

Section D – 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 (optional)

- 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)

X

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

X

Staple
blank, voided check here

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

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: _____

Expiration Date (month/year): _____ / _____

Applicant's Signature:

X

Section E 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. I may not assign any payment under my Anthem program.
3. I am applying for the coverage selected on this application.
4. 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.
5. **I understand that I will have a six-month waiting period for coverage of Basic Dental services and a 12-month waiting period for coverage of Major Dental services. (For a description of Basic and Major services, please refer to your Marketing materials.)**
6. I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
7. 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.
8. By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
9. **I understand 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.**
10. I acknowledge that I have read the Significant 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).

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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.

Signature of Applicant <i>(if age 18 or older or Custodial Parent's or Guardian's signature if applicant is under age 18)</i>		Date
X		
Signature of Spouse <i>(if to be covered)</i>		Date
X		
Section F Agent Certification		
Agent Name (please print) William J. McIlroy		Date
Agent Email Address bill@truthbenefits.com		
Agent No. A257	Agent Phone No. (888) 218-4712	Agent Fax No. (877) 434-9040
GA (if applicable)		GA code (if applicable)



Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.
Dental products are underwritten by Anthem Blue Cross and Blue Shield.
Independent licensees of the Blue Cross and Blue Shield Association.
® Registered marks Blue Cross and Blue Shield Association.