

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.

California Individual Application

Please indicate the reason for this application:

- Open Enrollment
 Special Enrollment Period (also complete Appendix A)

Step 1: Who is applying?

New coverage

- Change coverage
 Add dependent to existing coverage

Subscriber ID no. _____

Primary Applicant

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

- 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"/> Spanish (SPA)	<input type="checkbox"/> Chinese (ZHO) (C/M)
	<input type="checkbox"/> Korean (KOR)	<input type="checkbox"/> Tagalog (TGL)	<input type="checkbox"/> Vietnamese (VIE)
	<input type="checkbox"/> Other (write-in) _____		

Preferred spoken language	<input type="checkbox"/> English (ENG)	<input type="checkbox"/> Spanish (SPA)	<input type="checkbox"/> Chinese (ZHO) (C/M)
	<input type="checkbox"/> Korean (KOR)	<input type="checkbox"/> Tagalog (TGL)	<input type="checkbox"/> Vietnamese (VIE)
	<input type="checkbox"/> Other (write-in) _____		

PCD (DHMO only)	Dental group ID/PCD ID (DHMO only)	Current Patient <input type="checkbox"/> Yes <input type="checkbox"/> No
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Coverage(s) selected Dental 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, NEGLIGENTLY 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> <ul style="list-style-type: none"><input type="checkbox"/> Moved to U.S. from a foreign country or a U.S. territory<input type="checkbox"/> Permanent move to a new service area (within the U.S.). <p><input type="checkbox"/> 8. Non-calendar renewal 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 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)
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I confirm that the application was interpreted on my behalf

Signature of applicant (required)	Date (mm/dd/yyyy) (required)
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