

# 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: 818-654-4548 fax: 818-776-9865

## **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:**

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

**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: 818-654-4548**

Thank you for choosing...



# How to enroll

## If you are enrolling in Dental coverage only, or if you are a new or existing Anthem Blue Cross/ Anthem Blue Cross Life and Health Insurance Company Medical member who wants to add Dental:

- Complete and sign the attached application
- Determine your premium
- Choose your payment plan
- Write a check payable to Anthem Blue Cross
- Send the application and payment to the address below or to your agent



Please note that when you enroll in both a Medical and Dental plan, the same method of payment must be selected for both. For members with a Medical plan who are adding Dental coverage, you will need to send the first month's Dental premium with the application even if you currently pay your Medical premium by credit card or via automatic monthly checking account deduction.

### To determine your initial premium:

- If you want to pay your bill monthly, fill out the attached Checking Account Deduction Authorization and submit it along with a check for one month's premium and a blank check marked "VOID"
- If you want to pay your bill every two months, write a check for two months' premium
- If you want to pay your bill every three months, write a check for three months' premium

Again, for those already enrolled in a Medical plan who are adding Dental, or those enrolling in both a Medical and Dental plan, you must select the same method of payment for both.

If you have any questions, please call (818) 654-4548

Send your application and payment to:

**OLEG SKURSKIY**  
18375 Ventura Blvd # 226  
Tarzana, CA 91356

or by Fax 818-776-9865

Authorized Independent Agent, CA License 0E50389



Attach Check Here

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

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

GROUP NO. CERTIFICATE NO.

Check Billing Type Selected

- Monthly (by checking account deduction only)
Bimonthly
Quarterly

Select One

- Dental Blue 100 Basic
Dental Blue 200 Essential
Dental Blue 100 Plus
Dental Blue 200 Plus

Application Information: Applicant must complete this section.

PLEASE PRINT

Form with fields: LAST NAME, FIRST NAME, MI, SEX, BIRTHDATE, MARITAL STATUS, SOCIAL SECURITY NUMBER, HOME ADDRESS, BILLING ADDRESS, CITY, STATE, ZIP CODE, HOME PHONE NO., BUSINESS PHONE NO.

Spouse To Be Insured (Sign Below)

Form with fields: NAME OF SPOUSE, SEX, BIRTHDATE, SOCIAL SECURITY NUMBER

Children To Be Insured

Form with fields for 4 children: NAME, SEX, BIRTHDATE

Signatures (Required)

Any dispute between you and Anthem Blue Cross/Anthem Blue Cross Life and Health must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both you and Anthem Blue Cross and its affiliates are giving up the right to have any dispute decided in a court of law before a jury.

Statement of Understanding for Areas 2, 3, 10, 11 and 12 (counties with limited availability - see pages 12 and 13.) 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.

Form with fields: SIGNATURE OF APPLICANT/PARENT OR LEGAL GUARDIAN, TODAY'S DATE, SIGNATURE OF APPLICANT'S SPOUSE, TODAY'S DATE, SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER, TODAY'S DATE

Agent Information

Form with fields: SIGNATURE OF AGENT, AGENT NAME (PRINT), AGENT NUMBER

FOR ANTHEM BLUE CROSS ONLY. Form with fields: GROUP NO., CERTIFICATE NUMBER, AGENT NO., EFFECTIVE DATE, PRE-EXIST, AREA, BY, DATE

# Optional monthly checking account deduction

- 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 payable to Anthem Blue Cross. If the account listed is a joint account, both account holders' signatures are required.

## Checking Account Deduction 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 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 agree that your rights in respect to each such debit shall be the same as if it were a check drawn by you and 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 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 is dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor may result in the forfeiture of insurance.

Name of Bank	
Address	
City / State / Zip Code	

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

Policyholder's Name	
Policyholder's Social Security No. / Certificate No.	Group No.
Name on Checking Account (if different than above)	
Checking Account No.	
Authorized Signature (as it appears in the financial institution's records)	
Date	
Authorized Signature (as it appears in the financial institution's records) --	
Date	

→ Staple Blank, Voided Check Here ←