

Anthem[®] Dental Blue[®] Application

Please print – complete in blue or black ink only.

Important: To be eligible to apply for this coverage you must be less than 65 years of age.



Health. Join In.

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 (street and P.O. Box if applicable)					City		State		ZIP							
County		Gender M F	Date of Birth / /		Age	Phone Number ()		E-mail (not shared with any third party)								
If you currently have medical, dental or life coverage through Anthem Blue Cross and Blue Shield: <i>Identification No.</i>																
Section B–Dental 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). <input type="checkbox"/> Dental Blue[®] Basic 100 <input type="checkbox"/> Dental Blue[®] Essential 100 <input type="checkbox"/> Dental Blue[®] Essential 200																
Section C–Spouse/Domestic Partner & Child Dependents to be Covered Information (All fields required, attach separate sheet if needed)																
Dependent information must be completed for all additional dependents (if any) to be covered. List all dependents beginning with the eldest.																
First, MI (last name, if different)			Relationship to Applicant		Social Security Number*		Gender	Age	Date of Birth							
			Spouse/ Domestic Partner				M F		/ /							
			[Child]				M F		/ /							
			[Child]				M F		/ /							
			[Child]				M F		/ /							
Section D–Billing Information																
Frequency (select one) <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annually <input type="checkbox"/> Annually			Initial Premium <input type="checkbox"/> Bank Draft (see below) <input type="checkbox"/> Credit Card (see below) <input type="checkbox"/> Premium check enclosed (make check payable to Anthem Blue Cross and Blue Shield) Initial premium amount: \$ _____													
Method (select one) <input type="checkbox"/> HOME – Bills will be to the address above unless a different address is specified below: ----- <table style="width:100%; border: none;"> <tr> <td style="width:20%;">Name</td> <td style="width:40%;">Address (street and PO Box if applicable)</td> <td style="width:15%;">City</td> <td style="width:15%;">State</td> <td style="width:10%;">ZIP</td> </tr> </table> <input type="checkbox"/> AUTOMATIC BANK DRAFT – Premium is deducted on the same day of the month as your effective date; you must attach a blank, voided check. <i>If selecting Automatic Bank Draft: 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. This authorization is in effect until I notify Anthem in writing that I no longer desire this service, allowing Anthem reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals at their discretion.</i> Account holder's name (please print) _____ Account holder's signature _____ X _____ X _____ ----- <input type="checkbox"/> CREDIT CARD – A credit card can be used only for this <u>initial premium payment</u> . If your application is accepted, you will be billed directly for future payments or you may request a Premium Payment form to change to automatic bank withdrawal. Your credit card will not be charged unless you are approved for coverage. Cardholder's Name (as shown on the credit card) and Address: X _____ ----- <i>I authorize Anthem Blue Cross and Blue Shield to charge the credit card indicated for the amount specified in Initial Premium (above). 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.</i> Type of Credit Card: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> Amex Applicant's Signature _____ Credit Card Number _____ Expiration Date (month/year): _____ / _____												Name	Address (street and PO Box if applicable)	City	State	ZIP
Name	Address (street and PO Box if applicable)	City	State	ZIP												
Signature of Applicant (if age 18 or older, or Custodial Parent's or Guardian's signature if applicant is under age 18)										Date						
Signature of Spouse or Domestic Partner (if enrolling)			Date		Signature of Dependent/Child (18 or over, if enrolling)			Date								

Life and Disability products underwritten by Anthem Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of: In Indiana: Anthem Insurance Companies, Inc. In Kentucky: Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area): RightCHOICE[®] Managed Care, Inc. (RIT), Healthy Alliance[®] Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. In Ohio: Community Insurance Company. In Wisconsin: Blue Cross Blue Shield of Wisconsin ("BCBSWI"), which underwrites or administers the PPO and indemnity policies; CompCare Health Services Insurance Corporation ("CompCare"), which underwrites or administers the HMO policies; and CompCare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.

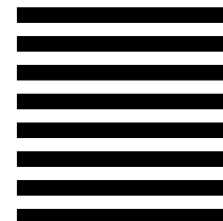
Section E-Agent Certification

Agent Signature X			Date	
Agent Name (please print) Steve King		Agent Street Address/Suite No./Personal Mail Box (PMB)No. 1226 N Truman Blvd.		
Agent ID No. MB1309000	City/State/Zip Crystal City, MO 63019	County Code	Area	
Agent Phone No. 636-937-5506	Agent Fax No. Toll free:1-877-937-9309	Agent Email Address steve@stevekingins.com		
General Agent (if applicable) (please print) N/A		General Agent code (if applicable) N/A		

IMPORTANT: DO NOT ENLARGE, REDUCE OR MOVE the FIM and POSTNET barcodes. They are only valid as printed!
Special care must be taken to ensure FIM and POSTNET barcode are actual size AND placed properly on the mail piece to meet both USPS regulations and automation compatibility standards.



NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO 23 FESTUS MO

POSTAGE WILL BE PAID BY ADDRESSEE

STEVEN KING INSURANCE AGENCY INC
1226 N TRUMAN BLVD
CRYSTAL CITY MO 63019-9909



Artwork for Envelope, Business, #9, 3 7/8 x 8 7/8 in (3.875" x 8.875")
Layout: c:\program files\envmgr32\dazzle32\lbi2x5.lyt
March 26, 2008 10:29:04

Produced by DAZzle Designer 2002, Version 4.3.08
(c) Envelope Manager Software, www.EnvelopeManager.com, (800) 576-3279
U.S. Postal Service, Serial #NO