

Nevada Insured



Please complete the application and return using any of the below options:

Fax

ATTN: Policy Processing
Fax: (702) 529-0482

Email

processing@nevadainsured.net

Mail

Nevada Insured
ATTN: Policy Processing
7936 W Sahara Ave
Las Vegas, NV 89117

Brochure Link: [Anthem Dental Insurance Brochure](#)



Anthem Blue Individual PPO Dental Plan Enrollment Application

If Anthem approves my application, please assign the following effective date: *(select one)*

- Immediately upon approval, or
- The 1st of the month following approval, or
- _____
Specify a later date (for example, the 15th of the month following approval)

If you are an Anthem Blue Cross and Blue Shield subscriber with group health coverage, please enter your Anthem I.D. number here:

Anthem I.D. Number

Applicant Information *Applicant must complete this section. Please print.*

Last Name		First Name		MI	Social Security Number		
Home Phone Number ()		Business Phone Number ()		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Age
Home Address (Must be complete. A P.O. box is not acceptable.)				Billing Address (if P.O. box or different from home address)			
City	State	ZIP Code		City	State	ZIP Code	

Spouse to be Insured *Signature required below*

Last Name of Spouse		First Name of Spouse		Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth (mm/dd/yy)	Social Security Number
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Children to be Insured

	NAME (first and last name)	GENDER	DATE OF BIRTH (mm/dd/yy)	SOCIAL SECURITY NUMBER
1.		<input type="checkbox"/> M <input type="checkbox"/> F		
2.		<input type="checkbox"/> M <input type="checkbox"/> F		
3.		<input type="checkbox"/> M <input type="checkbox"/> F		
4.		<input type="checkbox"/> M <input type="checkbox"/> F		

Signatures (required)

If any family member listed above is a minor, I (Applicant) accept full legal and financial responsibility for the coverage and information provided on this application. (If the responsible adult is not the natural parent but is the legal guardian, or is under court order to provide coverage, please submit substantiating court papers.) I (Applicant) understand that coverage is subject to all conditions and provisions specified in the policy. I (Applicant) understand that receipt of payment with this application does not create Anthem Blue Cross and Blue Shield coverage. Coverage will be effective only upon approval by Anthem.

Signature of Applicant/Parent or Legal Guardian X	Today's Date	Signature of Applicant's Spouse X	Today's Date
Signature of Applicant's Dependent Age 18 or Over X	Today's Date	Signature of Applicant's Dependent Age 18 or Over X	Today's Date

Agent Information

Name of Agent (print) NHU Ins. Agency, Inc	Agent Tax ID Number 2 0 8 3 9 0 9 5 8	Signature of Agent	Today's Date
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FOR ANTHEM USE ONLY

Group Number	Certificate Number	Effective Date	Area	By	Date
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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

Applicant Social 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:

- 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 once enrolled, 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: _____ (13 or 16 digits)
 Expiration Date: ____/____
 Cardholder ZIP Code: _____

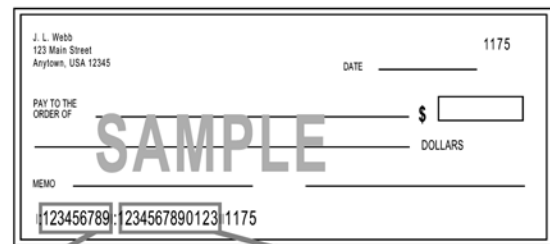
Authorized Signature (as it appears on the credit card) X	Cardholder Name (as it appears on the credit card) PRINT	Date
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Monthly Checking Account Automatic Premium Payment

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) X	Account Holder Name PRINT	Date
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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
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* 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.