Anthem Blue Cross

Send your completed application and payment to:
Anthem Blue Cross
P.O. Box 9051
Oxnard, CA 93031-9051

Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company
Individual Dental Plan Enrollment Application
for individuals and families under age 65

If you are an Anthem Blue Cross/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 Blue PPO plans provided by Anthem Blue Cross Life and Health Insurance Company

- ☐ Dental Blue Basic
- ☐ Dental Blue Enhanced

Dental HMO Plans provided by Anthem Blue Cross

- ☐ Dental SelectHMO
- ☐ Other _____

If you choose the Dental SelectHMO 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	MI	SEX	BIRTHDATE (Mo/Day/Year)	MARITAL STATUS	SOCIAL SECURITY NUMBER
			☐ M ☐ F		☐ S ☐ M	

HOME ADDRESS (Must be complete, P.O. Box not acceptable)			BILLING ADDRESS, IF DIFFERENT (or P.O. Box)		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE

HOME PHONE NO.	BUSINESS PHONE NO.
( )	( )

Spouse/Domestic Partner To Be Insured (Sign Below)

NAME OF SPOUSE/DOMESTIC PARTNER	SEX	BIRTHDATE (Mo/Day/Year)	SOCIAL SECURITY NUMBER
	☐ M ☐ F		

Children To Be Insured

NAME (First and Last)	SEX	BIRTHDATE (Mo/Day/Year)	NAME (First and Last)	SEX	BIRTHDATE (Mo/Day/Year)
1.	☐ M ☐ F		3.	☐ M ☐ F	
2.	☐ M ☐ F		4.	☐ M ☐ F	

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)

Statement of Understanding for Dental Blue PPO plan applicants in areas with limited availability: I understand the difference between a Participating Dentist and a Non-Participating Dentist, and would like to apply. I know that I probably will not be able to use a Participating Dentist and that I will probably pay more for dental care. When I use Non-Participating Dentists, I will pay the difference between the limited benefit that the plan pays and the actual charge by the Non-Participating Dentist. This means that I may be responsible for a larger portion of my dental bills.

Statement of Understanding for Dental SelectHMO plan applicants: I understand that, once enrolled, only the services I receive from my Anthem Blue Cross Dental SelectHMO participating provider will be covered by the plan.

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	

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	AGENT NAME (PRINT)	AGENT NUMBER
X	James Barricks	LMDLPKMMSZ

FOR ANTHEM BLUE CROSS ONLY

GROUP NO.	CERTIFICATE NUMBER	AGENT NO.	EFFECTIVE DATE	PRE-EXIST		AREA	BY	DATE
		–						

Anthem Blue Cross is the trade name of Blue Cross of California. 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 of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Applicant Social Security or ID No.

Payment Method (Premium payment required. Please choose from A or B.)

A. Please choose from the following options for initial payment and future payments. If you choose one of these options, you are not required to send in a paper check for initial payment:

☐ Credit/Debit Card *(complete Section C)* ☐ Monthly Checking Account Automatic Premium Payment *(complete Section D)*

If you choose Credit/Debit Card, please select the frequency you would like your premiums deducted: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly

NOTE: If no selection is made, this option will default to monthly.

☐ **B. If you did not select an option in Section A, please choose from the options below for your initial premium payment:**

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

If you choose Credit/Debit Card, please select the number of months for your initial premium payment debit: ☐ One Month ☐ Two Months ☐ Three Months

NOTE: If no selection is made, the default debit will be one month's premium for initial payment. If you choose one of these three options, you will receive a bill every two months thereafter.

C. Credit/Debit Card

As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. 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. If I provided my credit/debit card for the initial payment only in Section B, recurring payments will not be charged from my card. The amount may also change as outlined in my policy. 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 card payments. I further agree that if any such card payment 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, MasterCard, Discover and Star.
For Star, we accept 16 digit card numbers only.

Card No.: *(16 digits only)* Exp. : / Cardholder ZIP Code: –

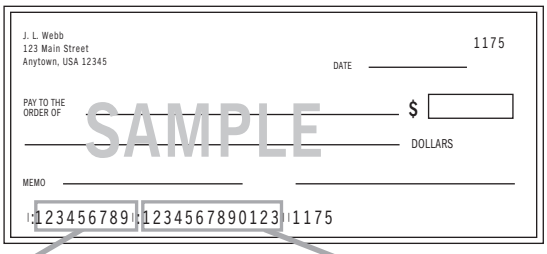
Authorized Signature *(As it appears on the credit card)*	Cardholder Name *(As it appears on the credit card)* PRINT	Date
X		

D. Monthly Checking Account Automatic Premium Payment

By providing your check information to the right, you authorize us to electronically debit your bank account. If you have not selected an initial premium payment option from Section B, your bank account will be debited one month's premium the day after 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 requested, your premiums will be debited on the first of each month.

Provide your Routing and Account numbers here.



Bank Routing No. | Bank Account No.

As a convenience to me, I request and authorize you to charge my account for monthly recurring premiums on each due date. 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 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 and/or Anthem Blue Cross Life and Health Insurance Company to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company 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 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 be billed every two months. **You will incur a $25 service charge for any withdrawal not honored.**

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

E. Electronic Check

Instead of sending a paper check, we can submit this same information electronically. You will need 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 PRINT	Bank Routing No.	Account No.	Amount	Check No.
			$	

** 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 information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.*