

Anthem[®] Dental Blue[®] Application

Please print – complete in blue or black ink only.

Important: To be eligible to apply for this coverage you must be less than 65 years of age.



Health. Join In.

Section A–Applicant Information						* This information is used for internal purposes only and will not be disclosed.										
Last Name			First Name			MI		Social Security Number*								
Home Address (street and P.O. Box if applicable)					City		State		ZIP							
County		Gender M F	Date of Birth / /		Age	Phone Number ()		E-mail (not shared with any third party)								
If you currently have medical, dental or life coverage through Anthem Blue Cross and Blue Shield: <i>Identification No.</i>																
Section B–Dental Coverage Information																
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). <input type="checkbox"/> Dental Blue[®] Basic 100 <input type="checkbox"/> Dental Blue[®] Essential 100 <input type="checkbox"/> Dental Blue[®] Essential 200																
Section C–Spouse/Domestic Partner & Child Dependents to be Covered Information (All fields required, attach separate sheet if needed)																
Dependent information must be completed for all additional dependents (if any) to be covered. List all dependents beginning with the eldest.																
First, MI (last name, if different)			Relationship to Applicant		Social Security Number*		Gender	Age	Date of Birth							
			Spouse/ Domestic Partner				M F		/ /							
			[Child]				M F		/ /							
			[Child]				M F		/ /							
			[Child]				M F		/ /							
Section D–Billing Information																
Frequency (select one) <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually			Initial Premium <input type="checkbox"/> Bank Draft (see below) <input type="checkbox"/> Credit Card (see below) <input type="checkbox"/> Premium check enclosed (make check payable to Anthem Blue Cross and Blue Shield) Initial premium amount: \$ _____													
Method (select one) <input type="checkbox"/> HOME – Bills will be to the address above unless a different address is specified below: ----- <table style="width:100%; border: none;"> <tr> <td style="width:20%;">Name</td> <td style="width:40%;">Address (street and PO Box if applicable)</td> <td style="width:15%;">City</td> <td style="width:15%;">State</td> <td style="width:10%;">ZIP</td> </tr> </table> <input type="checkbox"/> AUTOMATIC BANK DRAFT – Premium is deducted on the same day of the month as your effective date; you must attach a blank, voided check. <i>If selecting Automatic Bank Draft: I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. This authorization is in effect until I notify Anthem in writing that I no longer desire this service, allowing Anthem reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals at their discretion.</i> Account holder's name (please print) _____ Account holder's signature _____ X _____ X _____												Name	Address (street and PO Box if applicable)	City	State	ZIP
Name	Address (street and PO Box if applicable)	City	State	ZIP												
<input type="checkbox"/> CREDIT CARD – A credit card can be used only for this <u>initial premium payment</u> . If your application is accepted, you will be billed directly for future payments or you may request a Premium Payment form to change to automatic bank withdrawal. Your credit card will not be charged unless you are approved for coverage. Cardholder's Name (as shown on the credit card) and Address: X _____ <i>I authorize Anthem Blue Cross and Blue Shield to charge the credit card indicated for the amount specified in Initial Premium (above). If applicant is using the credit card of another cardholder: By signing this form, applicant represents and warrants that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for this payment and any charges accruing to it.</i> Type of Credit Card: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Amex Applicant's Signature _____ Credit Card Number _____ Expiration Date (month/year): _____ / _____																
Signature of Applicant (if age 18 or older, or Custodial Parent's or Guardian's signature if applicant is under age 18)									Date							
Signature of Spouse or Domestic Partner (if enrolling)			Date		Signature of Dependent/Child (18 or over, if enrolling)			Date								

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Section E-Agent Certification

Agent Signature X			Date
Agent Name (please print) Timothy N Jennings		Agent Street Address/Suite No./Personal Mail Box (PMB)No. P O Box 6374	
Agent ID No. G1294	City/State/Zip Jackson, WY 83002-6374	County Code	Area
Agent Phone No. (619) 435-6700	Agent Fax No. (415) 651-8696	Agent Email Address sales@individualhealth.com	
General Agent (if applicable) (please print)		General Agent code (if applicable)	