California
Individual Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Anthem Blue Cross, premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 212-1796. If you have questions about a previously submitted application, please call 1 (855) 383-7247.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage ☐ Change plan/policy coverage Policy No._____ ☐ Add dependent(s) to current coverage Policy No._____

Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. The earliest Effective Date for the annual Open Enrollment period is the first day of the following Calendar Year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable premium payment.

Applications can be received during the Open Enrollment period. Outside the Open Enrollment period referenced above, the applicant may still enroll if he/she has a qualifying event as defined below. Following a qualifying event, an applicant has 60 days to submit an application. In the case of a future Loss of Minimum Essential Coverage, applications may be submitted up to 30 days in advance of the qualifying event date.

Qualifying Events

Please check the qualifying event:

☐ Involuntary loss of Minimum Essential 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);

☐ Gain a dependent or become a dependent through marriage, domestic partnership, or appointment of domestic partnership;

☐ Gain a dependent or become a dependent through birth, adoption or placement for adoption;

☐ Mandated to be covered as a dependent pursuant to a valid state or federal court order;

☐ Release from incarceration;

☐ Health coverage issuer substantially violated material provision of health coverage contract;

☐ Access to new health benefit plans due to permanent move;

☐ 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;

☐ 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.

Please provide the date of the qualifying event: _____

If you are applying due to a qualifying event and your application is approved, your effective date is as follows:

- In the case of birth, adoption or placement for adoption or appointment of guardianship, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship; or
- In the case of marriage, or loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application.
- In the case of all other qualifying events, when the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. When the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*(required)
Home Address**			
City	State	ZIP	County
Billing Address (street and P.O. Box if applicable)			
City	State	ZIP	
Marital/Domestic Partner Status ☐ Single ☐ Married ☐ Domestic Partner	Sex ☐ M ☐ F	Date of Birth / /	
Primary Phone Number	Secondary Phone Number	E-mail***	

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

*** All information will be mailed to your home address, including billing, private and confidential communications as defined by California law, unless you designate a different address under the "Billing Address" field above. This will not impact rights you may have to invoke a separate Confidential Communication under the Health Insurance and Portability and Accountability Act ("HIPAA").*

****This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner
Social Security Number* (required)	Sex ☐ M ☐ F	Date of Birth / /	

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your or your spouse's or your Domestic Partner's children, including stepchildren, newborn and adopted children and any child for whom you or your spouse or domestic partner has assumed a parent-child relationship under age twenty-six 26. (List all dependents beginning with the eldest). 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	**First Name**	**MI**	**Sex**	**Date of Birth** **mm/dd/yyyy**	**Social Security Number* (required)**	**Relationship to Applicant**
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

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? ☐ Yes ☐ No

If YES, a separate Disabled Dependent Certification form must be submitted to determine eligibility.

☐ **Please send me a form.**

Are any of the applicants listed on the application currently incarcerated (except pending disposition of charges)? ☐ Yes ☐ No

If **YES**, who? _____

Preferred written language? (Optional)

☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Vietnamese (VIE) ☐ Spanish (SPN)

☐ English (ENG) ☐ Tagalog (TGL) ☐ Other (W09)

Preferred spoken language? (Optional)

☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Vietnamese (VIE) ☐ Spanish (SPN)

☐ English (ENG) ☐ Tagalog (TGL) ☐ Other (W09)

☐ 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”.

Select ONE Plan...then select ONE Individual Deductible/Coinsurance option.

Total Family Deductible is two (2) times the amount shown.

Applicants must reside in one of these counties to enroll: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Kern, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Plumas, San Benito, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, and Yuba.

Plan/Policy	Offered by Anthem Blue Cross**
METAL LEVEL BRONZE	
☐ Anthem Bronze 60 D PPO	☐ $5,000/30% 1FZ4
☐ Anthem Bronze Pathway PPO	☐ $5,750/20% 1FZH
☐ Anthem Bronze Pathway PPO	☐ $5,000/25% 1FZ5
☐ Anthem Bronze Pathway PPO	☐ $6,250/20% 1FZL
METAL LEVEL SILVER	
☐ Anthem Silver 70 D PPO	☐ $2,000/20% 1FZX
☐ Anthem Silver Pathway PPO	☐ $2,000/25% 1FZ9
☐ Anthem Silver Pathway PPO	☐ $1,750/30% 1FZB
METAL LEVEL GOLD	
☐ Anthem Gold 80 D PPO	☐ $0/20% 1G09
METAL LEVEL PLATINUM	
☐ Anthem Platinum 90 D PPO	☐ $0/10% 1G0F
Catastrophic Plans (only available for Applicants under age 30 or otherwise qualified)	
☐ Anthem Minimum Coverage D PPO	☐ $6,600/0% 1FZE
HSA Plans	
METAL LEVEL BRONZE	
☐ Anthem Bronze 60 D HSA PPO	☐ $4,500/40% 1FZQ

☐ **YES,** I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Anthem Blue Cross's banking partner. (Please fill in your social security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Anthem Blue Cross's banking partner.

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

Please choose a Primary Care Physician for each family member from the Provider Directory, which can be found at www.anthem.com, or by calling 1 (866) 297-7647. If you do not choose a PCP, then one will be selected for you.

Applicant	Primary Care Physician (PCP)	PCP ID	Current Patient	PMG/IPA ID*
Primary Applicant			☐ Yes ☐ No	
Spouse/ Domestic Partner			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	

**PMG = Participating Medical Group, IPA = Independent Practice Association*

☐ Please check box if any additional sheets of paper have been completed for this section. If so, please attach and return the additional sheets with this application.

Section F – Dental Coverage

Yes, I wish to purchase additional dental coverage to supplement the pediatric Essential Health Benefits to age 19 **which are included in the medical plans above.**

Select All that Apply:

☐ * Anthem Family Dental PPO (1FQZ) ☐ * Dental Select HMO (1F3E)

Select who you are enrolling (applies to individuals listed on this application only):

☐ Applicant only
☐ Applicant & Spouse or Domestic Partner only
☐ Applicant & all dependent children listed
☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

***This product is issued by Anthem Blue Cross and is regulated by the California Department of Managed Health Care.**

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

Applicant	Primary Care Dentist	Current Patient	Primary Care Dentist Number
Primary Applicant		☐ Yes ☐ No	
Spouse/ Domestic Partner		☐ Yes ☐ No	
Dependent Name:		☐ Yes ☐ No	
Dependent Name:		☐ Yes ☐ No	
Dependent Name:		☐ Yes ☐ No	

☐ Please check box if any additional sheets of paper have been completed for this section. If so, please attach and return the additional sheets with this application.

Section G – Other Health Coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, who? _____

Start date of benefits/coverage: ____/____/_____ End date of benefits/coverage: ____/____/_____

Do you, or anyone applying for coverage, currently have health care coverage? ☐ Yes ☐ No

If YES, please provide the following:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage

Will you be cancelling this coverage if approved for Anthem Blue Cross coverage? ☐ Yes ☐ No

If **YES**, what is the cancellation date? _____

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

All Applicants

I, the undersigned, understand that under the Anthem Blue Cross 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 1-866-297-7647 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 although Anthem Blue Cross requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Anthem Blue Cross, does not mean that coverage has been approved. I may not assign any payment under my Anthem Blue Cross program. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, Anthem Blue Cross reserves the right, based upon eligibility requirements, to accept or decline this application. I understand that if my application is denied, my bank account or credit card will not be charged.
- I will notify Anthem Blue Cross of any changes that affect my eligibility or my dependents eligibility for coverage. This includes changes in address, marriage, divorce, dissolution of domestic partnership, death, or dependent status.
- I understand Anthem Blue Cross may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem Blue Cross automatic debit process and will only occur each time I send a check to Anthem Blue Cross. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem Blue Cross and myself.
- I understand I am applying for individual health coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- I understand that 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.
- ☐ By checking this box, I authorize and expressly consent that Anthem Blue Cross and its affiliated companies may send and deliver to me any communication that is not required to be provided to me by United States mail, including but not limited to legally required Plan Notices, policies, agreements, evidence of coverage booklets and eligibility, enrollment and billing and explanation of benefits statements, electronically, either by e-mail or via the Internet. Examples of documents that will not be sent by electronic means and will continue to be sent by U.S. Mail include notices of cancellation, notices of grace period, notices that will terminate your coverage, and notices regarding a denial of coverage. I understand that I can revoke this authorization or request paper copies at any time by contacting Anthem Blue Cross customer service or online at www.anthem.com.
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent 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 Blue Cross 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, rescission or cancellation of my coverage(s).
- As part of the W-9 Certification required by the Internal Revenue Service, I certify that the SSN number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by

the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem Blue Cross. I am acting as their agent and representative.

This application shall be altered solely by the applicant or with his or her written consent.

Rescission of Membership

Every applicant age 18 or older acknowledges the following: I have provided true and complete answers to all questions in the application to the best of my knowledge and understand that all answers are important and will be considered in the acceptance or denial of this application. I understand that all information I know, that is responsive to a question on this application, must be provided in my answers consistent with California law. If Anthem Blue Cross discovers that you committed an act or practice that constitutes fraud, or intentional misrepresentation of material fact is found in this application, Anthem Blue Cross may rescind my plan/policy within the first 24 months from my effective date. I understand this means that Anthem Blue Cross will revoke my plan/policy as if it never existed back to the original Effective Date.

The primary applicant additionally acknowledges the following: All of my dependents listed on this application who are 18 years of age or older have read this application and have provided complete and accurate information for this application to the best of my knowledge and have signed the application below. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about all applicants, including my children under the age of 18, listed on this application is true and complete. Anthem Blue Cross may deny or rescind the entire plan/policy if it discovers that you committed an act or practice that constitutes fraud, or intentional misrepresentation of material fact is found in this application. Enrollees/insureds other than the individual(s) whose information led to the rescission on such plans/policies may be able to obtain coverage as set forth in the section **Eligibility following Rescission.**

I understand that if my plan/policy is rescinded, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be considered for benefits. I also understand that, consistent with California law, I will be required to pay for any services Anthem Blue Cross paid on my behalf and that Anthem Blue Cross will refund any premium paid by me, less my medical expenses that Anthem Blue Cross paid.

Eligibility following Rescission

For individual plans/policies that have been rescinded, eligible enrollees/insureds other than the individual(s) whose information led to the rescission on such plans/policies may continue coverage, without medical underwriting, in one of the following ways:

- enroll in a new individual plan/policy that provides the most equivalent benefits, or
- remain covered under the individual plan/policy that was rescinded.

In either instance, premium rates may be revised to reflect the number of persons on the plan/policy.

Anthem Blue Cross will notify in writing all enrollees/insureds of the right to coverage under an individual plan/policy, at a minimum, when it rescinds the individual plan/policy.

Anthem Blue Cross will provide 60 days for enrollees to accept the offered new individual plan/policy and this contract shall be effective as of the effective date of the original plan/policy and there shall be no lapse in coverage.

To the best of my information and belief, I have personally read and attest to the completeness and validity of the information provided on this application.

If I am accepted, this application will become part of the plan contract/policy between Anthem Blue Cross and me.

I, and any enrolled family members, agree to abide by the terms of that plan contract/policy. With the exception of minors and persons for whom this application has been interpreted (a signed Statement of Accountability must be attached, see Section J). If an Applicant does not read English, the interpreter must sign and submit a Statement of Accountability for interpreting this entire application (see Section J).

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.

SIGN HERE

Signature of Applicant* or Legal Representative X	Date
Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

Please check one of the following and complete the information below:

☐ 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.

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

Agent/Broker Signature X				Date
Agent/Broker Name (please print) TERRIE BOLYARD		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No. 320 E YOSEMITE AVE SUIE 101		
Agent/Broker ID/TIN 205426269	Agency ID/Parent TIN 205426269	City MERCED	State CA	ZIP 95340
Agent/Broker Phone No. 2093853343	Agent/Broker Fax No. 8662841448	Agent/Broker E-mail TERALYN@POLICYPLEASE.COM		
GA (if applicable)		GA code (if applicable)		

Section J – Statement of Accountability

Primary Applicant's Name: _____

To be completed when the 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:_____

I also interpreted and fully explained the "Application Understandings, Conditions and Agreement," the "Authorization for Use of Protected Health Information" and the "Payment Method."

Signature of Interpreter *(Required)*	Today's Date *(Required)*
X	

I confirm that the application was interpreted on my behalf.

Signature of Applicant *(Required)*	Today's Date *(Required)*
X	

Language interpreted (e.g. Spanish):

Please mail this application to the following address:

Anthem Blue Cross

P.O. Box 9041

Oxnard, CA 93031-9041

Or

Fax to: 1 (800) 327-9255

Payment Methods for Individual Applications – California

Anthem BlueCross

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Automatic Premium Payment (complete Section A)

☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account

☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)

Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

As a convenience to me, I request and authorize Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") 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 understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing Anthem a 30-day written notice. I agree that Anthem 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, Anthem shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Anthem's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem 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, Anthem 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. **Anthem accepts Visa and MasterCard.**

Card Number:

Expiration Date:

Billing address for this Credit / Debit Card:

City:

Zip Code:

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize Anthem either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Anthem uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.