



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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