# Anthem Extras Packages

## Senior Enrollment Application for California

Anthem

Send your completed application to:

Anthem Blue Cross Life and Health Insurance Company
PO Box 659982
San Antonio, TX 78265-9100
FAX: 1-877-238-1107

Please print – complete in blue or black ink only.

### Section A – Applicant Information

| Last Name | First Name | MI | |
|---|---|---|---|
| Home Address (Must be complete. PO Box not acceptable.) | City | State | ZIP Code |
| Billing Address (if different from above or for PO Box) | City | State | ZIP Code |
| Mailing Address (if different from above or for PO Box) | City | State | ZIP Code |

| County | Gender ☐ M ☐ F | Date of Birth / / | Age | Primary Phone Number ( ) - | Alternate Phone Number ( ) - |
|---|---|---|---|---|---|

| Email Address (not shared with any third party) | Are you, the applicant, a Medi-Cal beneficiary? ☐ Yes ☐ No |
|---|---|

If you currently have dental coverage through any carrier including Anthem Blue Cross, please provide:

Name of Carrier _____ Member Identification Number _____

Effective Date _____ Termination Date _____

Language Preference – When information is sent to you, we may be able to send it in a language other than English.

What language would you prefer? (Optional)

☐ Spanish ☐ Arabic ☐ Armenian ☐ Chinese ☐ Farsi ☐ Hindi ☐ Hmong
☐ Japanese ☐ Khmer ☐ Korean ☐ Punjabi ☐ Russian ☐ Tagalog ☐ Thai
☐ Vietnamese ☐ Other _____

### Section B – Coverage Information

**Important: To be eligible to apply for this coverage, you must be 65 years of age or older and not enrolled in a Medicare Advantage plan with Anthem.**

Effective date requested: _____/_____/_____ (MM/DD/YY)

Your coverage will start on the 1st of the month following approval of your completed application.

Please complete the information below.

| Medicare Supplemental Plan Status | Anthem Extras Packages you may choose from |
|---|---|
| ☐ I have an Anthem Innovative Medicare Supplemental Plan.<br>Effective Date _____ | ☐ Senior Standard Dental<br>☐ Senior Premium Dental<br>☐ Senior Premium Plus Dental Only |
| ☐ I have a different Anthem Medicare Supplemental Plan.<br>Effective Date _____ | ☐ Standard Package<br>☐ Premium Package without SilverSneakers/Fitness Program<br>☐ Premium Plus Package without SilverSneakers/Fitness Program<br>☐ Senior Premium Plus Dental Only |
| ☐ I do not have a Medicare Supplemental plan from Anthem. | ☐ Standard Package<br>☐ Premium Package<br>☐ Premium Package without SilverSneakers/Fitness Program<br>☐ Premium Plus Package<br>☐ Premium Plus Package without SilverSneakers/Fitness Program<br>☐ Senior Premium Plus Dental Only |

## Section C – Billing Information *Send no money now

Frequency (select one)

☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Payment Method

☐ **Automatic Bank Draft** (see below)

Premium is deducted on the 1st of the month.

☐ Paper Bill

Account Type

☐ Business Checking ☐ Business Savings ☐ Personal Checking ☐ Personal Savings

If you submit a personal check for premium payments, you automatically authorize us to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on your bank or credit union account statement as an Electronic Funds Transfer (EFT). Converting your paper check into an electronic payment does not authorize us to deduct premiums from your account on a monthly basis unless you have given us prior authorization to do so.

**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.**

Method (select one)

☐ **HOME** – Bills will be sent to your home address unless you list an alternate address here:

Name _____

Street Address (and PO Box if applicable) _____

City _____ State _____ ZIP Code _____

☐ **AUTOMATIC BANK DRAFT** – Premium is deducted on the 1st of the month, ***you must attach a blank, voided check.***

*If selecting Automatic Bank Draft: I authorize Anthem Blue Cross Life and Health Insurance Company (Anthem) to initiate premium deductions from the checking account indicated and the designated financial institution to debit the same account. 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 at their discretion.*

I also understand if changes I make to my auto withdrawal amount are processed close to the withdrawal date, Anthem may not be able to notify me of the new auto withdrawal amount before the withdrawal is made.

Account holder's name (please print)

Account holder's signature (if other than the applicant)

X .....

## Section D – Agreement Signature Required

| Signature of Applicant or Legal Guardian or Power of Attorney | Date |
|---|---|
| X ..... | |

## Section E – Agent Certification

**Agent Information and Declaration:** To the best of my knowledge, the information on this application is complete and accurate. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understands the explanation. I understand that if I willfully make any false representations, I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to $10,000.

| Agent Signature<br><br>X ..... | Date |
|---|---|

| Agent Name (please print) | Agent Street Address/Suite Number/Personal Mailbox (PMB) Number |
|---|---|

| Writing Agent Tax ID Number | City/State/ZIP Code | County |
|---|---|---|

| Agent Phone Number<br>(  )  - | Agent Fax Number<br>(  )  - | Agent Email Address |
|---|---|---|

| Payable Agent/Agency Name, if applicable (please print) | Payable Agent/Agency Tax ID Number (if applicable) |
|---|---|

**REQUIREMENT FOR BINDING ARBITRATION**

YOU AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY 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.

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 provided by California law, 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 AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE THAT EACH PARTY 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 LIFE AND HEALTH INSURANCE COMPANY 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 OR ANY OTHER ISSUES RELATED TO THE PLAN AND MEDICAL MALPRACTICE CLAIMS.

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.