Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

LOCATE THE CORRECT APP (USING PAGE 2) THEN 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: 877-566-5454 fax: 760-433-0304

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:

Barricks Insurance Services

276 N El Camino Real #6

Oceanside, CA 92058

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: 877-566-5454

Thank you for choosing...

Anthem Blue Cross

Anthem Extras Packages Senior Enrollment Application for California

Anthem BlueCross

Send your completed application and payment to:
Anthem Blue Cross Life and Health Insurance Company
P.O. Box 5028
Denver, CO 80217-5028
Fax: 1-877-238-1107

Please print – complete in blue or black ink only.

Important: To be eligible to apply for this coverage, you must be 65 years of age or older.

Section A – Applicant Information

******This information is used for internal purposes only and will not be disclosed.*

Last Name	First Name	MI	Social Security Number*

Home Address **(Must be complete. P.O. Box not acceptable)**	City	State	ZIP Code

Mailing Address **(if different from above or for P.O. Box)**	City	State	ZIP Code

County	Gender	Date of Birth	Age	Daytime Phone Number	Evening Phone Number
	☐ M ☐ F	/ /		( )	( )

Email Address (not shared with any third party)	Are you, the applicant, a Medi-Cal beneficiary? ☐ Yes ☐ No

If you currently have medical or dental coverage through Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, please provide:	If you are a current member of Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, what insurance do you have with us?
Member Identification Number: _____ Effective Date: _____ Termination Date: _____	☐ Individual Health ☐ Group Health ☐ Group Vision ☐ Individual Dental ☐ Group Dental

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 _____

Section B – Coverage Information

Effective date requested: If your application is approved, your coverage can start on any day of the month after the date we receive your application.

Please choose the date you would like your coverage to start: _____/_____/_____ (MM/DD/YY).

☐ Standard Package ☐ Premium Package ☐ Premium Plus Package ☐ Premium Plus Dental ***(only)***

Section C – Billing Information

Frequency (select one)
☐ Monthly ☐ Quarterly
☐ Semi-annually
☐ Annually

Initial Premium ☐ Automatic Bank Draft (see below) ☐ Premium Check Enclosed (make check payable to ***Anthem Blue Cross Life and Health Insurance Company***)

Total amount enclosed $ _____

If you submit a personal check for premium payments, you automatically authorize us to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on your bank or credit union account statement as an Electronic Funds Transfer (EFT). Converting your paper check into an electronic payment does not authorize us to deduct premiums from your account on a monthly basis unless you have given us prior authorization to do so.

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.

Method (select one)

☐ **HOME –** Bills will be sent to your home address unless you list an alternate address here:

Name _____

Street Address (and P.O. Box, if applicable) _____

City _____ State _____ ZIP Code _____

☐ **AUTOMATIC BANK DRAFT** – Premium is deducted on the same day of the month as your effective date; ***you must attach a blank, voided check.***

If selecting Automatic Bank Draft: I authorize Anthem Blue Cross Life and Health Insurance Company (Anthem) to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. This authorization is in effect until I notify in writing that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals at their discretion.

Account holder's name (please print)
X _____

Account holder's signature (if other than the applicant)
X _____

Section D – Agreement Signature Required

Signature of Applicant or Legal Guardian or Power of Attorney	Date

Section E – Agent Certification

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.

Agent Signature	Date

Agent Name (please print)	Agent Street Address/Suite Number/Personal Mailbox (PMB) Number
JAMES BARRICKS	276 N EL CAMINO REAL #6

Writing Agent Tax ID Number	City/State/ZIP Code	County	Area Code
063287258	OCEANSIDE, CA 92058	SAN DIEGO	

Agent Phone Number	Agent Fax Number	Agent Email Address
877-566-5454	760-433-0304	INSURE@BARRICKSINSURANCE.COM

Payable Agent/Agency Name (if applicable) (please print)	Payable Agent/Agency Tax ID Number (if applicable)

REQUIREMENT FOR BINDING ARBITRATION

YOU AND ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BINDING ARBITRATION TO SETTLE ALL DISPUTES, INCLUDING, BUT NOT LIMITED TO DISPUTES, RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY, AND/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 and/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.

YOU, ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE THAT EACH PARTY MAY BRING CLAIMS AGAINST THE OTHER ONLY IN YOUR OR ITS INDIVIDUAL CAPACITY AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. 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 AND/OR TO PARTICIPATE IN A CLASS ACTION 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 OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.