# 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 Blue Cross
Health. Join In.

# Anthem Blue Cross
# Individual Dental SelectHMO Plan Enrollment Application

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

| GROUP NO. | CERTIFICATE NO. |
|---|---|
| | |

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 ☐M ☐F | BIRTHDATE (Mo/Day/Year) | MARITAL STATUS ☐S ☐M | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|---|---|
| | | | | | | |

| 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 ☐M ☐F | BIRTHDATE (Mo/Day/Year) | SOCIAL SECURITY NUMBER |
|---|---|---|---|
| | | | |

## 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 | |
| NAME (First and Last) | SEX | | NAME (First and Last) | SEX | |
| 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: 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 REQUIRES BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. 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 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 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 OR ANY OTHER ISSUES RELATED TO THE PLAN.**

| 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 |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |

| 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:**

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

☐ **B. Please choose from the options below for your initial premium payment:**

☐ Paper Check* ☐ Electronic Check *(complete Section E)*

If you choose one of these two options, you will receive a bill every two or three months thereafter, depending on the billing frequency you select.

Select Frequency: ☐ Bimonthly ☐ Quarterly

## C. Monthly 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. 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.: _____ Exp. : ____/____ Cardholder ZIP Code: _____–_____

*(16 digits only)*

| 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. 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 28th 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 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 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 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 bi-monthly. **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

In lieu 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. |
|---|---|---|---|---|
| | | | $ | |

** Enclose check for first month's payment. By sending your paper check, you authorize us to convert your check to 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.*