Primary applicant name: _____

Welcome

California Individual Application

Dental HMO applicants must reside in one of these counties to enroll: Alameda County, Contra Costa, El Dorado except for Placerville and Lake Tahoe, Fresno, Kern except for Delano, Mojave, Taft, Tehachapi, Kings except for Hanford, Los Angeles, Marin, Monterey except for Salinas, Orange, Placer except for Lake Tahoe, Riverside except for Banning/Beaumont, Blythe, Twenty-Nine Palms and Yucca Valley, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz except for the city of Santa Cruz, Solano, Sonoma, Tulare except for Visalia, Ventura except for Santa Paula/Fillmore

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) 212-1796. But if you've worked with an agent or broker, contact them first.

About this form

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

You can apply for or change coverage any time during the year.

Tips when filling out this form

1. Answer all questions. Please print clearly using blue or black ink only.
2. You can also apply online at **anthem.com/ca**.
3. Refer to your Health Plan Guide for plan and enrollment details. Don't have a copy? Ask your agent or contact us.
4. 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 close to you.

Some frequently asked questions

1. **Do I need to include a payment?**
   Yes. 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.
2. **What if I already have coverage with another company?**
   Don't cancel your other coverage yet – your coverage is too important. We'll contact you when you're approved. Then you'll need to cancel your other coverage.

Please indicate the reason you are submitting this application for medical:
☐ Open Enrollment
☐ Special Enrollment Period – must also complete Appendix A

Step 1: Who is applying?

Primary Applicant

☐ New coverage ☐ Change coverage ☐ Add dependent to existing coverage ID No. _____

Last Name (Legal Name)	**First Name** (Legal Name)	**M.I.**	**Social Security Number**

Marital status ☐ Single ☐ Married ☐ Domestic Partner	**Sex** ☐ M ☐ 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 your home)	**City**	**State**	**ZIP**
Mailing address (optional - if different than your home)	**City**	**State**	**ZIP**

Primary phone	**Secondary phone**	**Email address**

Preferred written language ☐ English (ENG) ☐ Spanish (SPA) ☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Tagalog (TGL) ☐ Vietnamese (VIE) ☐ Other (write-in) _____

Preferred spoken language ☐ English (ENG) ☐ Spanish (SPA) ☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Tagalog (TGL) ☐ Vietnamese (VIE) ☐ Other (write-in) _____

☐ 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".

Primary Care Dentist (PCD)(DHMO only)	**PCD ID** DHMO only	**Current patient** ☐ Yes ☐ No

Coverage(s) Selected ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse/Domestic Partner and/or dependent coverage eligibility

Spouse or Domestic Partner

Last Name (Legal Name)	**First Name** (Legal Name)	**M.I.**	**Social Security Number**

Relationship to applicant ☐ Spouse ☐ Domestic Partner	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)

Primary Care Dentist (PCD)(DHMO only)	**PCD ID** DHMO only	**Current patient** ☐ Yes ☐ No

Coverage(s) Selected ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse/Domestic Partner and/or dependent coverage eligibility

Child dependent 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 ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)	
Primary Care Dentist (PCD)(DHMO only)	**PCD ID** DHMO only	**Current patient** ☐ Yes ☐ No	

Coverage(s) Selected ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse/Domestic Partner and/or dependent coverage eligibility

Child dependent

Last Name (Legal Name)	**First Name** (Legal Name)	**M.I.**	**Social Security Number**
Relationship to applicant ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)	
Primary Care Dentist (PCD)(DHMO only)	**PCD ID** DHMO only	**Current patient** ☐ Yes ☐ No	

Coverage(s) Selected ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse/Domestic Partner and/or dependent coverage eligibility

Child dependent ☐ **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 ☐ Child ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy)	
Primary Care Dentist (PCD)(DHMO only)	**PCD ID** DHMO only	**Current patient** ☐ Yes ☐ No	

Coverage(s) Selected ☐ Dental* ☐ Vision*
*Primary applicant must be included for Spouse/Domestic Partner and/or dependent coverage eligibility

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?**

Do you have a child age 26 or over who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition for whom coverage is being requested under this contract?
☐ No ☐ Yes **If yes,** you must submit a separate disabled dependent form to determine eligibility.
☐ Check this box and we'll send you the form.

Step 2: What coverage would you like?

Dental Plans

Dental HMO applicants must reside in one of these counties to enroll: Alameda County, Contra Costa, El Dorado except for Placerville and Lake Tahoe, Fresno, Kern except for Delano, Mojave, Taft, Tehachapi, Kings except for Hanford, Los Angeles, Marin, Monterey except for Salinas, Orange, Placer except for Lake Tahoe, Riverside except for Banning/ Beaumont, Blythe, Twenty-Nine Palms and Yucca Valley, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz except for the city of Santa Cruz, Solano, Sonoma, Tulare except for Visalia, Ventura except for Santa Paula/Fillmore

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 and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Dental plan option

- ☐ Prime Plan A (1RBD) *
- ☐ Prime Plan B (1RBE) *
- ☐ Prime Plan C (1RBF) *
- ☐ Dental Blue Basic (1JZ5) *
- ☐ Dental Blue Enhanced (1JZ6) *
- ☐ Dental Select HMO (1F3E) **

Prior & other dental coverage It's important we know.

- ☐ I currently have dental coverage (please fill out the info below)
- ☐ I previously had dental coverage
- ☐ I previously had orthodontia coverage

People with coverage (write ALL if everyone applying):

Prior or other dental coverage company:	**Effective date** (when this coverage started)
ID Number:	**Last date of coverage** (if applicable)

* 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.

Dental SelectHMO dentist If you choose the Dental SelectHMO plan, you must choose a Primary Care Dentist for the family and enter the number of the Dental Office you have chosen.

Primary Care Dentist	**Current Patient** ☐ Yes ☐ No	**Primary Care Dentist Number**

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 and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Vision plan option

- ☐ Blue View Vision Bundled (1RYD)
- ☐ Blue View Vision Enhanced (2SU6)
- ☐ Blue View Vision Plus (2SU7)
- ☐ Blue View Vision Value (2SU8)

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 send my first (initial) premium with this application, but it does not mean coverage has been approved. I'm applying for the coverage I chose on this form. To the extent permitted by law, Anthem has the right to accept or decline this application, and that there are no guarantees of any kind just because I filled out this form. 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.
- Anthem may change check payments to electronic Automated Clearinghouse (ACH) debit transactions. If this happens, my original check will be destroyed. This charge will appear on my bank statement but my check won't be given to my financial institution or sent back to me. This charge will not enroll me in any Anthem automatic debit process and will only occur each time I send a check to Anthem. Any resubmissions due to insufficient funds may also occur electronically. 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 myself.
- 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.
- 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'm signing here because I want to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, billing, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.
- I acknowledge that I have read the Important Legal Information section, and I agree to the coverage conditions. I state that 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. 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 give this authorization 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

YOU AND ANTHEM BLUE CROSS AGREE TO BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN /POLICY AND CLAIMS OF MEDICAL MALPRACTICE, 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. IT IS UNDERSTOOD THAT ANY DISPUTE INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY, INCLUDING 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, ANTHEM BLUE CROSS AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN YOUR OR ITS INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

By signing this application, I certify that the premium for my coverage will not be paid by a provider of health care services, hospital, non-profit organizations (including religious organizations) that have or whose primary donors have a financial interest in the benefits of the contract/evidence of coverage/policy, commercial entity with a direct or indirect financial interest in the benefits of the contract/evidence of coverage/policy or an employer that offers coverage under an employer health plan. I understand that if a third party is paying my premium, Anthem may decline to accept such premium payment if it is made by a person or entity from which it is not required by law to accept.

Please sign below

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

Did an agent help you? Make sure they fill out this section.

Agent (or broker) Certification All fields required.

I certify to the best of my knowledge, 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**

Agent Name (Please print clearly)

(A) Writing Agent TIN/SSN (Encrypted TIN is ok)	***(B) Writing Agent/Agency TIN** (Encrypted TIN is ok)		
Timothy N Jennings			
Agent address	**City**	**State**	**ZIP**
P O BOX 6374	Jackson	WY	83002

Agent Phone No.	**Agent Fax No.**	**Agent Email**
(307) 690-0427		sales@individualhealth.com

*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 incorrect, they're the most frequent reasons for delays in enrollment.
   - Your name and address information should be clear and readable
   - You've included your first month's premium payment
   - Everyone 18 and older signed this form
   - 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 Blue Cross, PO 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. If you have questions before then, call us at 1 (855) 383-7247.

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	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
☐ **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
☐ **2. Birth or Adoption** Had a baby, adoption of a child or placement of a child with you for adoption	**Select an effective date:** ☐ Same as the event date ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application* ☐ First day of month after the event date
☐ **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:** ☐ Same as the event date ☐ Based on when we receive your complete application*
☐ **4. Death** Death of a family member enrolled under current coverage	**Select an effective date:** ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application*
☐ **5. Lost service from contracted provider** Loss of services from contracting provider under another health benefit plan, as defined in Sections 10965 of the Insurance Code or 1399.845 of the Health and Safety Code, for a condition described in Health and Safety Code § 1373.96(c) (an acute condition, serious chronic condition, pregnancy, terminal illness, care of newborn between birth and 36 months of age, or performance of a surgery or other procedure that has been recommended and documented by the provider) and that provider is no longer participating in the health benefit plan	Based on when we receive your complete application*
☐ **6. 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*

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

Qualifying events	Coverage effective date
7. 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. Loss of eligibility 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) ☐ Moved to a new service area. Minimum Essential Coverage must have been in effect for one or more days of the 60 days prior to the move	First day of the month after we receive your complete application
☐ **8. Permanent Move** Moved to U.S. from a foreign country or a U.S. territory ☐ **9. Non-calendar renewal** Current policy does not renew on a calendar year basis (renews on a date other than January 1) ☐ **10. Jail or prison** Released from jail or prison (incarceration)	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 is effective the 1st day of the following month.
- Between the 16th and the last day of the month, coverage is effective the 1st day of the second following month.

Almost there! We need a bit more info.

We need supporting documentation for your qualifying event, such as a letter or official form from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected. If you're applying because you've lost your coverage, we need to know the reason why coverage was lost, and it must be included in the supporting documentation. In all instances, 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 of 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** (required)

I confirm that the application was interpreted on my behalf

Signature of Applicant (required)	**Date** (required)

Payment Methods for Individual Applications

Anthem BlueCross

Applicant/Member name	Primary applicant's Social Security number

The applicant/member is responsible for monthly payments to Anthem. Anthem does not accept payment of monthly payments from any person or entity other than the applicant/member, his or her relatives or legal guardian, or third party payors except to the extent required by state or federal law. Upon discovery that monthly payments were paid directly by a person or entity other than those listed above, Anthem may reject the payment and inform the applicant/member that the payment was not accepted and that the monthly payment remains due.

I authorize Anthem to debit the bank account listed or charge to 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 change(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. **I agree to pay any service charge that Anthem may bill me because the debit/charge was not honored.**

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.

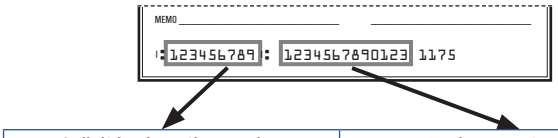
☐ Option 1 Bank Account Authorization: Have your first and future monthly payments automatically deducted from your bank account.

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: →



9-digit bank routing number	Bank account number

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 5 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 reset the automatic monthly payments.

Authorized signature (as it appears on bank's records)	Printed bank account holder's name (as it appears on account)	Date (MM/DD/YY)
X		

☐ 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 5 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 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 reset the automatic monthly payments.

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

Card number	Expiration date ____ (MM/YY)	
Billing address for this credit/debit card	City	ZIP code

Authorized signature (as it appears on card)	Printed card holder's name (as it appears on card)	Date (MM/DD/YY)
X		

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

Payment Methods for Individual Applications

Anthem BlueCross

Applicant/Member name	Primary applicant's Social Security number

☐ **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
			$

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 (MM/YY)

Billing address for this credit/debit card	City	ZIP code

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)	Printed bank account/card holder's name (as it appears on account/card)	Date (MM/DD/YY)
X		

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 1-866-249-4844. (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 Member Services 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 1-866-249-4844. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-866-249-4844 (711:TDD/TTY).

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-866-249-4844 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1-866-249-4844。(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 1-866-249-4844 تماس بگیرید.(711:TDD/TTY)

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 1-866-249-4844 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 lwm 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 1-866-249-4844. (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。1-866-249-4844 (TTY/TDD: 711)

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-866-249-4844។ (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 1-866-249-4844로 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 ਵਥੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਰਨ 1-866-249-4844 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 1-866-249-4844. (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 1-866-249-4844. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-866-249-4844 (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 1-866-249-4844. (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.