Anthem Blue Cross
Health. Join In.

Send your completed application and initial payment to:
Anthem Blue Cross Life and Health Insurance Company
P.O. Box 5028
Denver, CO 80217-5028
FAX: 877-238-1107

Anthem Blue Cross Life and Health Insurance Company
Anthem Extras Packages Enrollment Application
for individuals age 65 and over

Clear Form Fields

Agent # BCLNGNPVMZ

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

GROUP NO.	CERTIFICATE NO./IDENTIFICATION NO.

If you are an Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company member, what insurance do you currently have with us?

☐ Individual Health ☐ Individual Dental ☐ Individual Life ☐ Group Health ☐ Group Dental ☐ Group Vision ☐ Group Life/Disability

Plan choice - *select one*

Anthem Extras Packages — Dental plans provided by Anthem Blue Cross Life and Health Insurance Company

☐ Standard Package ☐ Premium Package ☐ Premium Plus Package ☐ Premium Plus Dental

Effective date requested: If your application is approved, your coverage can start on any day of the month after the date we receive your application.
Please choose the date you would like your coverage to start: _____/_____/_____ (MM/DD/YY).

Application Information: Applicant must complete this section. **PLEASE PRINT**

LAST NAME	FIRST NAME	MI	SEX	BIRTHDATE (Mo/Day/Year)	MARITAL STATUS	SOCIAL SECURITY NUMBER
			○M ○F		○S ○M	

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.	APPLICANT'S EMAIL ADDRESS
( ) -	( ) -	

Are you, the applicant, a Medi-Cal beneficiary? ○Yes ○No

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 and Dental PPO 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 OR LEGAL GUARDIAN	TODAY'S DATE
X	

Applicant Social Security or ID No.

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.

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) OLEG SKURSKIY	AGENT NUMBER BCLNGNPVMZ
Agent Street Address: 18375 VENTURA BLVD # 226		BCLNGNPVMZ
City: TARZANA	State: CA	ZIP: 91356
Agent Phone Number: 818 - 654 - 4548	Agent Email Address: OLEG@ASKOLEG.COM	

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. If paying your initial and future payments by monthly checking account deduction, please make your payment selection below. You are not required to send in a paper check for initial payment:**

☐ Monthly Checking Account Automatic Premium Payment (complete Section C)

☐ **B. If you did not select an option in Section A, please choose from the options below for your initial premium payment:**

◯ Paper Check*

C. 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 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 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 three 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 (As it appears in the financial institution's records) PRINT	Date

** 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.*