



Attach Check Here

**Anthem Blue Cross Life and Health Insurance Company
Individual Dental Blue PPO Plan Enrollment Application**

If you are an Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company subscriber, please enter your current group number and certificate number.

GROUP NO.	CERTIFICATE NO.
-----------	-----------------

Check Billing Type Selected

- Monthly (by checking account deduction only)
 Bimonthly Quarterly

Select One

Dental Blue 100 Basic
 Dental Blue 200 Essential
 Dental Blue 100 Plus
 Dental Blue 200 Plus

Application Information: Applicant must complete this section.

PLEASE PRINT

LAST NAME	FIRST NAME	MI	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M	SOCIAL SECURITY NUMBER
HOME ADDRESS (Must be complete, P.O. Box not acceptable)				BILLING ADDRESS IF DIFFERENT (or P.O. Box)		
CITY	STATE	ZIP CODE	CITY	STATE	ZIP CODE	
HOME PHONE NO. ()			BUSINESS PHONE NO. ()			

Spouse To Be Insured (Sign Below)

NAME OF SPOUSE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	SOCIAL SECURITY NUMBER
----------------	--	-------------------------	------------------------

Children To Be Insured

NAME (First and Last) 1.	SEX	BIRTHDATE (Mo/Day/Year)	NAME (First and Last) 3.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)
NAME (First and Last) 2.	SEX	BIRTHDATE (Mo/Day/Year)	NAME (First and Last) 4.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)

Signatures (Required)

Any dispute between you and Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both you and Anthem Blue Cross and its affiliates are giving up the right to have any dispute decided in a court of law before a jury.

Statement of Understanding for areas with limited availability. I understand the difference between a Participating Dentist and a Non-Participating Dentist, and would like to apply. I know that I 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/PARENT OR LEGAL GUARDIAN X	TODAY'S DATE	SIGNATURE OF APPLICANT'S SPOUSE X	TODAY'S DATE
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER X	TODAY'S DATE	SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER X	TODAY'S DATE

Agent Information

SIGNATURE OF AGENT X	AGENT NAME (PRINT) Thomas J. Roberts	AGENT NUMBER DHKGPQNVZ
--------------------------------	---	---------------------------

FOR ANTHEM BLUE CROSS ONLY

GROUP NO.	CERTIFICATE NUMBER	AGENT NO.	EFFECTIVE DATE	PRE-EXIST	AREA	BY	DATE
-----------	--------------------	-----------	----------------	-----------	------	----	------

Optional monthly checking account deduction

- ① Complete this section.
- ② Attach a blank check marked "VOID" to this form. (DEPOSIT SLIPS or TEMPORARY CHECKS ARE NOT ACCEPTABLE).
- ③ Submit a check for one month's premium payable to Anthem Blue Cross. If the account listed is a joint account, both account holders' signatures are required.

Checking Account Deduction Authorization

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and made payable to the order of Anthem Blue Cross, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn by you and signed personally by me. I authorize Anthem Blue Cross to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross premiums. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit is dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor may result in the forfeiture of insurance.

Name of Bank	
Address	
City / State / Zip Code	

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 will be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction option.

Policyholder's Name	
Policyholder's Social Security No. / Certificate No.	Group No.
Name on Checking Account (if different than above)	
Checking Account No.	
Authorized Signature (as it appears in the financial institution's records)	
Date	
Authorized Signature (as it appears in the financial institution's records) --	
Date	

→ **Staple Blank, Voided Check Here** ←