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) 987-5000 Fax: (818) 776-9865

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly, quarterly, bi-monthly.

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy

18375 Ventura Blvd. # 226

Tarzana, CA 91356

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.

If you have questions please contact our office at: (818) 987-5000

Thank you for choosing...

Anthem

Anthem

Colorado
Anthem Blue Individual PPO
Dental Plan Enrollment Application

If Anthem approves my application, please assign the following effective date: *(select one)*

- ☐ Immediately upon approval, or
- ☐ The 1st of the month following approval, or
- ☐ _____
  Specify a later date (for example, the 15th of the month following approval)

If you are an Anthem Blue Cross and Blue Shield subscriber with group health coverage, please enter your Anthem I.D. number here:

Anthem I.D. Number

Applicant Information *Applicant must complete this section. Please print.*

Last Name	First Name	MI	Social Security Number

Home Phone Number	Business Phone Number	Gender	Marital Status	Age	Date of Birth (mm/dd/yy)
( )	( )	☐ M ☐ F	☐ Single ☐ Married		

Home Address (Must be complete. A P.O. box is not acceptable.)			Billing Address (if P.O. box or different from home address)		
City	State	ZIP Code	City	State	ZIP Code

Spouse to be Insured *Signature required below*

Last Name of Spouse	First Name of Spouse	Gender	Date of Birth (mm/dd/yy)	Social Security Number
		☐M ☐ F		

Children to be Insured

	NAME (first and last name)	GENDER	DATE OF BIRTH (mm/dd/yy)	SOCIAL SECURITY NUMBER
1.		☐M ☐ F		
2.		☐M ☐ F		
3.		☐M ☐ F		
4.		☐M ☐ F		

Signatures (required)

If any family member listed above is a minor, I (Applicant) accept full legal and financial responsibility for the coverage and information provided on this application. (If the responsible adult is not the natural parent but is the legal guardian, or is under court order to provide coverage, please submit substantiating court papers.) I (Applicant) understand that coverage is subject to all conditions and provisions specified in the policy. I (Applicant) understand that receipt of payment with this application does not create Anthem Blue Cross and Blue Shield coverage. Coverage will be effective only upon approval by Anthem.

Signature of Applicant/Parent or Legal Guardian	Today's Date	Signature of Applicant's Spouse	Today's Date
X		X	
Signature of Applicant's Dependent Age 18 or Over	**Today's Date**	**Signature of Applicant's Dependent Age 18 or Over**	**Today's Date**
X		X	

Agent Information

Name of Agent (print)	Agent Tax ID Number	Signature of Agent	Today's Date
Oleg Skurskiy			

FOR ANTHEM USE ONLY

Group Number	Certificate Number	Effective Date	Area	By	Date

Mail your completed application to Anthem Blue Cross and Blue Shield with a check for the first month's premium to your agent or to: Anthem Blue Cross and Blue Shield, Individual Product Administration, P.O. Box 173334 Denver, CO 80217-9411. Thank you!

Payment Options

Applicant Social Security or ID Number

Payment Method (Premium payment required. Please choose from A or B.)

A. Please choose from the options below for your initial premium payment:

☐ Paper Check* ☐ Electronic Check ☐ Credit/Debit Card

B. Please choose from the following options for future payments.

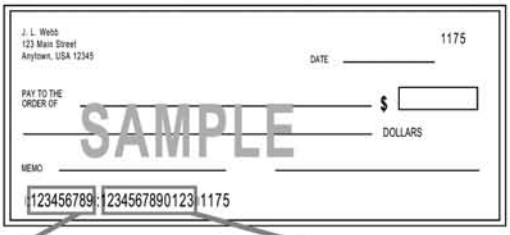
☐ Monthly Checking Account Automatic Premium Payment *(complete Section below)*
☐ Monthly Credit/Debit Card *(complete Section below)*
☐ Bi-monthly Paper Billing
☐ Monthly Paper Billing
☐ Quarterly Paper Billing—submit the three-month premium

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 sent in an initial premium payment from choice A, your bank account will be debited one month's premium the day after approval. This will include all products selected, including dental and/or life. 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.



9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Anthem Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. 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 Blue Shield 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 Blue Shield 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 will be billed monthly.

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 PRINT	Date
X		

Monthly Credit/Debit Card

As a convenience to me, I request and authorize you to charge my card 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. The amount may also change as outlined in my policy. 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 card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

☐Visa ☐ MasterCard [☐Discover]

Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ *(13 or 16 digits)*

Expiration Date: ☐☐/☐☐

Cardholder ZIP Code: ☐☐☐☐☐–☐☐☐☐

Authorized Signature *(as it appears on the credit card)*	Cardholder Name *(as it appears on the credit card)* PRINT	Date
X		

Electronic Check

In lieu of sending a paper check, we can submit this same information electronically. You will need to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

Account Holder Name PRINT	Bank Routing Number	Account Number	Amount	Check Number
			$	

** By sending your paper check, you authorize us to convert your check to an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.*