# Anthem® Dental Blue®

The first monthly premium must be paid with the application.

Anthem

Please print. Please complete in blue or black ink only.

**Important: To be eligible to apply for this coverage you must be less than 65 years of age.**

## Section A – Applicant Information

**This information is used for internal purposes only and will not be disclosed.*

| Last Name | First Name | MI | Social Security Number* |
|---|---|---|---|
| | | | |

Home Address (street and P.O. Box if applicable)

| City | State | Zip |
|---|---|---|
| | | |

| County | Marital Status ☐ Single ☐ Married | Sex M F | Age | Date of Birth / / |
|---|---|---|---|---|

| Daytime Phone Number ( ) | Evening Phone Number ( ) | E-mail (This information will not be shared with any third party.) |
|---|---|---|

If you currently have medical or life coverage through Anthem BCBS

Identification No. ____________________

Group No. ____________________

## Section B – Dental Coverage Information

**Effective date requested:** If your application is approved, your coverage can start on any day of the month after the date we receive your application.

Please choose the date you would like your coverage to start: ____/____/____(MM/DD/YY).

## Section C – Spouse/Domestic Partner & Child Dependents to be Covered Information

(All fields required. Attach a separate sheet if necessary.)

Dependent information must be completed for all additional dependents (if any) to be covered under this coverage.
(List all dependents beginning with the eldest.)

| First, MI (last name if different) | Relationship to Applicant | Social Security Number* | Sex | Age | Date of Birth mm/dd/yyyy |
|---|---|---|---|---|---|
| | **Spouse/ Domestic Partner** | | M F | | / / |
| | Child | | M F | | / / |
| | Child | | M F | | / / |
| | Child | | M F | | / / |
| | Child | | M F | | / / |

## Section D – Dental Coverage Selection

☐ **Dental Blue® Basic 100** ☐ **Dental Blue® Essential 100** ☐ **Dental Blue® Essential 200**

☐ Yes, I wish to add dental coverage (at an extra cost per individual)
If Yes, select ONE coverage type (applies to individuals listed on this application only):
- ☐ Applicant only
- ☐ Applicant, Spouse or Domestic Partner, and all dependent children listed
- ☐ Applicant & Spouse or Domestic Partner only
- ☐ Applicant & all dependent children listed

☐ Yes, if myself or any listed family member are declined for medical coverage, still enroll **all members selected above, if eligible.**

Dental benefits underwritten by Anthem Blue Cross and Blue Shield.
In most of Missouri: Anthem Blue Cross and Blue Shield is the trade name for RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

## Section E – Billing Information

*If you are a current Anthem member, your dental billing cycle will match your current medical or life billing.*

**Frequency** (select one)

☐ Monthly ☐ Quarterly
☐ Semi-annually ☐ Annually

**Initial Premium**

☐ Bank Draft (see below) ☐ Credit Card (see below)
☐ Premium check enclosed **Total amount enclosed/charged $** ______________

If paying by check, make the check payable to **Anthem Blue Cross and Blue Shield.**

**Method** (select one)

☐ **HOME**—Bills will be sent to your home billing address unless a separate billing address is listed below.

______________________________________________________________________
Name | Address (street and P.O. Box if applicable) | City | State | Zip

☐ **AUTOMATIC BANK DRAFT** (automatic premium withdrawals)—your premium will be deducted on the same day of the month as your assigned effective date. (You **MUST** attach a **blank** voided check)

***I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. I understand that this authorization is in effect until I notify Anthem in writing that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals if they wish to do so.***

| Account holder's name (please print) | Account holder's signature (if other than the applicant) |
|---|---|
| **X** | **X** |

Staple **blank, voided check** here

The first monthly premium must be paid with the application.

Staple **blank, voided check** here

☐ **IF PAYING BY CREDIT CARD:** A credit card can be used only for this initial premium payment. If your application is accepted, you will be billed for future payments or you can call us to change to automatic bank withdrawal. Your credit card will not be charged unless you are approved for coverage. Please complete all the fields below.

**Credit card information —**

Cardholder's Name (as shown on the credit card): ______________________

Cardholders' Address: ______________________

***If applicant is using the credit card of another cardholder:*** *By signing this form, applicant represents and warrants that he/she has the cardholder's authorization to use this card and, if not, that he/she will take full responsibility for this payment and any charges accruing to it.*

Type of Credit Card: ☐ VISA ☐ MasterCard ☐ Discover ☐ American Express

Credit Card Number: ______________________

Expiration Date (month/year): ________ /________

***Authorization:*** *I authorize Anthem Blue Cross and Blue Shield to charge the credit card indicated for the amount specified in* ***Initial Premium****.*

Applicant's Signature:
**X**

## Section F – Terms and Conditions

***Please read this section carefully before signing the application.***

1. I understand that sending my initial premium with this application, and the receipt of my payment by Anthem, does not mean that coverage has been approved. I understand that if my application is denied, my bank account or credit card will not be charged.
2. If my request for coverage is being handled by a producer, I understand that the producer is not authorized to waive a complete answer to any question in the application, pass on insurability, make or alter any contract or waive any of Anthems' other rights or requirements.
3. I may not assign any payment under my Anthem program.
4. I am applying for the coverage selected on this application.
5. I understand that, to the extent permitted by law, Anthem reserves the right to accept or decline this application, and that no right whatsoever is created by this application.
6. **If I purchase dental coverage for the Dental Blue® Essential, I understand that I will have a twelve month waiting period for coverage of Major Restorative Services.** ***(For a description of Preventive, Diagnostic and Major Restorative services please refer to your contract.)***
7. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
8. I understand Anthem 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 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. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
9. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
10. I understand that my domestic partner, if applicable, is only eligible for coverage if: he or she has been my sole domestic partner for 12 months or more; he or she is mentally competent; he or she is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; he or she is not married to or separated from anyone else; and he or she is financially interdependent with me.
11. I understand and agree I am applying for individual dental 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.
12. I acknowledge that I have read the 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 in accepting this application. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission 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.

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| **Signature of Applicant** *(if age 18 or older or Custodial Parent's or Guardian's signature if applicant is under age 18)*<br>**X** | Date |
|---|---|
| **Signature of Spouse or Domestic Partner** *(if to be covered)*<br>**X** | Date |

## Section G – Agent Certification

| Agent Signature<br>**X** | | Date |
|---|---|---|
| Agent Name (please print) Steven King | | Agent Email Address steve@stevekingins.com |
| **Agent No.** MB1309000 | Agent Phone No. Toll free: 1-877-937-5506 | Agent Fax No. |

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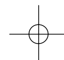

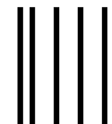

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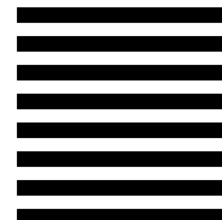

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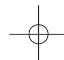

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