Anthem® Extras Packages Senior Enrollment Application for Virginia

Anthem Health Plans of Virginia, Inc.

Send your completed application and payment to:
Anthem Blue Cross and Blue Shield
PO Box 5028
Denver, CO 80217-5028
FAX: 1-877-238-1107

Please print – complete in blue or black ink only.

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.

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 (Must be complete. P.O. Box not acceptable)	City	State	ZIP Code
Mailing Address (if different from above or for P.O. Box)	City	State	ZIP Code

County	Gender	Date of Birth	Age	Daytime Phone Number	Evening Phone Number
	☐ M ☐ F			( )	( )

Email Address (not shared with any third party)

Do you currently have dental insurance that this new coverage will replace? ☐ Y ☐ N

If you currently have dental coverage through Anthem Blue Cross and Blue Shield, please provide: Member Identification Number: ____________________
Effective Date: ________________________________
Termination Date: ______________________________

If you are a current Anthem Blue Cross and Blue Shield member, what insurance do you have with us?

☐ Individual Dental ☐ Group Dental

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 ☐Amharic ☐Arabic ☐Bassa ☐Bengali ☐Chinese ☐Farsi ☐French
☐German ☐Hindi ☐Igbo ☐Korean ☐Russian ☐Tagalog ☐Urdu ☐Other ____________

Anthem Health Plans of Virginia, Inc. trades as Anthem Blue Cross and Blue Shield in Virginia, and its service area is all of Virginia except for the City of Fairfax, the town of Vienna, and the area east of State Route 123.
Independent licensee of the Blue Cross and Blue Shield Association.
® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.
The Blue Cross and Blue Shield name and symbol are the registered marks of the Blue Cross and Blue Shield Association.

Section B – 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).

☐ Premium Plus Dental (only)
☐ Standard Package

Section C – Billing Information

Frequency (select one)
☐ Monthly
☐ Quarterly
☐ Semi-annually
☐ Annually

Initial Premium
☐ Automatic Bank Draft (see below)
☐ Premium Check Enclosed (make check payable to ***Anthem Blue Cross and Blue Shield***)

Total amount enclosed $ __________________

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.

Method (select one)

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

Name____

Street Address (and P.O. Box if applicable)____

City ____________________________________ State ________________ ZIP Code ________________

☐ **AUTOMATIC BANK DRAFT** – Premium is deducted on the same day of the month as your effective date; ***you must attach a blank, voided check.***

If selecting Automatic Bank Draft: I authorize Anthem Blue Cross and Blue Shield (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 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.

Accountholders name (please print)
X --

Accountholder's signature (if other than the applicant)
X --

Section D – Agreement Signature Required

The undersigned applicant and agent certify that the applicant has read, or has read to him, the completed application and that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. **The applicant further understands that there is a waiting period in the Premium Plus Dental (only) plan.**

Signature of Applicant or Legal Guardian or Power of Attorney	Date

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.

Agent Signature	Date

Agent Name (please print)	Agent Street Address/Suite Number/Personal Mailbox (PMB) Number
James M. DuBrueler Jr.	167 Creekside Lane

Writing Agent Tax ID Number	City/State/ZIP Code	County	Area Code
	Winchester, VA 22602	Frederick	540

Agent Phone Number	Agent Fax Number	Agent Email Address
(540) 722-2529	(540) 223-9629	jimd@creeksideadvisors.net

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