Anthem BlueCross BlueShield

Dental Prime Individual Enrollment Form

Anthem
Dental Enrollment Department
PO Box 1193
Minneapolis MN 55440-1193

Please complete in blue or black ink only. For information or assistance in completing this form, call Customer Service at 1-877-567-1807.

Applicant Information - Applicants must be at least 18 years of age and not currently covered by another Anthem Blue Cross and Blue Shield group or individual dental plan.

Last Name	First Name	Middle Initial	Social Security Number

Gender ☐ M ☐ F	Day Phone Number	Evening Phone Number	E-mail Address	Date of Birth / /

Address	City	State	ZIP Code

Have you had dental coverage in the past or is this replacing current coverage: ☐Yes ☐No
If yes, when did coverage start _____ When did coverage end _____
Previous insurance carrier's name _____ What was your Policy Number_____

Agent Name	Agent ID	Agent Tax ID	Agent License ID	Agent Paid ID

Select One Plan Option and Payment Method

Options: ☐ **Plan A** No Deductible/$500 Maximum ☐ **Plan B** $50 Deductible/ $1000 Maximum
☐**Plan C** $50 Deductible/$1250 Maximum ☐Vision – you must enroll in a dental Plan in order to enroll for Vision

You can submit this application up to three months in advance of when you would like coverage to start. Coverage starts on the first day of the Requested Start Month. If you do not provide a start month, coverage will begin the first of the month after we receive your completed application. **Requested Start Month _____.**

Select Who Is To Be Enrolled: ☐ Applicant Only ☐ Applicant + One Dependent ☐ Family (Three or More Family Members)

Complete this section if you want to enroll family members. Dependent children under age 26 can be enrolled.

Relationship to Applicant	**First Name, Middle Initial, Last Name**	**Gender**		**Date of Birth** (mm/dd/yyyy)
☐Spouse ☐Domestic Partner		M	F	/ /
Dependent Child		M	F	/ /
Dependent Child		M	F	/ /

Select One Payment Option and Billing Frequency The first premium is charged immediately. Future premiums are deducted/charged around the 20th business day of each coverage period.

☐ **A. Direct Withdrawal from Checking/Savings Account:** ☐ **Monthly** ☐ **Quarterly** ☐ **Annual**
Name on Checking Account _____Bank Name_____
Routing Number _____ Checking Account Number _____

☐ **B. Credit Card or Debit Card**: ☐ **Monthly** ☐ **Quarterly** ☐ **Annual** ☐ MasterCard ® ☐ Visa ®
Credit/Debit Card Number _____ Exp. Date _____/_____ Security Code _____
Name As It Appears On Credit/Debit Card _____

AUTHORIZATION AND VERIFICATION – Sign and date application as verification of your enrollment.

I, the undersigned applicant and the agent, if applicable, certify that I have read or have had read to me the completed application and realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy. I authorize Anthem to withdraw funds from my bank account or debit my credit card. I understand that if funds/credit balances are not available or payment is not made on time I will no longer be eligible for coverage. If I decide I do not want the contract, I may return it within 10 days after receipt with a written statement requesting termination of the contract. Upon return, the contract will be deemed void, and any money paid will be promptly refunded. I understand if I terminate this contract or discontinue enrollment for any reason, I will not be able to re-enroll for a period of 12 months. I understand there are waiting periods in Plan B and Plan C. I am not enrolled in any other Anthem group or individual dental coverage.

Applicant Signature: **Date:** **Agent Signature:** **Date:**