

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...





**Anthem Blue Cross Life and Health Insurance Company
Individual Dental Plan Enrollment Application**

If you are an Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company member, please enter your current group number and certificate number.

GROUP NO.	CERTIFICATE NO.

Plan choice - select one

- Dental Blue Basic
- Dental Blue Enhanced

Application Information: Applicant must complete this section.

PLEASE PRINT

LAST NAME	FIRST NAME	MI	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> 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/Qualified Domestic Partner To Be Insured (Sign Below)

NAME OF SPOUSE/DOMESTIC PARTNER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	SOCIAL SECURITY NUMBER

Children To Be Insured

NAME (First and Last) 1.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	NAME (First and Last) 3.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)
NAME (First and Last) 2.	SEX <input type="checkbox"/> M <input type="checkbox"/> F		NAME (First and Last) 4.	SEX <input type="checkbox"/> M <input type="checkbox"/> 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 for Dental Blue plan applicants in areas with limited availability: I understand the difference between a Participating Dentist and a Non-Participating Dentist, and would like to apply. I know that I probably will not be able to use a Participating Dentist and that I will probably pay more for dental care. When I use Non-Participating Dentists, I will pay the difference between the limited benefit that the plan pays and the actual charge by the Non-Participating Dentist. This means that I may be responsible for a larger portion of my dental bills.

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 AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE 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, 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 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. 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 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.*

SIGNATURE OF APPLICANT/PARENT OR LEGAL GUARDIAN X	TODAY'S DATE	SIGNATURE OF APPLICANT'S SPOUSE/DOMESTIC PARTNER X	TODAY'S DATE
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER X	TODAY'S DATE	SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER X	TODAY'S DATE

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 X	AGENT NAME (PRINT)	AGENT NUMBER

FOR ANTHEM BLUE CROSS ONLY

GROUP NO.	CERTIFICATE NUMBER	AGENT NO.	EFFECTIVE DATE	PRE-EXIST	AREA	BY	DATE

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: Credit/Debit Card (complete Section C) Monthly Checking Account Automatic Premium Payment (complete Section D)
 If you choose Credit/Debit Card, please select the frequency you would like your premiums deducted: Monthly Bi-Monthly Quarterly
NOTE: If no selection is made, this option will default to monthly.

B. If you did not select an option in Section A, please choose from the options below for your initial premium payment:
 Paper Check* Electronic Check (complete Section E) Credit/Debit Card (complete Section C)
 If you choose Credit/Debit Card, please select the number of months for your initial premium payment debit: One Month Two Months Three Months
NOTE: If no selection is made, the default debit will be one month's premium for initial payment. If you choose one of these three options, you will receive a bill every two months thereafter.

C. 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. If I provided my credit/debit card for the initial payment only in Section B, recurring payments will not be charged from my card. 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)

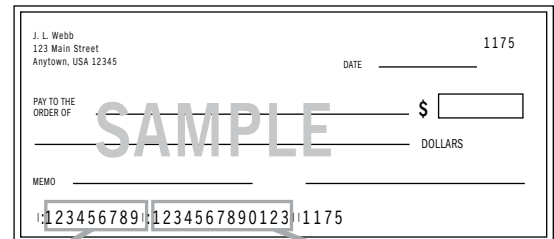
Authorized Signature (As it appears on the credit card) X	Cardholder Name (As it appears on the credit card) PRINT	Date
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D. Monthly Checking Account Automatic Premium Payment

By providing your check information to the right, you authorize us to electronically debit your bank account. If you have not selected an initial premium payment option from Section B, 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 6th 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. →



As a convenience to me, I request and authorize you to charge my account 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. 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 and/or Anthem Blue Cross Life and Health Insurance Company to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company 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 every two months. You will incur a \$25 service charge for any withdrawal not honored.

Authorized Signature (As it appears in the financial institution's records) X	Account Holder Name PRINT	Date
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E. Electronic Check

Instead 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.
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* When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer from your account or to process the payment as a check transaction. When we use information from your check to make an electronic fund transfer, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.