How to Enroll

For new members enrolling in dental coverage only:

- Complete and sign the attached application. Note: The participating dentist that you choose must appear on your application. You and your dependents must select the same participating general dentist.
- Determine your premium.
- Choose your payment plan.
- Write a check payable to Anthem Blue Cross or use a credit card.
- Send the application and payment to the appropriate Anthem Blue Cross address below, or to your agent.

For new members enrolling in Anthem Blue Cross medical and dental coverage:

- See instructions on the Individual Enrollment Application.

For Anthem Blue Cross medical members who want to add dental:

- Complete and sign the attached application.
- Determine your premium.
- Choose your payment plan.*
- Write a check payable to Anthem Blue Cross or use a credit card.
- Send the application and payment** to the appropriate Anthem Blue Cross address, or to your agent.

*You must select the same payment option for your ***dental*** plan that you have for your ***medical*** plan.

Even if you pay your ***medical* premium by a monthly checking account automatic premium payment, you must send the first month's ***dental*** premium with the application.

To determine your initial premium:*

- If you want to pay your bill **monthly**, fill out the attached Checking Account Automatic Premium Payment Authorization or credit card authorization along with a check for one month's premium.
- If you want to pay your bill **every other month (bimonthly)**, write a check for two months' premium.
- If you want to pay your bill **every three months**, write a check for three months' premium.

*If you are an Anthem Blue Cross medical plan member, you must select the same payment option for your ***dental*** plan that you have for your ***medical*** plan.

Send your application and payment to one of the following addresses:

Dental SelectHMO Plan enrollees under 65:
Oleg Skurskiy
18375 Ventura Blvd. # 226
Tarzana ,CA 91356

Dental SelectHMO Plan enrollees over 65:**
Oleg Skurskiy
18375 Ventura Blvd. # 226
Tarzana ,CA 91356

** Eligibility, rates and billing options for the SelectHMO dental products vary for Individuals over 65. Please contact your agent call 818-654-4548 for more information.

Authorized Independent Agent

or Fax the complete application at :

Fax 818-776-9865

Dental SelectHMO Enrollment Application

If you are an Anthem Blue Cross member, please enter your current Anthem Blue Cross group number and certificate number below.

Group No. | Certificate or ID No. | Proposed Effective Date

Plan Choice

☐ Saver SelectHMO (40) ☐ SelectHMO (41) ☐ Premier SelectHMO (42) **Dental Office No:**

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

Last Name	First Name	MI	Social Security No. or ID No.

Home Phone No.	Business Phone No.	Sex	Marital Status	Age	Date of Birth
( )	( )	☐ M ☐ F	☐ Single ☐ Married		

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

Spouse to be Included – Signature required below.

Last Name of Spouse	First Name	Sex	Date of Birth	Social Security No. or ID No.
		☐ M ☐ F		

Children to be Included

NAME (First and Last Name)	SEX	BIRTHDATE Mo Day Yr	NAME (First and Last Name)	SEX	BIRTHDATE Mo Day Yr
1			3		
2			4		

Signatures *(Required)*

Authorization to Obtain or Release Medical Information: I understand that California law prohibits an HIV test from being required or used as a condition of obtaining medical coverage.

If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)

I have personally read and completed this application. If I am accepted, this application will become part of the contract between Anthem Blue Cross and me. I and any enrolled family members agree to abide by the terms of that contract, including the arbitration provision that provides as follows:

Even if I pay money with this application, that money is only a deposit against future premium if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Anthem Blue Cross nor any affiliated company shall have any liability to me or anyone else listed on it, except for the obligation to return the money submitted with this application. If this application is not accepted, neither I nor anyone listed on it will be entitled to benefits or coverage from Anthem Blue Cross.

I also understand that only the services I receive from my Anthem Blue Cross Dental SelectHMO participating provider are covered by the plan or are subject to a savings if not covered.

Requirement for Binding Arbitration

If you are applying for coverage, please note that Anthem Blue Cross requires binding arbitration to settle all disputes against Anthem Blue Cross, including claims of medical malpractice. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require 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 proceeding. 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 pursue on a class basis any claim or controversy against the other.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

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	

Name of Agent (Print)	Agent No.	Signature of Agent	Today's Date
OLEG SKURSKIY	BCLNGNPVMZ	X Oleg Skurskiy	

BCLNGNPVMZ

ATTACH BLANK, VOIDED CHECK FOR BANK DRAFT AUTHORIZATION, IF APPLICABLE, HERE. DO NOT TAPE.

Applicant's Social Security or ID No.

Payment Method **Premium payment required. First payment will be credited to approved applicants only.** By sending your check to us, you authorize Anthem Blue Cross to convert your check into 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.

Credit Card **FAX to: (800) 327-9255**

☐ **Initial premium (For new member's Medical and Dental fees only)** ☐ **Monthly premiums**

Monthly Credit Card Authorization - 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 amount may vary as a result of changes I make, such as, but not limited to, adding and deleting dependents, or moving to a new location. 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. Credit Card: ☐ VISA ☐ MasterCard ☐ Discover

Card No.: Exp. :_____ Cardholder's Zip Code –

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

Checking Account Automatic Premium Payment

☐ **Monthly checking account deduction premium payments**

Name of Bank or Financial Institution: _____

Account No.: Bank Routing No.:

Submit a blank check marked "VOID" above where indicated (DEPOSIT SLIPS NOT ACCEPTABLE). If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account. Premiums may be prorated in order to adjust the initial paid to date or in the event of membership changes.

Monthly Checking Account Automatic Premium Payment – 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 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 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 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 be billed bimonthly. **You may incur a $25 service charge for any withdrawal not honored**.

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

Billing

☐ **Bimonthly** (Submit 2 months premium) ☐ **Quarterly** (Submit 3 months premium)

FOR ANTHEM BLUE CROSS USE ONLY

Group No.	Certificate No.	Agent I.D. No.	Effective Date
Pre-Exist	Area	By	Date