# Enrolling is Simple. Just Follow These 3 Easy Steps...

# <u>Step 1</u>

**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: fax:

## <u>Step 2</u>

**SELECT THE TYPE OF BILLING YOU WANT** – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

# Step 3

SEND THE COMPLETED APPLICATION TO:

## Please make your check payable to: Anthem Blue Cross

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

### If you have questions please contact our office at:

Thank you for choosing...





# Blue Cross Senior Dental PPO Plan Enrollment Application

If you are a Blue Cross of California or BC Life & Health subscriber, please enter your current group number and certificate number.

GROUP NO.

#### **Check Billing Type Selected**

(Attach Check Here)

Quarterly

] Monthly (By checking account deduction only.)

Bi-monthly

### PLEASE PRINT

Applicant Information: Applicant must complete this section.

First Name	MI Last Name					Social Security Number					
Home Phone	Business Ph	ione		Sex	Marital Status		Age	[	Date o	f Birth'	**
( )	( )										
Home Address (Must be complete - P.O. Bo	x not accepta	ble)		Billing Address	s (if different or P.O.	Box)					
City	S	tate	Zip Code	City			S	tate	Zip	Code	

#### Spouse To Be Insured (Sign Below)

Name of Spouse	Sex	Date of Birth**	Socia	al Sec	urity	/ Num	nber		

#### Signatures (Required)

If you are applying for coverage, please note that Blue Cross requires binding arbitration to settle all disputes, including claims of medical malpractice. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 required specified disclosures in this regard, including the following notice: 'it is understood that 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.' Both parties also agree to give up any right to purse on a class basis any claim or controversy against the other.

Signature of Applicant	Today's Date	Signature of Applicant's Spouse	Today's Date

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

**Statement of Understanding for Area 1 and 2 Non-Network Counties\*** only. I understand the difference between a Participating Dentist and a non-Participating Dentist and would like to apply. I know that I will 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.

Signature of Applicant	Today's Date	Signature of Applicant's Spouse	Today's Date

#### **Agent Information**

Name of Agen	nt (Print)	Signature of Agent	Ager	nt Tax I.D. Number		
OFFICE USE ONLY						
Group No.	Certificate No.	Agent Tax I.D. No.	Effective Date	Area	Ву	Date

\* Non-network counties include: Alpine, Mono, Sierra, Mariposa. Some counties may have limited network access, please contact your BC Life & Health representative. \*\* All applicants must be age 65 or older. DEN1002

# Monthly Bank Draft Authorization

### CHECKING ACCOUNT DEDUCTION AUTHORIZATION

As a convenience to me, I request and authorize to pay and charge to my account checks drawn account by and payable to the order of Blue Cro California (administrator for BC Life & Health In Company) provided there are sufficient collected in said account to pay the same upon presenta agree that your rights in respect to each such c shall be the same as if it were a check drawn o and signed personally by me. I authorize Blue C California (administrator for BC Life & Health In Company) to initiate debits (and/or corrections previous debits) from my account with financia institution indicated for payment of my Senior PPO Plan dues. This authority is to remain in eff until revoked by me in writing, and until you ac receive such notice. I agree that you shall be fu protected in honoring any such debit. I further that if any such debit be dishonored, whether v without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results forfeiture of insurance.

### NOTE: You will incur a service charge for any

*withdrawal not honored.* Should your withdrawal not be honored by your bank, you automatically will be removed from Monthly Checking Account Deduction and be billed quarterly. After 12 months, you may reapply for the monthly checking account deduction options.

#### Instructions:

- 1. Complete this section.
- Attach a blank check marked "VOID" to this form (deposit slips or temporary checks are not acceptable).
- Submit a check for one (1) month's premium made out to Blue Cross of California. If the account listed below is a joint account, both account holders' signatures are required.

All funds are drawn on the first of each month. Premiums may be pro-rated in order to adjust the initial paid to date or in the event of membership changes.

<b>TION</b> e YOU on that	Name of Bank
oss of isurance ed funds ition. I debit in you Cross of	Bank Address
	City/State/ZIP
isurance s to I Dental	Subscriber's Name
fect tually illy	Subscriber's Social Security No./Certificate No.
agree vith or	Group No.
in	Name on Checking Account (If different than above)
wal not Il be Iction	Checking Account No.
iay re- tion	Authorized Signature (As it appears in the financial institution's records)
	X

Date

Authorized Signature (spouse) (As it appears in the financial institution's records)

### Х

Date

Blue Cross of California is an independent licensee of the Blue Cross Association. The Blue Cross name and symbol are registered marks of the Blue Cross Association.