

# 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: (818) 987-5000 Fax: (818) 776-9865

## Step 2

**SELECT THE TYPE OF BILLING YOU WANT** – monthly (by checking account deduction or paper bill).

## Step 3

**SEND THE COMPLETED APPLICATION TO:**

Oleg Skurskiy  
18375 Ventura Blvd. # 226  
Tarzana, CA 91356

**We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.**

**If you have questions please contact our office at: (818) 987-5000**

Thank you for choosing...





ATTACH CHECK HERE

# Anthem Blue Individual PPO Dental Plan Enrollment Application

Once completed, fax both sides of this form to Anthem Individual Membership at 303-764-7282.

If Anthem approves my application please assign an effective date of the

- 1st of the month following approval
- \_\_\_\_\_ (mm/dd/yy)

If you are an Anthem subscriber, please enter your current Anthem group number and certificate number.

GROUP NO.	CERTIFICATE NO.

### Applicant Information – Applicant must complete this section.

Please print

Last Name		First Name		MI	Social Security No.		
Home Phone No. ( )		Business Phone No. ( )		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Date of Birth
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		

### Spouse to be Insured – Signature required below.

Last Name of Spouse	First Name	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (Mo/Day/Yr)	Social Security No.
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### Children to be Insured

	NAME (First and Last Name)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE			SOCIAL SECURITY NO.					
			MO	DAY	YR						
1		<input type="checkbox"/> M <input type="checkbox"/> F									
2		<input type="checkbox"/> M <input type="checkbox"/> F									
3		<input type="checkbox"/> M <input type="checkbox"/> F									
4		<input type="checkbox"/> M <input type="checkbox"/> F									

### Signatures (Required)

If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. If the responsible adult is not the natural parent, please submit court papers, authorizing guardianship. I understand that coverage is subject to all conditions and provisions specified in the Policy. I understand that receipt of money with this application does not create Anthem coverage. Coverage will come into effect only on approval by Anthem.

Signature of Applicant / Parent or Legal Guardian <b>X</b>	Today's Date	Signature of Applicant's Spouse <b>X</b>	Today's Date
Signature of Applicant / Parent or Legal Guardian <b>X</b>	Today's Date	Signature of Applicant's Spouse <b>X</b>	Today's Date

### Agent Information

Name of Agent (Print) <b>Oleg Skurskiy</b>	Agent Tax ID Number <b>BCLNGNPVMZ</b>	Check One EIN <input type="checkbox"/> SS# <input type="checkbox"/>	Signature of Agent	Today's Date
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### FOR ANTHEM USE ONLY

Group No.	Certificate No.	Agent Tax I.D. No.	Effective Date	Area	By	Date
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**Select Billing Type** Monthly Paper Billing Quarterly Paper Billing Monthly Electronic Funds Transfer (EFT)

Please choose the draft date on which you would like your premium debited from your account and complete the Monthly Bank Authorization below:

 1st  8th  15th  22nd of the month

## Monthly Bank Draft Authorization

**INSTRUCTIONS:**

1. Complete this section.
2. Attach a blank check marked "VOID" to this form (Deposit slips or temporary checks are not acceptable).
3. Submit a check for one-month's premium made out to Anthem Blue Cross and Blue Shield. If the account listed below is a joint account, both account holders' signatures are required.

**All funds are drawn on the first of each month. Premiums may be prorated in order to adjust the initial paid-to-date or in the event of membership changes.**

**OPTIONAL MONTHLY BANK DRAFT AUTHORIZATION.** 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 Life & Health Insurance Company, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I authorize Anthem Life & 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 Life & Health Insurance Company premium. This authority is to remain in effect until revoked by me in writing and until you actually receive such 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 through such dishonor results in forfeiture of insurance.

**NOTE TO APPLICANT:** Should your withdrawal not be honored by your bank, you will automatically be removed from monthly checking account deduction and be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction option.

**You will incur a service charge for any withdrawal not honored. Anthem must be notified of any changes to your bank account.**

Applicant's Name

Applicant's Social Security No.

Name on Checking Account (If different from above)

Checking Account No.

Name of Bank

Routing No.

**X**  
Authorized Signature (As it appears in the financial institution's records)

Date

Initial Premium Payment by Electronic Check

Select one:  1 month  3 months

Check No. Initial Premium Amount Electronic Check  
\$

Bank/Credit Union Routing No.

Checking Account No. (as it appears on your check)

Name on Account

**Initial Premium Payment by Credit Card***New members only. Not available to make a coverage change.*

Select one: <input checked="" type="checkbox"/> 1 month <input type="checkbox"/> 3 months	Initial Premium Amount Credit Card: \$	Credit Card <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard
Credit Card No.		Expiration Date
Cardholder's Name		Cardholder's ZIP Code
Authorized Signature <i>(as it appears on the credit card)</i> <b>X</b>		Today's Date