



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

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 <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. ()		APPLICANT'S EMAIL ADDRESS						
Are you, the applicant, a Medi-Cal beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> 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 X	TODAY'S DATE
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Applicant Social Security or ID No.
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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) John Conner	AGENT NUMBER CNKFGRRNQZ
Agent Street Address: 10425 Saddle Creek Drive		
City: Sacramento	State: CA	ZIP: 95829
Agent Phone Number: 916-682-1117	Agent Email Address: john@johnconner.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.)

<input type="checkbox"/> 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: <input type="checkbox"/> Monthly Checking Account Automatic Premium Payment (complete Section C)
<input type="checkbox"/> B. If you did not select an option in Section A, please choose from the options below for your initial premium payment: <input type="checkbox"/> 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.
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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)	Account Holder Name (As it appears in the financial institution's records) PRINT	Date
X		

* 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.