Anthem BlueCross

Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company Individual and Senior Dental Enrollment Application for Individuals and Families

If you are an Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company member, please enter your current group number and certificate number.

Group no.	Certificate no.

Plan choice – Select one

Dental PPO plans provided by Anthem Blue Cross Life and Health Insurance Company	Dental HMO plans provided by Anthem Blue Cross
☐ Dental Blue Basic ☐ Dental Blue Enhanced ☐ Other: _____	☐ Dental SelectHMO ☐ Other: _____
If you choose a Dental HMO plan, you must enter the number of the Dental Office you have chosen: _____	

Application information – Applicant must complete this section **PLEASE PRINT**

Last name	First name	M.I.

Sex	Marital status	Birth date (Mo/Day/Year)	Social Security no.
☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Domestic Partnership		

Home address (must be complete; P.O. Box not acceptable)	City	State	ZIP code
Billing address, if different (or P.O. Box)	City	State	ZIP code
Home phone no.	Business phone no.		

Spouse/Domestic Partner to be insured – Sign below. To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

Spouse/Domestic Partner last name	First name	M.I.

Sex	Birth date (Mo/Day/Year)	Social Security no.
☐ Male ☐ Female		

Children to be insured

Last name	First name	M.I.	Sex	Birth date (Mo/Day/Year)
1.			☐ Male ☐ Female	
2.			☐ Male ☐ Female	
3.			☐ Male ☐ Female	
4.			☐ Male ☐ Female	

Language preference – When information is sent to you, we may be able to send it in a language other than English. What language would you prefer? (Optional)

☐ Spanish ☐ Chinese ☐ Korean ☐ Japanese ☐ Tagalog ☐ Vietnamese ☐ Khmer ☐ Hmong ☐ Farsi ☐ Arabic
☐ Armenian ☐ Russian ☐ Other: _____

Signatures — Required

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. ***It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*** **THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.**

Signature of applicant/parent or legal guardian	Today's date	Signature of applicant's spouse/domestic partner	Today's date
X		X	
Signature of applicant's dependent age 18 or over	Today's date	Signature of applicant's dependent age 18 or over	Today's date
X		X	

Send your completed application and payment to:
PPO plan:
Anthem Blue Cross Life and Health Insurance Company
P.O. Box 9063
Oxnard, CA 93031

HMO plan:
Anthem Blue Cross
P.O. Box 9051
Oxnard, CA 93031

Agent information and declaration

To the best of my knowledge, the information on this application is complete and accurate. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understands the explanation. I understand that if I willfully make any false representations I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to $10,000.

Signature of agent	Print agent name	Agent no.
X	John Caris	G F G F R P K M S Y

FOR ANTHEM BLUE CROSS ONLY

Group no.	Agent no.	Effective date	Pre-exist	Area	By	Date

Payment Methods for Individual Dental Applications
California

Applicant / Member Name:	Primary Applicant's SSN:

(Premium Payment is required. Please choose from Option 1 or 2.)

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Checking Account Automatic Premium Payment (complete Section A)

☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. If you choose one of these options, you will receive a bill every month thereafter.

☐ Paper Check* ☐ Electronic Check (complete Section B) ☐ Credit / Debit Card (complete Section C)

A. Monthly Checking Account Automatic Premium Payment – By providing your check information, you authorize us to debit your bank account electronically. If you have selected this option, your bank account will be debited one month's premium as soon as the day of approval. Subsequent premium amounts will be debited on the day you request below:

Requested Debit Day: _____ (1st to 6th of each month). If no date is specified, your premiums will be debited on the 1st of each month.

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during underwriting, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit were to be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and will be billed monthly. **You will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Check Number	Amount
				$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross to charge my card for a one time initial debit upon approval. I understand that if this option is selected, my account will be debited for one month of premium as soon as the day of approval. I understand that the initial payment amount may vary as a result of change(s) during underwriting and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents or moving my residence. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment were to be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **We accept Visa and MasterCard.**

Card Number: Expiration Date: Cardholder Zip Code:

|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___|___| |__|__| / |__|__| |__|__|__|__|__| – |__|__|__|__|

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic fund transfer, funds will be withdrawn from your account as soon as the day of approval, and you will not receive your check back from your financial institution.