Ohio
Individual Dental and Vision Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Anthem, premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1(877) 212-1793. If you have questions about a previously submitted application, please call 1 (855) 330-1106.

RIGHT TO CANCEL: You have 10 days from the date of delivery to examine the policy. If you are not satisfied, for any reason, with the terms of the policy, you may return it to us within those 10 days. Return to Anthem Blue Cross and Blue Shield, P.O. Box 1115, Minneapolis, MN 55440-1115 by midnight on the tenth day. We will then issue a full refund of any premiums and fees paid, less any payments made for benefits on behalf of you or your dependents.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage ☐ Change policy coverage Policy No._____ ☐ Add dependent(s) to current coverage Policy No._____

Enrollment

You may apply for coverage at any time during the year. Your Effective Date will be the first day of the following month after receipt of application and premium. Your benefit and enrollment elections are intended to remain the same until your renewal date. For existing plan members, changes to your coverage can only be made at your renewal date, unless you have a qualifying event as defined below. Notice of a qualifying event must be received by Anthem within 31 days of the qualifying event. In the case of a future loss of Minimum Essential Coverage or renewal of non-calendar year health plan coverage, an application may be submitted up to 30 days in advance of the qualifying event date.

Qualifying Events

Please check the qualifying event:

☐ Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay premium;

☐ Loss of Minimum Essential Coverage due to dissolution of marriage/domestic partnership;

☐ Marriage/domestic partnership;

☐ Birth or adoption or placement for adoption or appointment of guardianship;

☐ Moved to a new exchange service area;

☐ Released from Incarceration;

☐ Death of a family member enrolled under your current coverage;

☐ Removal of non-calendar year health plan coverage;

☐ Court ordered coverage including child support order; and

☐ Other Qualifying Event: _____ (Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events.)

Please provide the date of the qualifying event checked above: _____

Coverage Effect Dates for Qualifying Events

If you are applying due to a qualifying event and your application is approved, your effective date is as follows:

- In the case of birth, adoption or placement for adoption or appointment of guardianship or court ordered coverage including child support order, coverage is effective on the date of birth, adoption, or placement for adoption or appointment of guardianship or the mandated effective date within the court order; or
- In the case of all other Qualifying Events listed above coverage is effective on the first day of the month following receipt of your application.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*
Home Address			
City	State	ZIP	County
Billing Address (street and P.O. Box if applicable)			
City	State	ZIP	
Marital Status ☐ Single ☐ Married	Sex ☐ M ☐ F	Date of Birth	
Primary Phone Number	Secondary Phone Number	E-mail*	

**This information is used for internal purposes only and will not be disclosed.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner
Social Security Number*	Sex ☐ M ☐ F	Date of Birth	

**This information is used for internal purposes only and will not be disclosed.*

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).

NOTE: IF ELECTING DEPENDENT COVERAGE, PLEASE LIST ALL ELIGIBLE CHILDREN UP TO AGE 26**.** An eligible child dependent may be your children or your spouse's or your Domestic Partner's children (to the end of the calendar month in which they turn age 26). You must complete a Certification form for a Mentally or Physically Incapacitated Dependent Child if your child is disabled, incapable of self-support, and age 26 or over. The form must also be completed by your physician. (List all dependents beginning with the eldest).

Last Name	First Name	MI	Sex	Date of Birth mm/dd/yyyy	Social Security Number*	Relationship to Applicant
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ Other:_____
			M F ☐ ☐			☐ Child ☐ Other:_____

**This information is used for internal purposes only and will not be disclosed.*

Preferred written language? (Optional)

☐ English (ENG) ☐ Spanish (SPN)

Preferred spoken language? (Optional)

☐ English (ENG) ☐ Spanish (SPN)

Section E – Dental Coverage

Select your plan option: These plans include Pediatric Dental Essential Health Benefits to the end of the month in which the enrollees turn age 19.

☐ Anthem Dental Family Value -2J5E
☐ Anthem Dental Family-1FV7
☐ Anthem Dental Family Enhanced-1FV8

These plans do *not* include Pediatric Dental Essential Health Benefits that are required by the Affordable Care Act. If your medical plan does not cover the Pediatric Dental Essential Health Benefits, then one of our other plans (see above) may be a better option for you.

- ☐ Smart Access Plan A -1RCF
- ☐ Smart Access Plan B-1RCG
- ☐ Smart Access Plan C-1RCH

Section F – Other Dental Coverage

Are you or any of your dependents listed on this application currently enrolled, or have recently been enrolled, in other dental care coverage? ☐ Yes ☐ No

If YES, please provide the following:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of current/prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage

Has your other coverage ended, or will you be terminating this coverage if approved for Anthem coverage? ☐ Yes ☐ No

If **YES**, what is the termination date? _____

Section G - **Vision Coverage**

Vision coverage for children under age 19 is already included in all our medical plans (Also known as Pediatric Essential Health Benefits). Choose a vision plan and applicants if you'd like to buy coverage that goes beyond these Pediatric Essential Health Benefits.

Please note: Vision coverage is available ***only*** if you are:

- Enrolling in a new dental plan on this application
- Enrolling in an Anthem medical plan through an Exchange
- Already enrolled in an Anthem medical plan or dental plan and it is your annual renewal.

Please provide your medical or dental plan number here_____

☐ Blue View Vision Individual - 1RYA

Select who you are enrolling (applies to individuals listed on this application only):

☐ Applicant only

☐ Applicant & all dependent children listed

☐ Applicant & Spouse or Domestic Partner only

☐ Applicant, Spouse or Domestic Partner and all dependent children listed

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

- I understand that although Anthem requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Anthem, does not mean that coverage has been approved. I may not assign any payment under my Anthem program. I am applying for the coverage selected on this application. 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. I understand that if my application is denied, my bank account or credit card will not be charged.
- I am responsible to timely notify Anthem of any change that would make me or any dependent ineligible for coverage.
- 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.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself.
- I understand I am applying for individual dental or individual dental and vision 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.
- 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.
- ☐ By checking this box, I authorize and expressly consent that Anthem and its affiliated companies may send e-mail communications instead of sending communications by mail, including but not limited to legally required Plan Notices and underwriting, enrollment and billing and explanation of benefits statements, to the e-mail address I have provided on this Application. I understand that I can revoke this authorization or request paper copies at any time free of charge by contacting Anthem customer service or online at www.anthem.com.
- 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. I understand that 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. Any act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits or cancellation of my coverage(s).
- I certify each Social Security Number listed on this application is correct.

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.

This application cannot be altered by the applicant absent the acknowledgement and consent of Anthem.

SIGN HERE

Signature of Applicant* or Legal Representative X	Date
Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

To be completed by your Anthem-appointed agent/broker:

Did you see the proposed subscriber and spouse/domestic partner, if applying at the time this application was executed? ☐ Yes ☐ No

If **NO**, please explain: _____

I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent/Broker Signature **X**			Date
Agent/Broker Name (please print)		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No.	
Agent/Broker ID/TIN	Agency ID/Parent TIN	City State ZIP	
Agent/Broker Phone No.	Agent/Broker Fax No.	Agent/Broker E-mail	
GA (if applicable)		GA code (if applicable)	

Underwritten by Community Insurance Company

Please mail this application to the following address:

Anthem Blue Cross and Blue Shield

P. O. Box 659806

San Antonio, TX 78265-9106

Or

Fax to: 1 (800) 848-2512

Payment Methods for Individual Applications – Ohio

Anthem BlueCross BlueShield

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Automatic Premium Payment (complete Section A)

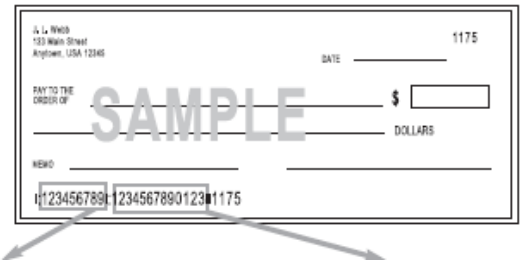
☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account

☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)



Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield ("Anthem") to pay and charge to my account checks drawn on that account by and made payable to the order of Anthem Blue Cross and Blue Shield, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing Anthem a 30-day written notice. I agree that Anthem shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Anthem's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross and Blue Shield ("Anthem") to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **Anthem accepts Visa ☐ and MasterCard ☐.**

Card Number:

Expiration Date:

Billing address for this Credit / Debit Card:

City:

Zip Code:

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize Anthem either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Anthem uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.

Get help in your language

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:
If you need assistance to understand this document in an alternate language, you may request it at no additional cost by calling the Member Services number (855-748-1808). (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Spanish
Si necesita ayuda para entender este documento en otro idioma, puede solicitarla sin costo adicional llamando al número de Servicios para Miembros (855-748-1808). (TTY/TDD: 711)

Arabic
إذا احتجت إلى المساعدة لفهم هذا المستند بلغة أخرى، فيمكنك طلب المساعدة دون تكلفة إضافية من خلال الاتصال برقم خدمات الأعضاء (855-748-1808). (TDD/TTY: 711)

Chinese
如果您需要協助以便以另一種語言理解本文件，您可以撥打成員服務號碼(855-748-1808)請求免費協助。(TTY/TDD: 711)

Dutch
Als u hulp nodig heeft om dit document te begrijpen in een andere taal, mag u daar zonder aanvullende kosten om vragen door te bellen met het ledenservicenummer (855-748-1808). (TTY/TDD: 711)

French
Si vous avez besoin d'aide pour comprendre ce document dans une autre langue, vous pouvez en faire la demande gratuitement en appelant les Services destinés aux membres au numéro suivant : 855-748-1808. (TTY/TDD: 711)

German
Falls Sie Hilfe in einer anderen Sprache benötigen, um dieses Dokument zu verstehen, können Sie diese kostenlos anfordern, indem Sie die Servicenummer für Mitglieder anrufen (855-748-1808). (TTY/TDD: 711)

Italian
Se ha bisogno di assistenza per la comprensione del presente documento in un'altra lingua, può richiederla senza alcun costo aggiuntivo chiamando il numero dedicato ai Servizi per i membri (855-748-1808). (TTY/TDD: 711)

Japanese
この書面を他の言語で理解するための支援が必要な場合には、メンバーサービス番号（855-748-1808）に電話して支援を求めることができます。追加費用はかかりません。(TTY/TDD: 711)

Korean
다른 언어로 본 문서를 이해하기 위해 도움이 필요하실 경우, 추가 비용 없이 회원 서비스 번호(855-748-1808)로 전화를 걸어 도움을 요청할 수 있습니다. (TTY/TDD: 711)

Oromo
Sanada kana afaan kan biroodhaan hubachuuf yoo gargaarsa barbaadde lakkoofsa bilbilaa tajaajila miseensaa (Member Services) (855-748-1808) waraqaa eenyummaa kee irra jiru irratti bilbiluudhaan kaffaltii dabalataa malee gaafachuu dandeessa. (TTY/TDD: 711)

Pennsylvania Dutch
Wann du Helfe brauchscht um selle Document zu verschtehe in en annere Schprooch, du kannscht fer sell frooge um nix zu bezaahle. Ruff Member Services Nummer (855-748-1808) aa. (TTY/TDD: 711)

Romanian
Dacă aveți nevoie de asistență pentru a înțelege acest document într-o altă limbă, puteți solicita aceasta în mod gratuit apelând numărul departamentului de servicii destinate membrilor (855-748-1808). (TTY/TDD: 711)

Russian
Если вам нужна помощь, чтобы понять содержание настоящего документа на другом языке, вы можете бесплатно запросить ее, позвонив в отдел обслуживания участников (855-748-1808). (TTY/TDD: 711)

Ukrainian
Якщо ви не розумієте цього документа й вам потрібна допомога з його перекладом на іншу мову, ви маєте право безкоштовно отримати цю послугу. Для цього зателефонуйте на номер служби підтримки учасників програми страхування (855-748-1808). (TTY/TDD: 711)

Vietnamese
Nếu quý vị cần hỗ trợ để hiểu được tài liệu này bằng một ngôn ngữ thay thế, quý vị có thể yêu cầu mà không tốn thêm chi phí bằng cách gọi số của Dịch Vụ Thành Viên (855-748-1808). (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.