAILS IN STEP 2 (page 9) FOR ALL QUESTIONS ANSWERED “YES”.

NOTICE: You must provide truthful and complete answers to the following questions to the best of your ability. We are relying on the information you provide to determine whether you are eligible for coverage. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician(s) to clarify your specific condition. We have the right to review all of your medical records to verify the accuracy of your information during the first 24 months you are covered. However, do not assume we will review all of your medical records before approving your application. If we issue coverage to you and later discover that you misrepresented or omitted information you knew in response to a question we may rescind your coverage, even after it has been issued. This means that you may lose your health benefits including coverage for treatment already received. Rescission may occur even if we review your medical records or seek medical confirmation of your health information as part of processing your application. Even if you currently have health insurance coverage or had prior coverage with Anthem Blue Cross and Blue Shield, you must fully disclose and answer all health history questions.

	YES	NO		YES	NO
1. Within the last 60 days, have you seen a health care provider(s), had a physical exam, laboratory test(s) or other diagnostic or screening test(s) such as Pap smear, blood (other than an HIV test) or urine test, x-ray(s), CAT scan, MRI, or mammogram?	<input type="checkbox"/>	<input type="checkbox"/>	3. Have you been prescribed or taken any prescription medication within the past 12 months except for birth control or short term (10 days or less) antibiotics? (This includes any prescription samples provided by your physician. If yes, explain in Step 2.)	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the last 12 months have you been advised by a health care provider to have, but have not yet had, surgery, treatment, examination, evaluation or test(s) for a medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	4. Are you pregnant or an expectant father, or will you be providing medical insurance for a newborn or new adoptee within the next 9 months?	<input type="checkbox"/>	<input type="checkbox"/>

Section K – Health History (continued)

- | | YES | NO |
|---|--------------------------|--------------------------|
| 5. Do you have implants, prosthesis or retained hardware? | | |
| A. Breast implants | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Eye/limb prosthesis | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Cochlear implant, pacemaker, defibrillator, valve replacement, shunt, stent(s), implantable pump | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Joint replacement/internal fixations (i.e. pins, plates, rods etc.), neurostimulators | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Any other prosthesis or implant (other than dental) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Within the last 2 years, have you had or consulted with a health care provider for, been diagnosed with, or treated for any of the following?
(all answers must be checked yes or no) | | |
| A. Headaches requiring prescription medication | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Loss of consciousness | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Sleep apnea/breathing difficulties while sleeping | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Recurrent fainting, weakness or dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Paralysis or numbness/tingling in limbs | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Chest pain | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Increased/irregular heart beat | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Low or high blood pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| I. High cholesterol | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Shortness of breath | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Heartburn (recurrent) | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Abnormal and/or Recurrent bleeding (unrelated to menstruation) | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Recurrent diarrhea and/or recurrent vomiting | <input type="checkbox"/> | <input type="checkbox"/> |
| N. Unexplained weight loss | <input type="checkbox"/> | <input type="checkbox"/> |
| O. Blood, sugar, and/or protein in urine | <input type="checkbox"/> | <input type="checkbox"/> |
| P. Recurrent pain (including back pain) | <input type="checkbox"/> | <input type="checkbox"/> |
| Q. Jaundice | <input type="checkbox"/> | <input type="checkbox"/> |
| R. Mass, cyst(s), or lump(s) in any body part including breast | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Within the last 5 years, have you consulted with a health care provider for, been diagnosed with, or treated for any of the following? | | |
| A. Abnormal Pap smear | <input type="checkbox"/> | <input type="checkbox"/> |
| B. HPV (Human Papilloma Virus), herpes, STD (sexually transmitted disease) | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Heavy menstrual bleeding, fibroids, endometriosis, problems of the ovary, or gynecological/genital disorder(s)? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Male infertility | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Female fertility/infertility | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Anemia, angina, heart attack, hypertension, phlebitis, stroke or heart, circulatory or blood disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Kidney, bladder or prostate disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Ulcers; pancreatitis; gallbladder, liver, stomach, or digestive disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Hernia; hemorrhoid; rectal, or intestinal disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Arthritis; TMJ (temporomandibular joint disorder); muscle/bone/tendon/joint/vertebral disc injury(s) or disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Migraine headaches, epilepsy/seizures, or brain/nervous disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Congenital heart disorder or condition, cleft lip/palate, birth defects, developmental delay | <input type="checkbox"/> | <input type="checkbox"/> |

- | | YES | NO |
|---|--------------------------|--------------------------|
| M. Asthma, allergies, tuberculosis, any lung or sinus disorder(s), or breathing problems | <input type="checkbox"/> | <input type="checkbox"/> |
| N. Psoriasis, rosacea, acne or skin disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| O. Cataract, glaucoma, eye or ear disorder(s) | <input type="checkbox"/> | <input type="checkbox"/> |
| P. Diabetes, thyroid, endocrine glands | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Within the last 5 years, have you experienced, suffered from, consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to alcoholism or abuse of alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Within the last 5 years, have you been advised by a health care professional to reduce alcohol intake? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you been hospitalized within the last 5 years for any mental, emotional, or behavioral disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Within the last five years have you had counseling or treatment for symptoms of any mental, emotional, or behavioral disorder? (If yes, please check all that apply below and explain in Step 2.) | <input type="checkbox"/> | <input type="checkbox"/> |
| A. Obsessive Compulsive Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Minor depression | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Anxiety/panic attacks | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Attention Deficit Disorder (ADD/ADHD) | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. In the last 10 years have you had consultation, experienced symptoms, been diagnosed, had treatment or treatment recommended for any of the following: | | |
| A. Schizophrenia, Major Depression/BiPolar Disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Eating disorder (i.e. anorexia/bulimia) | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Within the last 10 years, have you experienced (suffered from) or consulted with a health care provider for, or been diagnosed with, or treated for symptoms related to drug abuse? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever been diagnosed or been treated for any type of cancer, leukemia, melanoma or malignant tumor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Have you ever been diagnosed with hepatitis? (check all types that apply) | <input type="checkbox"/> | <input type="checkbox"/> |
| A. Hepatitis A | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Hepatitis B | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Hepatitis C, D, E | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever been diagnosed with, or treated for any of the following? | | |
| A. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or recommended antiviral therapy/treatment for AIDS or ARC | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Ankylosing Spondylitis, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Chronic Obstructive Pulmonary Disease (COPD), Cystic Fibrosis, Diabetes, Emphysema, Gaucher's Disease, Hemophilia, Kaposi Sarcoma, Lupus (systemic), Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Pneumocystis Carinii Pneumonia, Rheumatoid Arthritis, Scleroderma. | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are you a candidate for, or have you ever received an organ or bone marrow transplant? | <input type="checkbox"/> | <input type="checkbox"/> |

Section K – Health History (continued)

- 18a.** Within the last five years, have you had any illness, physical injury, persisting or new physical symptoms and/or health problems not mentioned elsewhere on this application that have not been evaluated or that you plan to have evaluated by a licensed health practitioner? YES NO
- 18b.** Within the last two years, have you visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist or other licensed health practitioner that has not been disclosed elsewhere on this application? YES NO

- 19.** Have you been hospitalized or treated in urgent care or the emergency room within the last 12 months for any condition other than pregnancy? YES NO

Prescription Medications

List *all* prescription medications taken within the last 12 months by any family member listed on this application (if not indicated in Step 2)

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name, Phone No. of Physician or Hospital
					Name: _____ Phone: _____
					Name: _____ Phone: _____
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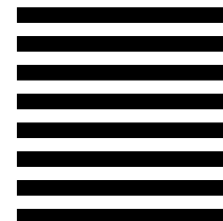
STEP 2: If you answered "YES" to any of the health history questions, give complete details (see the example below)
 Please attach a separate sheet if more room is needed.

Question Number of "YES"	Patient First Name	Physician Name & Telephone (with area code)	Specific Diagnosis & Treatment	Name & Dosage of Medication & Dates of Use		Duration of Condition		Was Surgery Performed?		Description of Surgery/ Procedures & Date(s)	Current Status
				Begin mm/yy	End mm/yy	Begin mm/yy	End mm/yy	YES	NO		
Example #27	Mary	Dr. John Doe 555-555-1000	Tonsillitis	Amoxicillin 250 mg. 4x day 8/2002	9/2002	8/2002	9/2002	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Tonsillectomy 09/2002	Good
								<input type="checkbox"/>	<input type="checkbox"/>		
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