

Please print. Please complete in blue or black ink only. If you are also applying for health and/or life coverage, please do not use this form. Instead, you should apply for health, dental and life coverage using the Missouri Individual Enrollment Application.

- New dental application     Change to existing dental coverage

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

**Section A – Applicant Information** *\*This information is used for internal purposes.*

Last Name	First Name	MI	Social Security Number*
Home Address (street and P.O. Box if applicable)			
City		State	Zip
County	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Sex M    F	Age /    /
Daytime Phone Number (    )	Evening Phone Number (    )	E-mail (This information will not be shared with any third party.)	
Do you currently have coverage through Anthem Blue Cross and Blue Shield? Please check all that apply: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Life		Health, Dental or Life 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) or 1st or 15th of the month.

**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
	<b>Spouse/ Domestic Partner</b>		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/change dental coverage (at an extra cost per individual)  
If Yes, select ONE coverage type (applies to individuals listed on this application only):

<input type="checkbox"/> Applicant only	<input type="checkbox"/> Applicant, Spouse or Domestic Partner, and all dependent children listed
<input type="checkbox"/> Applicant & Spouse or Domestic Partner only	<input type="checkbox"/> Applicant & all dependent children listed

In Missouri (excluding 30 counties in the Kansas City area): 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 of Anthem Insurance Companies, Inc. 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 health or life billing. If you are a new dental enrollee, you must complete this section. If you are only changing to a different dental product, skip to Section F.*

**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**.

**Payment Option only for First/Initial Payment**

- 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

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

Credit Card Number: \_\_\_\_\_

Applicant's Signature:

Expiration Date (month/year): \_\_\_\_\_ / \_\_\_\_\_

**X**

**Payment Options for Future Premium Payments (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
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- 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

Staple  
blank, voided check here

## 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/changing 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 plan, 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/changing 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, 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.

<b>Signature of Applicant</b> <i>(if age 18 or older, or Custodial Parent's or Guardian's signature if applicant is under age 18)</i> X		Date
<b>Signature of Spouse or Domestic Partner</b> <i>(if to be covered)</i> X		Date
<b>Section G – Agent Certification</b>		
Agent Signature X		Date
Agent Name (please print)		Agent Email Address
Agent No.	Agent Phone No.	Agent Fax No.

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