Once completed, fax both sides of this form to Anthem Individual Membership at (303) 764-7282. Or mail your completed application to Anthem Blue Cross and Blue Shield with a check for the first month’s premium to your agent or to:
Anthem Blue Cross and Blue Shield, Individual Product Administration, P.O. Box 9051, Oxnard, CA 93031-9051.

It is unlawful to knowingly provide false, incomplete or misleading facts to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
Payment Options

Payment Method (Premium payment required. Please choose from A or B.)

A. Please choose from the options below for your initial premium payment:
- Credit/Debit Card
- Paper Check
- Electronic Check

B. Please choose from the following options for future payments:
- Monthly Credit/Debit Card (complete Section below)
- Monthly Paper Billing
- Quarterly Paper Billing—submit the three-month premium
- Monthly Checking Account Automatic Premium Payment (complete Section below)
- Bi-monthly Paper Billing

Monthly Credit/Debit Card
As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the initial payment amount may vary as a result of change(s) during underwriting, and/or subsequent payment amounts may vary as a result of change(s) I make on enrollment, such as, but not limited to, adding and deleting dependents or moving my residence. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you 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, you 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.

- Visa
- MasterCard
- Discover

Card Number: ______________________________ Talk: _______________________________
(13 or 16 digits)

Authorized Signature [as it appears on the credit card] | Cardholder Name [as it appears on the credit card] | PRINT | Date

X

Monthly Checking Account Automatic Premium Payment
By providing your check information to the right, you authorize us to electronically debit your bank account. If you have not sent in an initial premium payment from choice A, your bank account will be debited one month’s premium the day after approval. This will include all products selected, including dental and/or life. Subsequent premium amounts will be debited on the day you request below.

Requested debit day: [ ] (1st to 28th 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 you to pay and charge to my account checks drawn on that account by and 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 underwriting, 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 or moving my residence. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross and Blue Shield to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross and Blue Shield premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you 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, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from monthly checking account automatic premium payment and will be billed monthly.

You will incur a $25 service charge for any withdrawal not honored.

Authorized Signature (as it appears in the financial institution’s records) | Account Holder Name | PRINT | Date

X

Electronic Check
In lieu of sending a paper check, we can submit this same information electronically. You will need to complete the information below. We require an exact amount and check number of the check you are using. Please void this check to prevent future use.

Authorized Signature | Account Holder Name | PRINT | Bank Routing Number | Account Number | Amount | Check Number

* By sending your paper check, you authorize us to convert your check to an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.