# **Anthem Blue Dental PPO Plan**

For Individuals and Families





Anthem Blue Cross and Blue Shield 700 Broadway Denver, Colorado 80273 anthem.com



06-00029 (6/06) Colorado



Freedom to choose any dentist

Access to dental care at discounted fees

Wide range of dental services

Coverage for preventive care and diagnostic services begins on your policy effective date

### **PPO Dental Plan Coverage for Individuals and Families**

We designed our Anthem Blue Dental PPO plan for individuals and families to help promote good oral hygiene and preventive care and to offer you convenient, affordable dental coverage. In other words, to make you smile!

The Anthem Blue Dental PPO plan features coverage for routine check-ups, X-rays and cleanings that begins the day your policy is effective.

You will be covered for fillings after six continuous months of coverage, and for major dental care after 12 continuous months of coverage, offering significant cost savings on procedures such as root canals, crowns and dentures.

With the Anthem Blue Dental PPO plan, you may visit any dentist you choose. However, your out-of-pocket costs will be lower if you use dentists in our network.

Please read this brochure for information about how our Anthem Blue Dental PPO plan works, including the plan's benefits, exclusions and limitations.



#### **How the Plan Works**

When you choose an in-network dental provider, you'll receive services at Anthem Blue Cross and Blue Shield's negotiated discounted rates. We still provide benefits when you choose an out-of-network provider; however, your out-of-pocket expenses may be higher, because our negotiated fees don't apply to out-of-network providers. You're responsible for any charges exceeding the stated benefit amount for both in-network and out-of-network dentists.

Your current dentist may already be an in-network provider. For an up-to-date listing of dental providers in our network, go to **anthem.com** and click the **Find a Doctor** link. It could save you money.

When visiting an out-of-network provider, we let you know up front how much the plan pays for covered services. This means you may calculate how much you'll have to pay once you've determined your dentist's fee for a specific procedure.

If your current dentist isn't in our network and you want him or her to join our network, please contact us at the address or phone number below:

Anthem Network Services P.O. Box 9069 Oxnard, CA 93031-9069 888-209-7852



The following is an example of how Anthem Blue Cross and Blue Shield's negotiated rates may save you money. Negotiated rates may vary among in-network dental providers.

In-network Dentists					
If the billed amount is:	\$850				
And Anthem's negotiated rate is:	\$430				
Anthem will pay 50% of the negotiated rate:	\$215*				
You pay the difference between the negotiated rate and what Anthem pays.	\$215				

Out-of-network Dentists					
If the billed amount is:	\$850				
Anthem will pay the amount specified in the benefit schedule:	\$347				
You pay the difference between the billed amount and the scheduled benefit.	\$503				

\*This assumes any deductible has been met and you haven't reached your annual maximum. Billed amounts and negotiated rates in the above table were determined by using an example of in-network and out-of-network rates for dentists in the Denver, Colorado, area (ZIP code 80273) for American Dental Association procedure code D2750. The information in this example is from Anthem Blue Cross and Blue Shield's 2005 claims data. Negotiated rates may vary by in-network dentists, based on their contractual relationship with Anthem.

#### **Calendar-year Deductible**

You're responsible for a \$50 per person deductible per calendar year, with a maximum of three deductibles per family (\$150), before you receive benefits for covered services. The calendar-year deductible is waived for preventive and diagnostic services when they're provided by an in-network dentist.

#### **Calendar-year Maximum Benefit**

Your Anthem Blue Cross and Blue Shield dental benefits are limited to \$1,000 for each enrolled member during a calendar year.

#### **Waiting Periods**

Coverage for preventive and diagnostic care begins on your plan effective date. Coverage for basic care begins after six continuous months of coverage, and coverage for major care begins after 12 continuous months of coverage.

#### **Customer Service**

Our professional customer service representatives are available to help you and answer questions about your plan. The toll-free number is listed on the dental plan ID card you'll receive once you're enrolled.

#### **Benefit Schedules**

To use our schedules, check your dentist's fee and then determine how much the plan pays. You can then easily calculate what you'll pay for a specific service after you meet your deductible. The plan pays either the specified amount or the actual amount charged by your dentist, whichever is lower.

Customer service representatives are available to help you and answer questions about your plan.



#### **Preventive and Diagnostic Care**

- Coverage begins on your plan effective date.
- The calendar-year deductible of \$50 per person, with a maximum of three deductibles per family (\$150), is waived for preventive care and diagnostic services when a member uses an in-network dentist.
- Coverage includes two oral examinations and two dental cleanings per member per year.
- The total benefit for single and bitewing X-rays may not exceed the benefit for full-mouth X-rays.

Procedure	Plan	Pays
	In-network	Out-of-network
Periodic oral exam (limited to 2 per member per year)	100%	\$26.00
Bitewing X-rays (single film)	100%	\$16.00
Bitewing X-rays (2 films)	100%	\$27.00
Single (periapical) X-rays (first film)	100%	\$14.00
Single X-rays (each additional film)	100%	\$14.00
Bitewing X-rays (4 films)	100%	\$36.00
Full-mouth X-rays (limited to 1 set every 5 years)	100%	\$65.00
Routine cleaning (limited to 2 per adult¹ per year)	100%	\$54.00
Routine cleaning (limited to 2 per child²per year)	100%	\$38.00
Cleaning with fluoride (limited to 2 per child per year)	100%	\$57.00
Sealants per tooth	100%	\$32.00

<sup>&</sup>lt;sup>1</sup> Adult: Any person or dependent 19 years of age or older covered by the Anthem Blue Dental PPO plan

Rates are effective as of July 1, 2006, and are subject to change.

#### **Basic Dental Care**

- Benefits begin after coverage has been effective for six continuous months.
- The calendar-year deductible of \$50 per person, with a maximum of three deductibles per family (\$150), must be satisfied before we will pay any benefits.

Procedure	Plan Pays				
	In-network	Out-of-network			
Filling (1 surface)	80%	\$62.00			
Filling (2 surfaces)	80%	\$78.00			
Filling (3 surfaces)	80%	\$96.00			
Filling (4 or more surfaces)	80%	\$118.00			

Rates are effective as of July 1, 2006, and are subject to change.



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<sup>&</sup>lt;sup>2</sup> Child: Any person or dependent 18 years of age or younger covered by the Anthem Blue Dental PPO plan

#### **Major Dental Care**

- Benefits begin after coverage has been effective for 12 continuous months.
- The calendar-year deductible of \$50 per person, with a maximum of three deductibles per family (\$150), must be satisfied before we will pay any benefits.

Procedure	Pla	an Pays
	In-network	Out-of-network
Extraction (erupted tooth or exposed root)	50%	\$42.00
Surgical removal of erupted tooth	50%	\$74.00
Removal of impacted tooth (soft tissue)	50%	\$74.00
Removal of impacted tooth (partial bony)	50%	\$106.00
Removal of impacted tooth (complete bony)	50%	\$124.00
Four or more scaling/root planing per quadrant	50%	\$104.00
Gingivectomy (1 to 3 teeth per quadrant)	50%	\$91.00
Gingivectomy (4 or more contiguous teeth per quadrant)	50%	\$152.00
Anterior root canal (1 canal)	50%	\$261.00
Bicuspid root canal (2 canals)	50%	\$279.00
Molar root canal (3 canals)	50%	\$333.00
Crown (porcelain fused to high noble metal)	50%	\$328.00
Pontic (porcelain fused to high noble metal)	50%	\$328.00
Upper partial denture cast metal with resin	50%	\$475.00
Complete maxillary denture	50%	\$510.00

Rates are effective as of July 1, 2006, and are subject to change.

#### **Eligibility and Enrollment**

To be eligible for enrollment, you must meet all of the following requirements:

- A resident of the state of Colorado who properly applies for coverage and is accepted by Anthem Blue Cross and Blue Shield.
- A resident of the United States for at least six months.
- Not enrolled under any other Anthem Blue Cross and Blue Shield Individual or Group dental plan.

Plus you must be **one** of the following:

- Age 64 or younger.
- The applicant's lawful spouse, age 64 or younger.
- The applicant's unmarried child up to age 19.
- The applicant's unmarried child and financial dependent, through age 24.

#### **Plan Effective Date**

You may choose your effective date—either immediately upon approval, the first of the month following approval or a later date. Your plan effective date will be printed on the dental plan ID card you'll receive once your enrollment is approved.

Benefits for major dental care begin after coverage has been effective for 12 continuous months.

Anthem Blue Dental PPO Plan Rates Effective Ju	ly 1, 2006
One adult	\$36.91
Two adults	\$73.82
Adult with one child	\$58.94
Adult with two children	\$80.97
Adult with three or more children	\$103.00
Family (one child)	\$95.85
Family (two children)	\$117.88
Family (three or more children)	\$139.91
One child	\$22.03
Two children	\$44.06
Three or more children	\$66.09

These are monthly premium rates. For quarterly rates, multiply the monthly rate by three.

#### **Terms of Coverage**

Coverage under the Anthem Blue Dental PPO plan remains in force as long as the required premiums are paid on time and as long as you remain eligible for coverage. Coverage ceases when a member becomes ineligible due to divorce or a change in dependent status. (In the case of divorce and overage dependents, Anthem Blue Cross and Blue Shield will offer you a similar plan.) Anthem may change the premiums for this plan after providing you with 30-day advance written notice. Anthem will not change the premium schedule for this plan on an individual basis but only for all members in your class and plan.

#### **Exclusions and Limitations**

For complete details about plan benefits, limitations and exclusions, please refer to the certificate. In the event of a conflict between anything printed in this brochure and the certificate, the terms of the certificate will prevail.

#### Diagnostic and preventive services:

- Oral evaluations: Limited to two per calendar year in any combination of the following types of evaluations: periodic, limited, comprehensive, detailed/extensive and periodontal evaluations.
- Bitewing radiographs (one set of up to four films): Limited to once per calendar year.
- Vertical bitewings (seven to eight films): Up to eight films will be covered in any five-year period. Benefits are not payable if performed on the same date of service as a panoramic film or full-mouth radiographs.
- Periapical X-rays: Limited to four films per calendar year. Benefits are not payable if performed on the same date of service as a panoramic film or full-mouth radiographs.
- Complete series (panoramic film or full-mouth radiographs): Limited
  to once every five years. Complete series of radiographs include
  bitewings and will count as one occurrence for that calendar year. Nine
  or more radiographs in any combination of periapical, occlusal and
  bitewing radiographs will be considered a complete series.
- Adult prophylaxis: Limited to a total of two per calendar year, singly or in combination with a periodontal maintenance procedure. Allowance includes cleaning, scaling and polishing the teeth.
- Child prophylaxis: Limited to two per calendar year for children up to age 16. Allowance includes cleaning, scaling and polishing the teeth.
- Fluoride treatments (topical application): Limited to two per calendar year for dependent children up to age 19.
- Sealants for unrestored permanent first and second molars: Limited to
  one application per tooth and one replacement per tooth if the
  replacement is performed at least 36 months after initial application.
  Covered only for dependent children up to age 16.
- Space maintainers: Limited to once per quadrant per lifetime for children up to age 16. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes initial prosthesis only and all adjustments within six months of placement.
- Replacement space maintainers: Covered only after 12 months have passed since initial placement.
- Consultations: Diagnostic service provided by a dentist other than the practitioner providing treatment is limited to one per calendar year.
- Office visit for observation: Limited to two visits per calendar year in combination with other covered oral evaluations. Not covered when associated with other services or procedures.
- Amalgam restorations: Limited to once per surface per tooth every 24 months. Replacement of existing restoration is allowed no more than once every 24 months.
- Composite resin restorations: Limited to once per surface per tooth every 24 months. Replacement of existing restoration is allowed no more than once every 24 months. Benefits for composite resin restorations on posterior permanent teeth and primary teeth will be based on the maximum allowable amount for the corresponding amalgam restoration.

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- Root canal therapy: Covered services include a treatment plan, clinical
  procedures, postoperative radiographs and follow-up care. If multiple
  endodontic treatments are necessary on the same tooth within a period of
  one year, the allowance will be made for only one procedure. Root canal
  therapy is limited to one initial treatment per tooth per lifetime and one
  re-treatment per tooth per lifetime. Coverage is for permanent teeth only.
- Apicoectomy/periradicular services: The maximum allowable amount for apicoectomy/periradicular services includes reimbursement for the removal of granulation tissue at the apex of the tooth. No additional benefit is available for the removal of granulation tissue at the apex of the tooth if billed separately from the apicoectomy/periadicular service.
- · Retrograde fillings are not covered
- Therapeutic pulpotomy (excluding final restoration): Coverage is for primary teeth only.
- Pulp capping, direct and indirect: Coverage is for permanent teeth only.
- Gross pulpal debridement: Not payable if performed in conjunction with root canal treatment or palliative emergency treatment.
- Gingivectomy or gingivoplasty: Limited to once per quadrant in any three years. When performed in conjunction with a crown build-up, post and core, or with a crown, the gingivectomy or gingivoplasty is considered part of that procedure, and there will be no additional benefit.
- Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis (removal of subgingival and/or supragingival plaque and calculus): Limited to once per lifetime.
- Periodontal scaling and root planing: Limited to once per quadrant every 24 months.
- Periodontal maintenance procedure: Covered only when following active periodontal therapy. Limited to two procedures per calendar year, singly or in combination with routine prophylaxis.
- Crowns, inlays, onlays: Benefits for crowns, inlays and onlays are limited to once per tooth in any seven-year period, whether placement was under this policy or under any prior dental coverage, even if the original crown was stainless steel or temporary. Laboratory-fabricated restorations and crowns are covered only when the tooth cannot be restored with routine filling material.
- Re-cementing of crowns/inlays/onlays: Limited to a lifetime maximum of once per crown/inlay/onlay.
- Crown/onlay repairs: Limited to once per crown/onlay in any sevenyear period.
- Stainless steel crowns (for primary teeth only): Benefits are not provided for stainless steel crowns when used as a temporary crown.
- Removable complete (immediate or permanent) and partial dentures, but only if the tooth/teeth being replaced were extracted after the member's effective date: Limited to once in seven years. Benefits are available for the replacement of complete or partial dentures but only if the prosthesis is seven years old or older and cannot be made serviceable. Benefits are payable for either complete or immediate dentures, but not both.
- Denture adjustments: Limited to once per year per denture.
- Denture repairs: Limited to once per denture in a seven-year period.
- Re-cementing a bridge: Limited to a lifetime maximum of once per bridge.
- Post and core: Limited to once per tooth in a seven-year period, after root canal therapy.

- Core buildup: Limited to once per tooth in a seven-year period.
- Bridge repair: Limited to once per bridge in a seven-year period.
- Amounts exceeding the cost of the material are not covered if a tooth or teeth can be restored with amalgam (with the exception of composite resin on anterior teeth) and other material is used. Anterior teeth exhibiting pathology eligible for composite restorations are central incisors, lateral incisors, cuspids and the facial surface of bicuspids are not covered.
- Services provided before or after the term of this coverage: Services
  received before your effective date under this policy or incurred after
  the termination date of this coverage, except as specified elsewhere in
  this policy, are not covered.
- Professional services received from a person who lives in your home or who is related to you by blood, marriage or adoption are not covered.
- Cosmetic dentistry: Any services performed for cosmetic purposes, including, but not limited to, external bleaching, bleaching of non-vital discolored teeth, veneers, crowns on teeth not exhibiting pathology and facings on crowns on posterior teeth, are not covered, unless they are for correction of functional disorders or as a result of an accidental injury occurring while you were covered for dental benefits under this policy are not covered.
- Replacement of an existing fixed or removable prosthesis for which benefits were paid if replacement occurs within seven years of the original placement, unless the prosthesis is being used during the healing period for recently extracted anterior teeth, is not covered.
- Replacement of crowns, inlays, onlays and laboratory-fabricated restorations if replacement occurs within seven years of the original placement is not covered.
- Lost or stolen dentures or appliances: Replacement of existing full or partial dentures or appliances that have been lost or stolen is not covered.
- Charges for any duplicate prosthetic device or appliance, or for a "spare" set of dentures or any other duplicate appliance such as, but not limited to, removable orthodontic retainers, is not covered.
- Any prescribed drugs, pre-medication or analgesia, including charges for nitrous oxide or any similar local anesthetic when the charge is made separately from a covered service are not covered.
- Replacement of existing restorations for any purpose other than the treatment of pathology or decay is not covered.
- The extraction of immature erupting third molars and nonpathologic, asymptomatic third molars is excluded. Third molar extractions are not covered under age 16.
- Any services related to the diagnosis or treatment by any method of any
  condition related to the jaw joint (temporomandibular joint or TMJ) or
  associated musculature, nerves and other tissues, regardless of the
  reason(s) such services are necessary, are not covered.
- Prosthetics for patients under 16 years of age, including, but not limited to, fixed bridges, dentures, removable partials, crowns, inlays and onlays, are not covered.
- Teeth lost before coverage under this policy are not eligible for prosthetic replacement unless the prosthetic replacement replaces one or more eligible natural teeth lost during the term of this coverage.
- Orthodontic services: Cephalometric film, braces, appliances and all related services are not covered.

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#### **How to Enroll**

#### If you're a new member and want dental coverage ONLY:

- Complete and sign the attached application.
- Determine your premium rate and your initial payment (see Payment Options on page 16).
- Send the application, your first payment and your completed Payment Options Form to your agent or to Anthem Blue Cross and Blue Shield at the address below.
- You also may pay your initial monthly or quarterly premium by automatic deduction from your checking account, MasterCard® or Visa®.

#### If you're currently enrolled in an Anthem Blue Cross and Blue Shield health care benefits plan and want to ADD dental coverage:

- Complete the attached application.
- Determine your premium rate and your initial payment.
- Determine your payment option—it must be the same as for your health coverage. If you're using monthly checking account deduction, you must still send a check for the first month's premium with the application.
- Send the application 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 173334 Denver, CO 80217-9411



Anthem.

## Colorado Anthem Blue Individual PPO Dental Plan Enrollment Application

If Anthem approves my applica the following effective date: (se		1				Jenta	I Pla	III EIII	OIIII	ien	ιAμ	piic	alio
☐ Immediately upon approv	al, or						If yo	u are an Aı	nthem B	lue Cro	nss and f	Blue Sh	ield
☐ The 1st of the month follo	owing approval, or						subs	criber with	group h	nealth	coverage		
	76.57							r your Anth em I.D. Nun		numbe	er here:		
Specify a later date (for e	xample, the 15th o	of the month	following approval)				Anun	I I		1	1	ш	
Applicant Information	Applicant must co	omplete this	section. Please print	t.									
Last Name			First Name			MI		Social Sec	curity Nu	ımber	Li	- [	1
Home Phone Number	Bu	siness Phone	Number	Gender	Marit	al Status		Age	Date o	of Birth	(mm/dd/	yy)	
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Home Address (Must be comp	lete. A P.O. box is n	ot acceptable	2.)	Billing A	ddress (if P.	D. box or diff	ferent fro	m home ad	ldress)				
City		State	ZIP Code	City					State	1.	ZIP Cod	е	
Spouse to be Insured S	ignature required	below	1										
Last Name of Spouse		First Na	me of Spouse	Gender	Date o	f Birth (mm/	(dd/yy)	Socia	I Securit	y Numi	ber .		
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Children to be Insured										_			
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Signatures (required)												*	
If any family member lister (If the responsible adult is papers.) I (Applicant) under payment with this applica	not the natural erstand that cove	parent but erage is sub	is the legal guard eject to all condition	ian, or is under ons and provision	court orde	er to provided in the p	de cove policy. I	rage, plea (Applican	ase sub nt) unde	mit su erstand	ubstanti d that re	ating o	court
Signature of Applicant/Parent  X	or Legal Guardian		Today's Date	Signatu	re of Applica	ant's Spouse					Toda	y's Date	)
Signature of Applicant's Deper	ndent Age 18 or Ove	er	Today's Date		e of Applica	nt's Depende	ent Age 1	18 or Over			Toda	y's Date	2
X	550		3.753	x	535	35	550					0	
Agent Information													
Name of Agent (print)	VED	Agent Tax		اعاماه	Signature	of Agent		7 W.			Toda	y's Date	9
INSURASEE	KEK	2 0		1 2 0 0				19 1 L					
Court Number	estificate Nomb		- And Control of the	ANTHEM US	and in column 2 is not as in column 2 in c			Dete					
Group Number C	ertificate Number		Effective Date	e Area	В	y		Date					

An independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. @ Registered marks Blue Cross and Blue Shield Association.

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 173334 Denver, CO 80217-9411. Thank you!

It is unlowful 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 Claimant busines or linear control or Regulatory Agencies.

06-00028 (6/06)

#### **Payment Options**

Initial premium payment options: You have three options to choose from to pay your first month's premium:

- Send a paper check
- Provide payment via electronic check
- Use your credit/debit card

Complete instructions are provided on the Payment Options

Future payments options: Anthem Blue Cross and Blue Shield provides the following convenient payment options for your future payments:

- Monthly checking account automatic premium payment
- Monthly paper billing
- Monthly credit/debit card
- Bi-monthly paper billing
- Quarterly paper billing

The Payment Options Form provides complete information and instructions for each payment method. Please review carefully, make your selections for initial and future payments, fill out the appropriate information and submit the completed Payment Options Form with your application.

Flexible and convenient— You may choose from three payment options and five billing options.



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#### Paym

Payment Options				Applicant Sc	ocial Security or ID	) Number
Payment Method (Premium payment	required. Please choose from A or B.)					
A. Please choose from the options	below for your initial premium payment:					
☐ Paper Check*	☐ Electronic Check		☐ Credit/Debit Card			
B. Please choose from the followin	g options for future payments.					
☐ Monthly Checking Account Automa	tic Premium Payment (complete Section below)	☐ Monthly Cred	it/Debit Card (complete Section I	below) 🗆 Bi-	-monthly Paper Bi	illing
☐ Monthly Paper Billing	2 8 5	☐ Quarterly Pap	er Billing—submit the three-mor	nth premium	450 %	1 <u>5</u> 54
Monthly Checking Account Automa	tic Premium Payment					
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tronically debit your bank account.	If you have not sent in an initial premium		↓ L. Webb 123 Main Street		1175	
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the first of each month.						긔
Provide your routing and accou	nt numbers here.	9-Digit Bank Ro	outing Number	Rank Acco	ount Number	
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there are sufficient collected funds is subsequent payment amounts may rights in respect to each such debits debits) from my account with the fir ing you a 30-day written notice. I ag intentionally or inadvertently, you s' you will automatically be removed f	and authorize you to pay and charge to my account said account to pay the same upon presentation vary as a result of change(s) I make once enrolle shall be the same as if it were a check signed pe ancial institution indicated for payment of my Anti ree that you shall be fully protected in honoring a sall be under no liability whatsoever even though som monthly checking account automatic premiun are for any withdrawal not honored.	in. I understand that the inited, such as, but not limited ersonally by me. I authorize them Blue Cross and Blue any such debit. I further ag such dishonor results in fo	itial payment amount may vary as d to, adding and deleting depende e Anthem Blue Cross and Blue Sl Shield premiums. This authority is pree that if any such debit be dishour feiture of insurance. NOTE: Sho	s a result of change(s) ents or moving my resi hield to initiate debits is to remain in effect u onored, whether with	) during underwritir idence. I agree tha (and/or corrections intil revoked by me or without cause a	ng, and/or at your s to previous e by provid- and whether
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□Visa	☐ MasterCard	[Discover]		
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Authorized Signatu	re (as it appears on the credit card)		Cardholder Name (as it appears on the credit card) PRIN	T Date
<u>X</u>				

#### **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.

Account Holder Name PRINT	Bank Routing Number	Account Number	Amount	Check Number
			\$	

<sup>\*</sup> 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.