

# Enrolling is Simple. Just Follow These 3 Easy Steps...

## **Step 1**

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department  
at: \_\_\_\_\_ fax: \_\_\_\_\_

## **Step 2**

**SELECT THE TYPE OF BILLING YOU WANT** – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

## **Step 3**

**SEND THE COMPLETED APPLICATION TO:**

**Please make your check payable to: Anthem Blue Cross**

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

**If you have questions please contact our office at:**

Thank you for choosing...





# Dental SelectHMO Enrollment Application

If you are an Anthem Blue Cross member, please enter your current Anthem Blue Cross group number and certificate number below.

Group No.

Certificate or ID No.

Proposed Effective Date

## Plan Choice

- Saver SelectHMO (40)     
  SelectHMO (41)     
  Premier SelectHMO (42)

Dental Office No:

## Applicant Information - Applicant must complete this section.

Please print

Last Name		First Name			MI		Social Security No. or ID No.				
Home Phone No. ( )		Business Phone No. ( )		Sex <input type="checkbox"/> M <input type="checkbox"/> F		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Age		Date of Birth	
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			

## Spouse to be Included - Signature required below.

Last Name of Spouse		First Name			Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of Birth		Social Security No. or ID No.			
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## Children to be Included

	NAME (First and Last Name)	SEX	BIRTHDATE			NAME (First and Last Name)	SEX	BIRTHDATE		
			Mo	Day	Yr			Mo	Day	Yr
1						3				
2						4				

## Signatures (Required)

**Authorization to Obtain or Release Medical Information:** I understand that California law prohibits an HIV test from being required or used as a condition of obtaining medical coverage. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)

I have personally read and completed this application. If I am accepted, this application will become part of the contract between Anthem Blue Cross and me. I and any enrolled family members agree to abide by the terms of that contract, including the arbitration provision that provides as follows:

Even if I pay money with this application, that money is only a deposit against future premium if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Anthem Blue Cross nor any affiliated company shall have any liability to me or anyone else listed on it, except for the obligation to return the money submitted with this application. If this application is not accepted, neither I nor anyone listed on it will be entitled to benefits or coverage from Anthem Blue Cross. I also understand that only the services I receive from my Anthem Blue Cross Dental SelectHMO participating provider are covered by the plan or are subject to a savings if not covered.

### Requirement for Binding Arbitration

If you are applying for coverage, please note that Anthem Blue Cross requires binding arbitration to settle all disputes against Anthem Blue Cross, including claims of medical malpractice. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice. "It is understood that 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 proceeding. 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." Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.**

Signature of Applicant / Parent or Legal Guardian <b>X</b>		Today's Date		Signature of Applicant's Spouse <b>X</b>		Today's Date	
Signature of Applicant's Dependent Age 18 or over <b>X</b>		Today's Date		Signature of Applicant's Dependent Age 18 or over <b>X</b>		Today's Date	
Name of Agent (Print)		Agent No.		Signature of Agent <b>X</b>		Today's Date	



**ATTACH BLANK, VOIDED CHECK FOR BANK DRAFT AUTHORIZATION,  
IF APPLICABLE, HERE. DO NOT TAPE.**

**Applicant's Social Security or ID No.**

**Payment Method Premium payment required. First payment will be credited to approved applicants only.** By sending your check to us, you authorize Anthem Blue Cross to convert your check into an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

**Credit Card**

**FAX to: (800) 327-9255**

**Initial premium (For new member's Medical and Dental fees only)**       **Monthly premiums**

**Monthly Credit Card Authorization** - 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 amount may vary as a result of changes I make, such as, but not limited to, adding and deleting dependents, or moving to a new location. 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. Credit Card:  VISA     MasterCard     Discover

Card No.: \_\_\_\_\_ Exp. : \_\_\_\_\_ Cardholder's Zip Code: \_\_\_\_\_ - \_\_\_\_\_

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

**Checking Account Automatic Premium Payment**

**Monthly checking account deduction premium payments**

**Name of Bank or Financial Institution:** \_\_\_\_\_

Account No.: \_\_\_\_\_ Bank Routing No.: \_\_\_\_\_

Submit a blank check marked "VOID" above where indicated (DEPOSIT SLIPS NOT ACCEPTABLE). If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account. Premiums may be prorated in order to adjust the initial paid to date or in the event of membership changes.

**Monthly Checking Account Automatic Premium Payment** - 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 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 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 bimonthly. **You may incur a \$25 service charge for any withdrawal not honored.**

Authorized Signature (As it appears in the financial institution's records)	Date
X	X

**Billing**

**Bimonthly** (Submit 2 months premium)     **Quarterly** (Submit 3 months premium)

FOR ANTHEM BLUE CROSS USE ONLY			
Group No.	Certificate No.	Agent I.D. No.	Effective Date
Pre-Exist	Area	By	Date