



Primary applicant name: _____

Welcome

California Individual Application

Thanks for choosing us. We're glad you're here.

If you have any questions while filling out this form, give us a call at 1 (877) 567-1804. But if you've worked with an agent or broker, contact them first.

About this form

Use this form to apply for **new** dental and/or vision coverage or to **change** existing coverage with Anthem Blue Cross (Anthem).

You can apply for, or change coverage:

1. During the annual Open Enrollment period

Your coverage will start based on when we receive your complete application. The earliest date coverage can start is January 1st.

If we get your application:

- Between November 1 through December 15, coverage starts January 1.
- Between December 16 and January 31, coverage starts February 1.

2. When you have a Special Enrollment period due to a qualifying event

When you're done with this form, fill out **Appendix A: Special Enrollment**, which includes information about qualifying events and when coverage starts.

For new dental and vision:

- You can apply any time of year.
- Your coverage will start based on when we receive your complete application. Coverage starts the 1st day of the month after the date we receive your complete application.

Tips for filling out this form

- Answer all questions. Please print clearly using blue or black ink only.
- Please submit all pages.
- You can also apply online at anthem.com/ca.
- If you're enrolling in a dental HMO plan, you must choose a Primary Care Dentist (PCD). View a list of dentists for your plan on anthem.com/ca or call us. If you don't choose a PCD, we'll pick one located close to you.
- Please include your payment. We can't complete your application without your first month's premium payment. Without it, your enrollment will be delayed. Don't worry though – we won't charge your card or cash your check or money order until you've been enrolled.

Some frequently asked questions

1. Do I need to include a payment?

Yes. We can't process your application without your first month's premium payment. Without it, your enrollment will be delayed. We won't charge your card or cash your check or money order until you've been enrolled.

2. Why do you need my Social Security Number (SSN)?

The IRS requires us to collect it. It won't be shared unless required by law.

Anthem Blue Cross is the trade name of Blue Cross of California.
Independent licensee of Blue Cross Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

California Individual Application

Step 1: Who is applying?

Primary Applicant				Please indicate the reason for this application: <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Special Enrollment Period (also complete Appendix A)					
Last name (legal name)				First name (legal name)		M.I.		Social Security Number - -	
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner				Sex <input type="checkbox"/> M <input type="checkbox"/> F		Date of birth (mm/dd/yyyy) / /		County (for home address)	
Home address (not a P.O. Box)				City			State		ZIP
Billing address (optional - if different than home address)				City			State		ZIP
Mailing address (optional - if different than home address)				City			State		ZIP
Email address: Applies only to Dental Net DHMO plans: I agree to receive my plan-related communications for myself and any dependents, either by email or electronically. This may include my certificate of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my benefits. I will make sure Anthem has my most up to date email. I know that at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Anthem. I (or my enrolled dependents) will update our communication preferences by going to anthem.com/ca or calling Member Services at 1 (877) -567-1804. For Dental PPO, Vision, Life and Disability plans Anthem will deliver plan materials and related items by mail.									
Primary phone					<input type="checkbox"/> Applicant DOES speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a "Statement of Accountability. (Appendix B).				
Preferred written language		<input type="checkbox"/> English (ENG) <input type="checkbox"/> Korean (KOR) <input type="checkbox"/> Other (write-in) _____			<input type="checkbox"/> Spanish (SPA) <input type="checkbox"/> Tagalog (TGL)		<input type="checkbox"/> Chinese (ZHO) (C/M) <input type="checkbox"/> Vietnamese (VIE)		
Preferred spoken language		<input type="checkbox"/> English (ENG) <input type="checkbox"/> Korean (KOR) <input type="checkbox"/> Other (write-in) _____			<input type="checkbox"/> Spanish (SPA) <input type="checkbox"/> Tagalog (TGL)		<input type="checkbox"/> Chinese (ZHO) (C/M) <input type="checkbox"/> Vietnamese (VIE)		
PCD (DHMO only)				Dental group ID/PCD ID (DHMO only)			Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No		
Coverage(s) selected <input type="checkbox"/> Dental <input type="checkbox"/> Vision To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.									

Spouse or Domestic Partner

Last name (legal name)	First name (legal name)	M.I.	Social Security Number - -
Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm/dd/yyyy) / /	
PCD (DHMO only)	PCD ID (DHMO only)	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Coverage(s) selected <input type="checkbox"/> Dental <input type="checkbox"/> Vision To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.			

Dependent Child

Children must be under age 26.

Children over the age of twenty-six (26) may be eligible for coverage as a dependent if they are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and chiefly dependent upon the policyholder or subscriber for support and maintenance. To qualify as an overage dependent, the Dependent's disability must start before the end of the period he or she would become ineligible for coverage.

Last name (legal name)	First name (legal name)	M.I.	Social Security Number - -
Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm/dd/yyyy) / /	
PCD (DHMO only)	PCD ID (DHMO only)	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Coverage(s) selected <input type="checkbox"/> Dental <input type="checkbox"/> Vision To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.			

Dependent Child

Last name (legal name)	First name (legal name)	M.I.	Social Security Number - -
Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm/dd/yyyy) / /	
PCD (DHMO only)	PCD ID (DHMO only)	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Coverage(s) selected <input type="checkbox"/> Dental <input type="checkbox"/> Vision To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.			

Dependent Child☐ **Check here if you have more dependents.** Print an extra copy of this page and attach to your application.

Last name (legal name)	First name (legal name)	M.I.	Social Security Number - -
Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth (mm/dd/yyyy) / /	
PCD (DHMO only)	PCD ID (DHMO only)	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
Coverage(s) selected <input type="checkbox"/> Dental <input type="checkbox"/> Vision To enroll a spouse/domestic partner and/or dependent, the primary applicant also must be enrolled.			

Eligibility

The answer to this question is needed to determine your eligibility.

Are any applicants currently incarcerated (with more than 60 days left to serve before release) as a result of a conviction? (not just pending disposition of charges)
☐ No ☐ Yes **If yes, who?**

Step 2: What coverage would you like?

Dental Plans

Dental coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a dental plan if you want to buy coverage for more than these Pediatric Dental Essential Health Benefits.

Dental HMO applicants must reside in one of these counties to enroll: Alameda; Contra Costa; El Dorado; Fresno; Kern except for Delano, Mojave, Taft, and Tehachapi; Kings; Los Angeles; Marin; Monterey; Orange; Placer; Riverside; Sacramento; San Bernardino except for Twenty-Nine Palms and Vicinity, and Yucca Valley; San Diego; San Francisco; San Joaquin; San Luis Obispo; San Mateo; Santa Barbara; Santa Clara; Santa Cruz; Solano; Sonoma; Tulare; Ventura.

Dental plan options

Dental PPO

- ☐ Essential Choice Bronze (5SKJ)*
- ☐ Essential Choice Silver (5SKK)*
- ☐ Essential Choice Gold (5SKL)*
- ☐ Essential Choice Platinum (5SKM)*
- ☐ Essential Choice Incentive (5SKN)*

Dental HMO (DHMO)

- ☐ Dental Net 3000D (3T9D)**

* These products are issued by Anthem Blue Cross Life and Health Insurance Company and are regulated by the California Department of Insurance.

** These products are issued by Anthem Blue Cross and are regulated by the California Department of Managed Health Care.

Prior & other dental coverage

Name of person covered (Last, First, M.I.)	Coverage (check all that apply)	Insurer name	Policy ID no.	Dates (if applicable) (mm/dd/yyyy)
	<input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: End:
	<input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: End:
	<input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: End:
	<input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: End:
	<input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			Start: End:

Vision Plan

Vision coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a vision plan if you want to buy coverage for more than these Pediatric Vision Essential Health Benefits.

Vision plan options

- ☐ Blue View Vision Basic (5LBZ)
- ☐ Blue View Vision Premier (5LEZ)
- ☐ Blue View Vision Ultra (5LDK)
- ☐ Blue View Progressive Select (5LAP)
- ☐ Blue View Progressive Preferred (5LAK)
- ☐ Blue View Vision Plus (2SU7)
- ☐ Blue View Vision Value (2SU8)
- ☐ Blue View Vision Enhanced (2SU6)
- ☐ Blue View Vision Bundled (1RYD)

Step 3: Please read and sign

Important legal information

All Applicants

I, the undersigned, understand that under the (Anthem) plan/policy in which I am enrolling, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician. Contact customer service at 1 (855) 383-7247 with any questions about the use of network providers and the financial impact of using out-of-network providers.

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.

I understand that:

- I must include my first premium payment with this application, but that does not mean coverage has been processed. I'm applying for the coverage I chose in Step 2. Anthem has the right to accept or decline this application. If my application is denied, my bank account or credit card will not be charged, and if I paid with a money order, it will be returned to me.
- I'm responsible to let Anthem know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- Check payments may be handled as Automated Clearinghouse (ACH) debit transactions. That means if I pay by check, the paper check will be destroyed and the debit payment will appear on my bank statement. My check won't be given to my financial institution or sent back to me. This does not mean I will be enrolled in an automatic debit process to pay my premium. Any resubmissions due to insufficient funds may also be electronic. All checking transactions will remain secure, and my payment by check means I agree to these terms.
- I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and me.
- By providing a phone number, I agree and consent that Anthem and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.
- I'm applying for individual dental and/or vision coverage which is not part of any employer sponsored plan and I'm responsible for all of the premium payments and making sure that all premiums are paid on time.
- I certify that each Social Security Number listed on this application is correct.
- My Domestic Partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.

I represent that I have read the Important Legal Information section, and I agree to the coverage conditions. I represent the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem in accepting this application. Within the first 24 months following issuance of this policy, any act or practice that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits or cancellation of my coverage(s).

I sign this application for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative. This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE AGREEMENT OR ANY OTHER ISSUES RELATED TO THE AGREEMENT AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. FOR CLAIMS THAT EXCEED THE JURISDICTION OF THE SMALL CLAIMS COURT THAT ARE SUBJECT TO BINDING ARBITRATION UNDER THIS AGREEMENT, CALIFORNIA HEALTH AND SAFETY CODE SECTION 1363.1 AND INSURANCE CODE SECTION 10123.19 REQUIRE SPECIFIED DISCLOSURES IN THIS REGARD: 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, NEGLIGENCE OR INCOMPETENTLY RENDERED, WILL BE DETERMINED BY SUBMISSION TO ARBITRATION AS PERMITTED AND PROVIDED BY FEDERAL AND CALIFORNIA LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, 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. YOU AND ANTHEM BLUE CROSS AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. IF YOUR POLICY IS SUBJECT TO 45 CFR 147.136, THIS AGREEMENT DOES NOT LIMIT YOUR RIGHTS TO INTERNAL AND EXTERNAL REVIEW OF ADVERSE BENEFIT DETERMINATIONS AS REQUIRED BY THAT LAW. ENFORCEMENT OF THIS ARBITRATION CLAUSE, INCLUDING THE WAIVER OF CLASS ACTIONS, SHALL BE DETERMINED UNDER THE FEDERAL ARBITRATION ACT ("FAA"), INCLUDING THE FAA'S PREEMPTIVE EFFECT ON STATE LAW. BY SIGNING, WRITING OR TYPING YOUR NAME BELOW YOU AGREE TO THE TERMS OF THIS AGREEMENT AND ACKNOWLEDGE THAT YOUR SIGNED, WRITTEN OR TYPED NAME IS A VALID AND BINDING SIGNATURE.

Please sign below

	Primary Applicant (or legal representative)	Date (mm/dd/yyyy)
	Spouse/Domestic Partner (or legal representative)	Date (mm/dd/yyyy)
	Dependent Child (age 18 or over)	Date (mm/dd/yyyy)
	Dependent Child (age 18 or over)	Date (mm/dd/yyyy)
	Dependent Child (age 18 or over)	Date (mm/dd/yyyy)

Did an agent or broker help you?

☐ Yes ☐ No If yes, make sure they fill out this section.

Agent (or Broker) Certification

All fields required.

I certify to the best of my knowledge and belief, the responses herein are accurate.

- ☐ I have not had any interactions whatsoever with this applicant either by phone, e-mail or in person and did not provide any information, advise or assist the applicant in any manner in providing answers or responses to any questions in the application.
- ☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars (\$10,000), as authorized under California Health and Safety Code Section 1389.8(c)/Insurance Code Section 10119.3.

Agent/Broker signature

Date (mm/dd/yyyy)

Agent name (please print clearly)

*(A) Writing Agent TIN/SSN (encrypted TIN is ok)

** (B) Writing Agent/Agency/ TIN (encrypted TIN is ok)

Agent address

City

State

ZIP

Agent phone no.

Agent fax no.

Agent email

Field (A)** – If you are a Direct Agent, provide your Writing Agent TIN/SSN. *Field (B)** - If this policy is sold through an Agency without a Writing Agent, enter the selling Agency TIN in Field (A) and Field (B); If you are a Writing Agent and this policy is sold through an Agency, enter the Writing Agent TIN/SSN in Field (A) and the selling Agency TIN in Field (B).

Here's what's next.

- 1) Can you check a few items? When illegible or missing, they can cause enrollment delays.
 - Your name and address is clear and complete.
 - You've included your first month's premium payment.
 - Everyone 18 and older applying for coverage signed this form
 - Please make sure you submit all the pages of the application, including this page, even if you don't have an agent.
 - If enrolling due to a qualifying event, you've completed Appendix A: Special Enrollment.
- 2) All good? Send this to us by mail to Anthem Dental, P.O. Box 659960, San Antonio, TX 78265-9146 or by fax to 1 (800) 848-2512.
- 3) We'll be in touch in the next few weeks (or sooner). If you have questions before then, call us at 1 (877) 567-1804.

Thank you!

Appendix A: Special Enrollment

If you're an existing member and wish to change coverage or add or remove a dependent(s), please fill out this section along with your application.

Qualifying event date	
Date of qualifying event (mm/dd/yyyy) / /	For Loss of Coverage, this is the last date of existing or prior coverage. For all other events, please enter the date based on the qualifying event.

You must apply for coverage within 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
<input type="checkbox"/> 1. Marriage or Domestic Partnership Got married or in a domestic partnership that becomes eligible for coverage (see step 3 for description of eligibility).	First day of the month after we receive your complete application
<input type="checkbox"/> 2. Birth or adoption Had a baby, adoption of a child or placement of a child with you for adoption	Select an effective date: <input type="checkbox"/> Same as the event date <input type="checkbox"/> First day of the month after we receive your complete application <input type="checkbox"/> Based on when we receive your complete application* <input type="checkbox"/> First day of month after the event date
<input type="checkbox"/> 3. Court order or guardianship Required by a court order to provide an eligible child(ren) coverage, including a child support order, filed an application for appointment of guardianship of a child or appointment of guardianship of a child	Select an effective date: <input type="checkbox"/> Same as the event date <input type="checkbox"/> Based on when we receive your complete application*
<input type="checkbox"/> 4. Death Death of a family member enrolled under current coverage	Select an effective date: <input type="checkbox"/> First day of the month after we receive your complete application <input type="checkbox"/> Based on when we receive your complete application*
<input type="checkbox"/> 5. Returning from active duty Member of the Reserve Forces of the U.S. military returning from active duty or member of the California National Guard returning from active duty under Title 32 of the U.S. Code	Based on when we receive your complete application*
<input type="checkbox"/> 6. Loss of coverage: Lost or will lose Minimum Essential Coverage: Involuntary loss of coverage (loss of minimum essential coverage includes loss of eligibility of coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, permanent move, etc. Loss of eligibility for coverage does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).	First day of the month after we receive your complete application

* If the coverage date is based on when we receive your complete application, then if we receive it:

- Between the 1st and 15th day of the month, coverage starts the 1st day of the following month.
- Between the 16th and the last day of the month, coverage starts the 1st day of the second following month.

You must apply for coverage within 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
<p>7. Permanent move</p> <p><input type="checkbox"/> Moved to U.S. from a foreign country or a U.S. territory</p> <p><input type="checkbox"/> Permanent move to a new service area (within the U.S.).</p> <p><input type="checkbox"/> 8. Non-calendar renewal</p> <p>Current policy does not renew on a calendar year basis (renews on a date other than January 1)</p> <p><input type="checkbox"/> 9. Jail or prison</p> <p>Released from jail or prison (incarceration)</p>	Based on when we receive your complete application*

* If the coverage date is based on when we receive your complete application, then if we receive it:

- Between the 1st and 15th day of the month, coverage starts the 1st day of the following month.
- Between the 16th and the last day of the month, coverage starts the 1st day of the second following month.

Almost there! We may need a bit more info.

We need supporting documentation for most qualifying events, such as a letter or official form from the source (employer, state or federal agency, for example) to confirm the qualifying event occurred. It should also include the date the event happened, and the names of all applicants affected. If you're applying because you've lost coverage, we need supporting documentation with the reason coverage was lost. In all cases, we might need additional documentation to confirm eligibility.

Give us or your agent a call if you have any questions.

Appendix B: Statement of Accountability

Statement of Accountability

Fill out when applicant cannot complete application.

Note: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I, _____, personally read and completed this Individual Application for the applicant named below because:

- ☐ Applicant does not read English
- ☐ Applicant does not speak English
- ☐ Applicant does not write English
- ☐ Applicant is Limited English Proficient
- ☐ Other (explain) _____

I interpreted the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the

☐ Applicant or by: _____

Language interpreted

☐ Spanish ☐ Chinese ☐ Korean ☐ Tagalog ☐ Vietnamese ☐ Other _____

I also interpreted and fully explained the "Important legal information" and the "Payment Method".

Signature of interpreter (required)

Date (mm/dd/yyyy) (required)

I confirm that the application was interpreted on my behalf

Signature of applicant (required)

Date (mm/dd/yyyy) (required)

Applicant/Member name	Primary applicant's Social Security number
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I, the applicant am responsible for monthly payments to Anthem. I authorize Anthem to debit the bank account listed or charge the credit/debit card listed for my first monthly payment on or after the day that my coverage is approved. By signing this form, I understand that the amount of the first payment may change from what I was told because my coverage has not been approved yet. In addition if I select Option 1 or Option 2 below, I understand that my future payments may vary as a result of changes(s) I make once enrolled, including but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified according to my plan/policy. In addition, I understand if changes I make are close to the auto withdrawal date, Anthem may not be able to notify me before the withdrawal is made. **I agree to pay any service charge that Anthem may bill me because the debit/charge was not honored.** I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Please choose how you want to pay your monthly payments for all of your plans. Put a check in the box for either Option 1, Option 2 or Option 3.

☐ **Option 1 Bank Account Authorization: Have your first and future monthly payments automatically deducted from your bank account.**

All of your monthly payments will be taken out of the bank account you check below.

Checking account: ☐ Business ☐ Personal

Savings account: ☐ Business ☐ Personal

Enter the requested debit date from your bank account (1st to 6th of each month). If no date is requested your monthly payments will be debited on the first of each month.

Write the routing and account numbers that are on your check here: →

MEMO	
123456789	1234567890123 1175

9-digit bank routing number	Bank account number
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I authorize Anthem to automatically debit the bank account listed above each month to make my monthly payments. I agree that **Anthem's rights with each debit are the same as if the debit was a check that I signed.** I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem to automatically debit my account (and to make corrections to previous debits). This authority stays in effect until I let Anthem know that I no longer want them to debit my account by giving them a 30-day advance written notice. I understand that if my bank does not allow Anthem to debit my account for any reason, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Authorized signature (as it appears on bank's records) X	Printed bank account holder's name (as it appears on account)	Date (MM/DD/YY)
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☐ **Option 2 Credit/Debit Card Authorization: Have your first and future monthly payments automatically charged to your credit/debit card.**

Complete the information below

Enter the requested charge date for your credit/debit card (1st to 6th of each month).

I authorize Anthem to automatically charge my credit/debit card listed below each month to make my monthly payments. I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem to charge my credit/debit card until I let them know that I no longer want them to charge my credit/debit card by giving them a 30-day advance written notice. I agree that Anthem, in honoring the monthly payments charged to my credit/debit card, is not responsible for any fees charged by my bank. I understand if that if any Anthem credit/debit transaction is not honored, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Anthem accepts ☐ Visa or ☐ Mastercard (Note to applicant: Please check one.)

Card number	Expiration date <input type="text"/> (MM/YY)	
Billing address for this credit/debit card	City	Zip code
Authorized signature (as it appears on card) X	Printed card holder's name (as it appears on card)	Date (MM/DD/YY)

See page two for Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.

Applicant/Member name	Primary applicant's Social Security number <div style="border-bottom: 1px solid black; width: 100px;"></div>
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☐ **Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.**
 Choose one of the ways below that you would like to pay only your first monthly payment.
☐ Check (enclose your paper check with application) ☐ Electronic check (fill out section A below) ☐ Credit/Debit card (fill out section B below)
A. Electronic check: Instead of sending us a paper check, you can use an electronic check that allows Anthem to take the money right from your bank account to make your first payment on the day that your coverage is approved. You will not get the check back from your bank. (We will not keep this information on file or use it for any future payments.) Please fill out this information.

Printed account holder name	Routing number	Account Number	Amount of first payment \$
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B. Credit/Debit card: I allow Anthem to charge the credit or debit card I listed below one time for my first monthly payment. This payment will cover the first monthly payment for all of the plans I have with Anthem.
 Anthem accepts ☐ Visa or ☐ Mastercard (Note to applicant: Please check one.)

Card number	Expiration date <div style="border-bottom: 1px solid black; width: 40px;"></div> (MM/YY)
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Billing address for this credit/debit card	City	Zip code
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I authorize Anthem to debit/charge the bank account or credit/debit card listed above **to make my first monthly payment only.**
 I agree that Anthem will not have to pay any fees that my bank may charge because my electronic check or credit/debit card was rejected even if I can no longer continue coverage. I understand that **this is a one-time payment and that I am responsible for making sure Anthem receives my future monthly payments after this first payment.**

Authorized signature (as it appears on bank account/card) X	Printed bank account/card holder's name (as it appears on account/card)	Date (MM/DD/YY) <div style="border-bottom: 1px solid black; width: 100px;"></div>
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Get help in your language

Language Assistance Services



Curious to know what all this says? We would be too. Here's the English version:

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما لمساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721. (TTD/TTY: 711)

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող եք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese

重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTD/TTY: 711)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwv tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要: この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Khmer

សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចចូលរណាម្នាក់អានវាជូនអ្នក។
អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសាសាបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ
សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721 (TTY/TDD: 711)

Korean

중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵੱਖੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ।
(TTY/TDD: 711)

Russian

ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้
เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย
หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.