Request for Summary Billing for Individual Health Plans

Forms and Reference Guide

Designed for convenience in combining the billing of either multiple subscribers and/or multiple Individual plans

A Summary Bill is a convenient way to combine the billing for two or more products and/or two or more Individual policies. However, if more than one person is on the Summary Bill, then each insured person has coverage under his or her own Individual plan/policy.

A Summary Bill can also be used for families who may have separate Individual policies or products. It can provide the convenience of receiving one bill for all family members for their individual policies. **Please Note:** When family members enroll in different plans, each member is enrolled in his or her own Individual plan/policy with regard to covered benefits. Summary Billing does not combine any coverage benefits.

A Summary Bill is not a suitable substitute for group coverage or any type of employer-sponsored group insurance benefit program.

Please Note: There is a limit to 50 Individual plans/products per Summary Bill and not all plans can be placed on a Summary Bill. To find out if the plan you intend to include in a Summary Bill qualifies, please call Customer Service at 866-249-4844.

Instructions:

- *A minimum of two (2) policies (medical, dental or life) and/or with multiple subscribers must be approved and paid on the same date in order to establish and maintain a Summary Bill.*
- *Make a copy of the Applicant Summary Bill Agreement for each Summary Bill applicant and have each applicant sign and date the Agreement.*
- *Attach each Applicant Summary Bill Agreement to its corresponding application.*
- *Attach a legible copy of the completed and signed Request for Summary Bill Cover Sheet to the group of applications and agreements.* ***Note:*** *Please print in blue or black ink and keep the original for your files.*
- *You can fax or mail all completed applications, agreements and cover sheets to: Anthem Blue Cross, P.O. Box 9051, Oxnard, CA 93031-9051. Fax: 800-327-9255.*

Please refer to the applicable plan's Evidence of Coverage or Certificate booklet for more information on benefits, conditions, limitations, and exclusions.

Anthem Blue Cross is the trade name of Anthem Blue Cross. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Request For Summary Bill Cover Sheet

Summary Billing does not constitute a Small Group policy, a Small Group Certificate of Coverage or any type of employer-sponsored group insurance benefit.

☐ New Summary Bill – List all applicants on this form, then attach a copy of the form and a copy of the Agreement (reverse side) for each applicant. If making initial payment by check, please attach a separate premium check to each application.

☐ New Applicant(s) Add to Existing Summary Bill – Write the Summary Bill number on this form (current date and signature required), list each applicant to be added and a copy of the Agreement for each applicant.

NOTE: Summary Bills are limited to 50 Individual policies/products per Summary Bill number. If you have more than 50 policies/products, we will need to enroll those on a new Summary Billing. There is no limit to how many Summary Bills you can have.

Summary Bill Recipient			Summary Bill Number (if applicable)
Contact Name		Phone ( )	Fax ( )
Common Billing Address			Suite #
City	State	ZIP Code	E-Mail Address

Underwriting acceptance is not guaranteed.

Indicate billing type: ☐ Bimonthly Bill ☐ Quarterly Bill
If a billing cycle is not selected, we will assign a bimonthly billing cycle.

Name of Applicant(s)	Social Security or ID No.	Medical	Life	Dental	Total Premium Received
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

Signature of Employer *(if applicable)*	Date	Name of Employer *(if applicable – please print)*
Signature of Agent	Date	Name of Agent *(please print)*

Please make copies for your files.

Applicant Summary Bill Agreement

Anthem. Blue Cross

IMPORTANT NOTICE

Please make a copy of this form for EACH Summary Bill applicant before obtaining signatures.

I, the undersigned, understand that the attached applications are for Individual insurance plans/policies which **do not** conform to Employee Retirement Income Security Act (ERISA) legal requirements applicable to employer-sponsored benefit plans and **do not** constitute any type of employer-sponsored group insurance benefits program. I agree that if Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company received or receives information that the individuals included on the Summary Bill should be considered a Small Group, group or employer-sponsored group insurance benefit program, Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company will discontinue the Summary Bill and each individual will be billed separately. I have read the complete Summary Billing for Individual Health Plans Forms and Reference Guide. The employer is not paying any part of the premium either directly or through reimbursement and since the employer does not sponsor the health plan, the employer is not deducting any part of the premiums from gross income under Section 106 or 162 of the Internal Revenue Code, if applicable.

I understand that my enrollment in Anthem Blue Cross' or Anthem Blue Cross Life and Health Insurance Company's Health Plan includes combined bimonthly or quarterly billing with other plan subscribers/insureds. I agree to submit my dues/premiums to Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company through my employer acting on my behalf. I remain fully responsible for the timely submission of my dues/premiums to Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company.

I understand that either Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company or I may terminate the Summary Billing agreement at any time. Applicable bimonthly/quarterly premiums will then be billed directly to me starting at the due date. I understand that it is my obligation to inform Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company in writing of any change of address, employment or status of dependents at least 31 days prior to the next billing due date.

I have read and understand this notice and the terms and conditions of my payment options of my plan(s) as amended, to include combined billing procedures.

X ______________________________ ______________________

Subscriber's Signature Date

X ______________________________

Subscriber's Printed Name

X ______________________________

Subscriber's Social Security or ID No.

X ______________________________

Summary Bill Number *(if applicable)*

Please have each applicant on Summary Bill sign and date this form.
Please sign and return this agreement with your completed application.

Applicant Summary Bill Agreement

Anthem Blue Cross

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