Individual Dental Plan

Application for Dental Coverage

P.O. Box 14046, Roanoke, VA 24038-4046

Instructions:

1. Please print and fill out this application **completely in ink**. Failure to do so may cause a delay in processing the application.
2. **Initial any corrections** and do not use correction fluid.
3. Remember to **sign** and **date** the application, and enclose your initial payment.
4. All adult persons (age 18 or older) to be covered must sign in section 5, Certification.

1. Applicant Information

Last Name First M.I. | Social Security Number

Home Address *(Street or Rural Route required - do not use P.O. Box)* City County State ZIP

Billing Address *(If different than above)* City County State ZIP

❒ Check here if all correspondence is to be mailed to the billing address | Email address:

Birthdate *(mm/dd/yyyy)* ____/____/____ | Sex ❒ M ❒ F | Marital Status ❒ Married ❒ Single ❒ Divorced

Telephone Number(s): Day: ( ) Evening: ( )

For current Individual Dental Customers

I wish to: ❒ add dependents / spouse to my current policy ❒ remove dependents / spouse from my current policy

Policy Number: ____________________

Names to be removed: ____________________

Put names to be added in Section 3.

2. Requested Effective Date: 1st of ____________ , ______

Month Year

NOTE: if we receive your completed application by the 20th of the month, your earliest effective date will be the 1st of the next month. *After* the 20th, the earliest coverage can begin is on the 1st of the month that follows one month after the month in which we receive the application.

FOR CUSTOMERS ALSO APPLYING FOR MEDICARE SUPPLEMENT COVERAGE: No dental coverage will be in force until your applications for Medicare Supplement and this Individual Dental Plan are approved by Anthem Blue Cross and Blue Shield. The Individual Dental Plan effective date will be the same as the effective date of your Medicare Supplement policy.

3. Family Information *for persons to be covered or added*

Last Name First M.I. *(use additional paper if necessary)*	Social Security Number	Birthdate mm/dd/yyyy	Sex	Full-Time College Student?
Spouse			❒ M ❒ F	N/A
Child			❒ M ❒ F	❒ Y ❒ N
Child			❒ M ❒ F	❒ Y ❒ N
Child			❒ M ❒ F	❒ Y ❒ N

Do all persons to be covered (other than full-time college students) live at the same address? ❒ Y ❒ N

If **No**, please provide the names and addresses of persons who do not reside at the address listed in Section 1:

____

____

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc.
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Do Not Detach

Payment Information

Complete Steps 1-3 to calculate your initial premium payment, which includes a one-time non-refundable $25 policy fee.

1. Fill in Your Monthly Premium.

(Choose one of 1-6, add 7 if applying with children.)

		Rate	Amount
1)	Adult under 50	$32.25	$ ________
2)	Adult 50 or older	$37.50	$ ________
3)	Two adults under 50	$64.50	$ ________
4)	Two adults 50 & over	$75.00	$ ________
5)	Two adults, one under 50 & spouse 50 or over	$69.75	$ ________
6)	1st child with no adult applicant	$32.25	$ ________
7)	Dependent child(ren) $20.75 x ___(# of children, up to 6)		$ ________
	Monthly Premium		$ ________

2. Multiply your Monthly Premium from Step 1 by the number of months you want to pay. If using monthly bank draft, skip to Step 3.

MONTHLY PREMIUM	x	NUMBER OF MONTHS	=	TOTAL PREMIUM
$ ________	x	3 *(paying quarterly)*	=	$ ________
$ ________	x	6 *(paying semiannually)*	=	$ ________
$ ________	x	12 *(paying annually)*	=	$ ________

3. Fill in Your Total Premium from Step 2.

(or your monthly premium from Step 1 if using bank draft.)

TOTAL PREMIUM $ ________

ADD POLICY FEE + $ 25.00

INITIAL PAYMENT DUE WITH APPLICATION = $ ________

(Even if you plan to use bank draft)

Please Select Your Payment Option on the Back of this Section.

Payment Information *(continued)*

4. Initial Payment Options

Your initial premium payment, from Step 3 on the reverse side, is owed with this application. Please let us know how you prefer to make this initial payment by checking the appropriate box below.

☐ **PERSONAL CHECK**

☐ **CREDIT CARD**

PLEASE NOTE: *Credit card is* ***NOT*** *an option for ongoing premium payments.*

☐ VISA

☐ MASTERCARD

Name on Card: ______________________

Card #: ______________________

Expiration Date: ________ / ________
mm / yyyy

5. Ongoing Payment Options

Please let us know whether you prefer to pay ongoing premium payments by bank draft or check by checking the appropriate box below:

☐ **AUTOMATIC DRAFT**

To pay **monthly**, choose this option.

BANK DRAFT AUTHORIZATION:

I authorize Anthem Blue Cross and Blue Shield to deduct from my checking account indicated here, the amounts calculated on the front of this Payment Information form.

I understand that my future payments will equal the Initial Payment shown on the front, less the one-time $25 policy fee.

Applicant's Name: ______________________

Applicant's Address: ______________________

Checking Account #: ______________________

Bank Name: ______________________

Bank Account Holder's
Signature & Date: ______________________

Please attach a voided check with your application.

☐ **PERSONAL CHECK**

To pay for several months at a time, please check one:

☐ Bill me every 3 months *(quarterly)*

☐ Bill me every 6 months *(semiannually)*

☐ Bill me every 12 months *(annually)*

For Anthem Use Only

Transit # ______________________

Bank Code ______________________

ID # ______________________

4. Other Insurance Information

A. Is any person to be covered on this program covered under any policy that includes dental benefits? ❒ Y ❒ N

B. Is group dental coverage available to any person as an employee? ❒ Y ❒ N

If **YES** to A or B, name of person(s) enrolled in or eligible for dental coverage: ______________________

Type of Dental Coverage:
❒ Anthem Blue Cross and Blue Shield Group Dental
❒ Individual Dental
❒ Federal Employee Health Benefits Program
❒ Other Group Dental ______________________

Identification Number: ______________________ Group Number: ______________________

Effective date: ____/____/____ *mm/dd/yyyy* Ending date: ____/____/____ *mm/dd/yyyy*

C. Will this program replace any current dental coverage? ❒ Y ❒ N

If **YES**, reason for changing coverage: ______________________

Date Current Coverage Ends: ____/____/____ *mm/dd/yyyy* *or* ❒ Current coverage will end when this dental coverage begins.

5. Certification

I and my agent (if applicable) certify that I have read or have had read to me this completed application. I understand that any answer or statement made within this application that is untrue and is material to the risk assumed by Anthem Blue Cross and Blue Shield may prevent the recovery of benefits under the policy. Such answer or statement may also result in the termination or voiding of the policy back to its effective date.

I understand that:

1. **no coverage will be in force until my application is approved by Anthem and that the effective date will be the date assigned by Anthem;**
2. **there is a 6 month waiting period for primary services and an 18 month waiting period for prosthodontic and complex services.**
3. **my policy fee is non-refundable; and**
4. **no sales agent or broker is authorized to do any of the following: accept risks, make decisions about policy eligibility,change any policy provision, add terms to any policy, or terminate any policy.**

I understand that the policy that I am applying for is an individual dental insurance policy. As such, I understand that the policy, if issued, shall not be used as an employer-provided dental benefit plan. I certify that no employer of any person covered under this policy may pay any premium for this coverage, directly or indirectly, including through wage adjustment. I understand that "employer" does not include a trade or business wholly owned by an individual, or individual and spouse, that has no other employees or that does not offer dental benefits to any other employees. Also, as it pertains to this provision, a church may purchase an individual policy if only purchasing it for one employee. I understand that premiums not paid in accordance with this provision shall result in the non-renewal or discontinuance of the policy issued from this application.

Date ____/____/____ *mm / dd / yyyy* ✗ ______________________
Signature of Applicant or Legal Representative if applicable

Date ____/____/____ *mm / dd / yyyy* ✗ ______________________
Signature of Spouse or Legal Representative if applicable

Date ____/____/____ *mm / dd / yyyy* ✗ ______________________
Signature of Other Adult Person to be covered or Legal Representative if applicable

Date ____/____/____ *mm / dd / yyyy* ✗ ______________________
Signature of Other Adult Person to be covered or Legal Representative if applicable

Date ____/____/____ *mm / dd / yyyy* ✗ ______________________
Signature of Agent if applicable

If a legal representative signs on behalf of the applicant or any other adult person to be covered, a copy of the legal representative's authority must be attached to the application.

6. Agent Information *(if applicable)*

Receipt Date: ______________________ Email Address: ______________________

___ ___ ___ ___ ___ ___ - ___ ___ ___ ___ Agency Number / Agent Number

______________________ Print Name

( ) ______________________ Telephone Number

Coverage is not available to Virginians residing in the city of Fairfax, the town of Vienna or the area east of State Route 123.