Anthem® Extras Packages Senior Enrollment Application for California

Send your completed application and payment to:
Anthem Blue Cross Life and Health Insurance Company
PO 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 and not enrolled in a Med Advantage plan with Anthem.

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. PO Box not acceptable)	City	State	ZIP Code
Billing Address (if different from above or for PO Box)	City	State	ZIP Code
Mailing Address (if different from above or for PO Box)	City	State	ZIP Code

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

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

If you currently have dental coverage through any carrier including Anthem Blue Cross and Blue Shield, please provide:
Name of Carrier_____ Member Identification Number_____
Effective Date_____ Termination Date_____

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 ☐Arabic ☐Armenian ☐Chinese ☐Farsi ☐Hindi ☐Hmong ☐Japanese ☐Khmer ☐Korean
☐Punjabi ☐Russian ☐Tagalog ☐Thai ☐Vietnamese ☐Other _____

Section B – Coverage Information

Effective date requested:
If your application is approved, your coverage can start on any day (between the 1st-25th) of the month after the date we receive your application.
Please choose the date (between the 1st-25th) you would like your coverage to start: _____/_____/_____ (MM/DD/YY).

Current Medicare Supplemental Plan	**Plans you are eligible to choose:**
☐ Plan A ☐ Plan F ☐ Plan G ☐ Plan N	☐ Standard Package ☐ Premium Package ☐ Premium Package without SilverSneakers/Fitness Program ☐ Premium Plus Package ☐ Premium Plus Package without SilverSneakers/Fitness Program ☐ Senior Premium Plus Dental only
☐ Plan Innovative F	☐ Senior Standard Dental ☐ Senior Premium Dental ☐ Senior Premium Plus Dental

Section C – Billing Information

Frequency (select one)

☐ Monthly
☐ Quarterly
☐ Semi-annually
☐ Annually

Initial Premium

☐ Automatic Bank Draft (see below)

Premium is deducted on the same day of the month as your effective date, if the draft date is not indicated.

Draft Date: _____ Draft dates available are the 1st-25th of the month.

☐ Premium Check Enclosed (make check payable to ***Anthem Blue Cross Life and Health Insurance Company***)

Total amount enclosed $ _____

Account Type

☐ Business Checking ☐ Business Savings
☐ Personal Checking ☐ Personal Savings

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 PO Box if applicable)_____

City _____ State _____ ZIP Code _____

☐ **AUTOMATIC BANK DRAFT** – Premium is deducted on the same day of the month as your effective date, if draft date is not indicated in Section C; ***you must attach a blank, voided check.***

If selecting Automatic Bank Draft: I authorize Anthem Blue Cross (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 Anthem 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.

I also understand if changes I make to my auto withdrawal amount are processed close to the withdrawal date, Anthem may not be able to notify me of the new auto withdrawal amount before the withdrawal is made.

Account holders 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 Jim Barricks		Date	
Agent Name (please print)	 Jim Barricks 276 N El Camino Real #6 Oceanside, CA 92058-1726 Phone: (310) 678-6315 CA License #0383850 WWW.BARRICKSINSURANCE.COM	ersonal Mailbox (PMB) Number	
Writing Agent Tax ID Number LMDLPKMMSZ	City/Sta		
Agent Phone Number	Agent Fax Number	gent Email Address INSURE@BARRICKS.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.