Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

@C7 5 H9 ˙H<9 ˙7 CFF9 7 H˙5 DD˙fl G=B; ˙D5 ; 9 ˙&L˙H<9 B˙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:

GhYd ˙&

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...

Anthem. BlueCross

California
Individual Dental and Vision Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company, premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 212-1796. If you have questions about a previously submitted application, please call 1 (855) 383-7247.

RIGHT TO CANCEL: You have 10 days from the date of delivery to examine the policy. If you are not satisfied, for any reason, with the terms of the policy, you may return it to us within those 10 days. Return to Anthem Blue Cross and Blue Shield, P.O. Box 1115, Minneapolis, MN 55440-1115 by midnight on the tenth day. We will then issue a full refund of any premiums and fees paid, less any payments made for benefits on behalf of you or your dependents.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage ☐ Change policy coverage Policy No.___________________ ☐ Add dependent(s) to current coverage Policy No.______________________

Enrollment

You may apply for new coverage at any time during the calendar year. Your Effective Date will be the first day of the following month after receipt of your application and premium.

Qualifying Events for Existing Members

Please check the qualifying event:

- ☐ Gain a dependent or become a dependent through marriage, domestic partnership or appointment of partnership;
- ☐ Gain a dependent or become a dependent through birth, adoption or placement for adoption
- ☐ Mandated to be covered as a dependent pursuant to a valid state or federal order;
- ☐ Released from incarceration;
- ☐ Death of a family member enrolled under your current coverage;
- ☐ Renewal of non-calendar year health plan coverage;
- ☐ Covered children reached limiting age of policy; or
- ☐ Other Qualifying Event: _________________________ (Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events.)

Comments____

Please provide the date of the qualifying event checked above: _______________________

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If you are applying due to a qualifying event and your application is approved, your effective date is as follows:

- In the case of gaining a dependent or becoming a dependent through birth, adoption or placement for adoption, or mandated to be a dependent, coverage is effective on the date of birth, adoption, or placement for adoption or the date within the mandated order to be a dependent; or
- In all other cases listed above, coverage is effective on the first day of the month following receipt of your application.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*
Home Address **			
City	State	ZIP	County
Billing Address (street and P.O. Box if applicable)			
City	State	ZIP	
Marital Status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of Birth	
Primary Phone Number	Secondary Phone Number	E-mail*	

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

*** All information will be mailed to your home address, including billing, private and confidential communications as defined by California law, unless you designate a different address under the "Billing Address" field above. This will not impact rights you may have to invoke a separate Confidential Communication under the Health Insurance and Portability and Accountability Act ("HIPAA").*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner
Social Security Number*	Sex ☐ M ☐ F	Date of Birth	

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

Section D – Child Dependents to be Covered Information
(All fields required. Attach a separate sheet if necessary).

NOTE: IF ELECTING DEPENDENT COVERAGE, PLEASE LIST ALL ELIGIBLE CHILDREN UP TO AGE 26**.** An eligible child dependent may be your children or your spouse's or your Domestic Partner's children (to the end of the calendar month in which they turn age 26). You must complete a Certification form for a Mentally or Physically Incapacitated Dependent Child if your child is disabled, incapable of self-support, and age 26 or over. The form must also be completed by your physician. (List all dependents beginning with the eldest).

Last Name	First Name	MI	Sex	Date of Birth mm/dd/yyyy	Social Security Number*	Relationship to Applicant
			M F ☐ ☐			☐ Child ☐ Other:_________
			M F ☐ ☐			☐ Child ☐ Other:_________
			M F ☐ ☐			☐ Child ☐ Other:_________
			M F ☐ ☐			☐ Child ☐ Other:_________
			M F ☐ ☐			☐ Child ☐ Other:_________

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

Do you have a child age 26 or over who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition for whom coverage is being requested under this contract? ☐ Yes ☐ No

If yes, a separate Disabled Dependent Certification form must be submitted to determine eligibility.

☐ Please send me a Disabled Dependent Certification form.

Preferred written language? (Optional)

☐ English (ENG)

☐ Spanish (SPN)

Preferred spoken language? (Optional)

☐ English (ENG)

☐ Spanish (SPN)

☐ Applicant **DOES** speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a "Statement of Accountability".

Section E – Dental Coverage

Select your plan option below:

The below plans DO NOT include Pediatric Dental essential health benefits as defined by the Affordable Care Act:

☐ Dental Blue Basic** - 1JZ5 ☐ Dental Blue Enhanced** - 1JZ6 ☐ Dental Select HMO* - 1F3E
☐ Prime Plan A** - 1RBD ☐ Prime Plan B** - 1RBE ☐ Prime Plan C** - 1RBF

If you choose the SelectHMO plan, you must choose a Primary Care Dentist for the family and enter the number of the Dental Office you have chosen.

Primary Care Dentist	Current Patient	Primary Care Dentist Number
	☐ Yes ☐ No	

*** These products are issued by Anthem Blue Cross and are regulated by the California Department of Managed Health Care.**

**** These products are issued by Anthem Blue Cross Life and Health Insurance Company and are regulated by the California Department of Insurance.**

Section F – Other Dental Coverage

Are you or any of your dependents listed on this application currently enrolled, or have recently been enrolled, in other dental care coverage? ☐ Yes ☐ No

If YES, please provide the following:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of current/prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage

Has your other coverage ended, or will you be terminating this coverage if approved for Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company coverage? ☐ Yes ☐ No

If **YES**, what is the termination date? ______________________________

Section G – Vision Coverage

Vision coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits).

Choose a vision plan and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.
Please note: Vision coverage is available ***only*** if you are:

- Enrolling in a new dental plan on this application
- Enrolling in an Anthem medical plan through an Exchange
- Already enrolled in an Anthem medical plan or dental plan and it is your annual renewal.

Please provide your medical or dental plan number here____________

☐ Blue View Vision Individual – 1RYD

Select who you are enrolling (applies to individuals listed on this application only):

☐ Applicant only

☐ Applicant & all dependent children listed

☐ Applicant & Spouse or Domestic Partner only

☐ Applicant, Spouse or Domestic Partner and all dependent children listed

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

All Applicants

I, the undersigned, understand that under the Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company plan/policy in which I am enrolling, I will have considerably higher personal financial costs if I use an out-of-network dentist than if I use a network dentist. Contact customer service at 1-866-297-7647 with any questions about the use of network providers and the financial impact of using out-of-network providers.

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.

- I understand that although Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company, does not mean that coverage has been approved. I may not assign any payment under my Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company program. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company reserves the right to accept or decline this application, and that no right whatsoever is created by this application. I understand that if my application is denied, my bank account or credit card will not be charged.
- I am responsible to timely notify Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company of any change that would make me or any dependent ineligible for coverage.
- I understand Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company automatic debit process and will only occur each time I send a check to Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.

- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and myself.
- I understand I am applying for individual health coverage which is not part of any employer-sponsored plan I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- I understand that my domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.
- ☐ By checking this box, I authorize and expressly consent that Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and its affiliated companies may send and deliver to me any communication that is not required to be provided to me by United States mail, including but not limited to legally required Plan Notices, policies, agreements, evidence of coverage booklets and underwriting, enrollment and billing and explanation of benefits statements, electronically, either by e-mail or via the Internet. Examples of documents that will not be sent by electronic means and will continue to be sent by U.S. Mail include notices of cancellation, notices of grace period, notices that will terminate your coverage, and notices regarding a denial of coverage. I understand that I can revoke this authorization or request paper copies at any time by contacting Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company customer service or online at www.anthem.com.
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company in accepting this application. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits or cancellation of my coverage(s).
- I certify each Social Security Number listed on this application is correct.

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company. I am acting as their agent and representative.

This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

REQUIREMENT FOR BINDING ARBITRATION

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 MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. 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 permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, 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 AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND MEDICAL MALPRACTICE CLAIMS.

By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

SIGN HERE	Signature	Date
	Signature of Applicant* or Legal Representative X	Date
	Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
	Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code Section 1389.8(c)/Insurance Code Section 10119.3.

I certify, to the best of my knowledge, the information in the application is complete and accurate. I further certify that I explained to the applicant, in easy-to-understand language, the risk of proving inaccurate information; and the applicant understands the explanation.

Agent/Broker Signature X			Date
Agent/Broker Name (please print)		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No.	
Agent/Broker ID/TIN LMDLPKMMSZ	Agency ID/Parent TIN LMDLPKMMSZ	City	State / ZIP
Agent/Broker Phone No.	Agent/Broker Fax No.	Agent/Broker E-mail	
GA (if applicable)		GA code (if applicable)	

Section J – Statement of Accountability

Primary Applicant's Name: ________________________________

To be completed when the applicant cannot complete application.

NOTE: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I, ____, personally read and completed this Individual Application for the applicant named below because:

☐ Applicant does not read English

☐ Applicant does not speak English

☐ Applicant does not write English

☐ Applicant is Limited English Proficient

☐ Other (explain):____

I interpreted the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

☐ Applicant Or by:____

I also interpreted and fully explained the "Application Understandings, Conditions and Agreement," and the "Payment Method."

Signature of Interpreter *(Required)*	Today's Date *(Required)*
X	

I confirm that the application was interpreted on my behalf.

Signature of Applicant *(Required)*	Today's Date *(Required)*
X	

Language interpreted (e.g. Spanish):

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Please mail this application to the following address:

Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company

PO Box 9041

Oxnard, CA 93031-9041

or

Fax to: 1 (800) 327-9255

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Payment Methods for Individual Applications – California

Anthem BlueCross

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Automatic Premium Payment (complete Section A)

☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

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

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account

☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)

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.

SAMPLE
1175
DATE
PAY TO THE ORDER OF
$
DOLLARS
MEMO
123456789 1234567890123 1175

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") to pay and charge to my account checks drawn on that account by and made 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 eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing Anthem a 30-day written notice. I agree that Anthem 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, Anthem shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Anthem's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

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

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review 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, moving my residence changing coverage, and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem 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, Anthem 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. **Anthem accepts Visa ☐ and MasterCard ☐.**

Card Number: ____________________ Expiration Date: __________

Billing address for this Credit / Debit Card: ____________________ City: __________ Zip Code: __________

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize Anthem either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Anthem uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.

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