



EmployeeElect for 2-50 Member Small Groups
 Health care plans offered by Anthem Blue Cross. Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company

Employee Application

anthem.com/ca

Please complete using black ink/type, seal the inside pages for privacy and return to your Group Administrator. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, please answer all questions and be sure to sign and date your application.

Group No.

1a. Medical Coverage - please ask your employer which Medical options are available before checking your selection:

- | | | | | | |
|--|--|--|--|--|--|
| <input type="checkbox"/> Premier PPO \$10 Copay* | <input type="checkbox"/> Solution 2500 PPO** | <input type="checkbox"/> Lumenos HSA 2000 (100/70)** | <input type="checkbox"/> HMO \$10 100%* | <input type="checkbox"/> Lumenos HSA 1500 (100/70)** | If HMO, be sure to provide physician number in section 3 |
| <input type="checkbox"/> Premier PPO \$20 Copay* | <input type="checkbox"/> Solution 3500 PPO** | <input type="checkbox"/> Lumenos HSA 3000 (100/70)** | <input type="checkbox"/> HMO \$25 100%* | <input type="checkbox"/> Advantage PPO \$25 Copay** | |
| <input type="checkbox"/> Premier PPO \$30 Copay* | <input type="checkbox"/> Solution 5000 PPO** | <input type="checkbox"/> Lumenos HSA 5000 (100/70)** | <input type="checkbox"/> Classic \$20 HMO* | <input type="checkbox"/> Saver PPO ** | *offered by Anthem Blue Cross |
| <input type="checkbox"/> PPO \$20 Copay** | <input type="checkbox"/> Elements Hospital Preferred** | <input type="checkbox"/> Lumenos HSA 1500 (80/50)** | <input type="checkbox"/> Classic \$30 HMO* | <input type="checkbox"/> Basic PPO ** | |
| <input type="checkbox"/> PPO \$30 Copay* | <input type="checkbox"/> Elements Hospital Plus** | <input type="checkbox"/> Lumenos HSA 2500 (80/50)** | <input type="checkbox"/> Classic \$40 HMO* | <input type="checkbox"/> PPO 2400 (HSA-Compatible)** | **offered by Anthem Blue Cross Life and Health Insurance Company |
| <input type="checkbox"/> PPO \$40 Copay* | <input type="checkbox"/> Elements Hospital** | <input type="checkbox"/> Lumenos HSA 3500 (80/50)** | <input type="checkbox"/> Saver \$20 HMO* | <input type="checkbox"/> PPO 3500 (HSA-Compatible)** | |
| <input type="checkbox"/> PPO \$25 Copay GenRx** | <input type="checkbox"/> Lumenos HIA Plus 750** | <input type="checkbox"/> High Deductible EPO* | <input type="checkbox"/> Saver \$30 HMO* | <input type="checkbox"/> Lumenos HIA Plus 3000** | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> PPO \$35 Copay GenRx** | <input type="checkbox"/> Lumenos HIA Plus 500** | | <input type="checkbox"/> Saver \$40 HMO* | <input type="checkbox"/> Power HealthFund 750** | |
| <input type="checkbox"/> PPO \$45 Copay GenRx** | | | <input type="checkbox"/> Select \$25 HMO* | <input type="checkbox"/> Power HealthFund 500** | |
- If directed by your employer, Anthem Blue Cross Life and Health will facilitate the opening of a Health Savings Account in your name.

1b. Dental Coverage - please ask your employer which Dental options are available before checking your selection:

- | | | | |
|---|--|---|--------------------------------------|
| <input type="checkbox"/> Dental Blue Silver 100-80** | <input type="checkbox"/> High Option PPO** | <input type="checkbox"/> Dental Net* | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dental Blue Silver Plus 100-80** | <input type="checkbox"/> Standard Option PPO** | For above Dental Net plan, you must select a Dental Office Number:
 | |
| <input type="checkbox"/> Dental Blue Gold 100-80** | <input type="checkbox"/> Basic Option PPO** | | |
| <input type="checkbox"/> Dental Blue Gold Plus 100-80** | | Voluntary Dental Coverage
<input type="checkbox"/> Dental PPO**
<input type="checkbox"/> Dental Saver SelectHMO* - You must select a Dental Office Number (to the left) | |
| <input type="checkbox"/> Dental Blue Platinum 100-80** | | | |
| <input type="checkbox"/> Dental Blue Platinum Plus 100-80** | | | |
| *offered by Anthem Blue Cross **offered by Anthem Blue Cross Life and Health Insurance Company | | | |

1c. Vision Coverage - please check with your employer to make sure these options are available before selecting:

- Blue View OR Blue View Plus offered by Anthem Blue Cross Life and Health Insurance Company

1d. Life Coverage - please check with your employer to make sure these options are available before selecting:

- | | |
|---|--|
| Optional Dependent Life Insurance (only if offered by your employer) | Supplemental Life Insurance (in addition to Term Life, if it is offered) <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> \$10,000/\$1,000 (\$10,000 spouse/child 6 months-24 yrs; \$1,000 less than 6 months) | Amount: <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 |
| <input type="checkbox"/> \$5,000/\$500 (\$5,000 spouse/child 6 months-24 yrs; \$500 less than 6 months) | offered by Anthem Blue Cross Life and Health Insurance Company |

2. Please provide the following enrollment information (must be completed by the employee):

- | | | | |
|---|---|------------------------------------|--|
| <input type="checkbox"/> New group enrollment | <input type="checkbox"/> New hire | <input type="checkbox"/> COBRA | COBRA/Cal-COBRA Effective Date:
 |
| <input type="checkbox"/> Family addition | <input type="checkbox"/> Change of coverage | <input type="checkbox"/> Cal-COBRA | |
| <input type="checkbox"/> Late enrollment | <input type="checkbox"/> Other: _____ | | |
- (Cal-COBRA applicants must submit first month's premium)

Last Name		First Name		M.I.	Social Security or ID No.
Home Address (P.O. Box not acceptable unless rural P.O. Box)			Apt No.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner (DP)	Spouse/DP Social Security or ID No.
City	State	ZIP Code	# of Dependents including Spouse/DP		Home Phone No. ()
Employer Name		Occupation/Job Title			Business Phone No. ()
Hire Date	<input type="checkbox"/> Part time <input type="checkbox"/> Full time	Salary (Required) \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		# of Hours Worked per Week
Life Insurance Beneficiary - Last Name		First	M.I.	Relationship	



Social Security or ID No. _____

Spouse/DP Social Security or ID No. _____

3. Please tell us about yourself and your eligible enrolling dependents:

Eligible dependent is an employee's lawful spouse or domestic partner; a child of an employee who is the permanent legal guardian of that child and for whom a valid court order establishing guardianship has been submitted; the unmarried child(ren) of the employee or, of the employee's spouse/domestic partner who are (i) under age 19 or, (ii) age 19 to age 24] who qualify as dependents for federal income tax purposes and are full-time students; or (iii) over age 19 who qualify as dependents for federal income tax purposes and incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition. Annually, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may require written proof of student status or proof of child's continuing disability due to physical or mental illness or injury. Written proof of relationship may be required for certain enrollments. For example, an existing subscriber who is adding a dependent spouse or domestic partner must provide a copy of a Marriage Certificate, Declaration of Domestic Partnership or equivalent document. For enrollment of an adopted child, legal evidence of adoption (or intent to adopt) is required.

If spouse's last name is different than yours, is he/she a domestic partner? Yes No

FAMILY ADDITION: Date of marriage or domestic partnership declaration: _____ Date of adoption: _____

Sex	Last Name	First Name	MI	Height	Weight	Birthdate Mo. Day Year	Disabled	HMO PLANS ONLY:	
								Primary Care Physician No. or 3-digit Medical Group/IPA No.	Current Patient
<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse/DP						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: Any enrolling dependent(s) who do not live at the address listed in Section 2 on previous page, please provide their address(es) on a separate piece of paper.

4. Please complete if you want to decline coverage for yourself and/or any eligible dependents:

Type of Coverage:	Declined for:	Reason for declining: (proof of coverage may be required)
Medical coverage	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Covered by spouse's/domestic partner's sponsored group plan; Carrier name: _____ ID#: _____
Dental coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Covered by Individual Policy; Carrier name: _____ ID#: _____
Vision coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Covered by Tricare <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> MediCal <input type="checkbox"/> Enrolled in any other insurance plan; Carrier name: _____ ID#: _____
Life coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Other: _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP'S MEDICAL AND/OR GROUP LIFE INSURANCE PLAN, as well as a six-month pre-existing condition exclusion UNLESS ENTITLED TO A SPECIAL ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT). The twelve (12) month wait will not apply if: (1) I certify at the time of initial enrollment that the coverage under another employer health benefit plan, a state child health insurance program, or a state Medicaid plan was the reason for declining enrollment and I lose coverage under that employer health benefit plan, a state child health insurance program, or a state Medicaid plan; (2) my employer offers multiple health benefit plans and I elected a different plan during an open enrollment period; (3) a court orders that I provide coverage under this plan for a spouse or minor child or (4) if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, they may be able to be enrolled if enrollment is requested within 31 days after the marriage, birth, adoption or placement for adoption.

If I declined enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other health insurance or group health plan coverage except coverage under a state child health insurance program, or a state Medicaid plan, I must request enrollment within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

If I declined enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of coverage under a state child health insurance program, or a state Medicaid plan, I must request enrollment for this group coverage within 60 days: (a) after the date my coverage under any of these plans ends; or (b) after the date I become eligible for state premium assistance for group coverage.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

X

Signature if declining coverage for self/dependents _____

Date (Month/Day/Year) _____



After completion, please remove tape and fold closed to seal.

Social Security or ID No. _____

5A. Health Questionnaire for Groups Enrolling 11-50 Employees - this confidential information will not be seen or given to your employer

Groups with 1-10 Enrolling Employees: **Do not complete this section; you are only required to complete the previous section.**

Has any person listed on this application:

- Ever had, consulted for, had treatment rendered, been advised to have treatment, or received treatment or been hospitalized for any of the following conditions:
Cardiovascular disease or heart attack; stroke; disorder of the kidney, stomach, intestines or liver; musculoskeletal conditions; mental or nervous condition; central nervous system disorders; diabetes; any disorder of the lungs or respiratory system; cancer or immune deficiency disorder, AIDS, or AIDS-related complex, not including the results of HIV testing? Yes No
- During the last 24 months, had surgery or been confined in any hospital, sanitarium, convalescent facility or specialized care facility or had medical expenses more than \$5,000? Yes No
- Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner? Yes No
- a. Is any female to be covered currently pregnant? Yes No
If yes, Due Date: ____ / ____ / ____
- b. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application?..... Yes No
- Does anyone listed on this application use tobacco products?..... Yes No

If you answer "Yes" to all or part of the above questions 1-4b, please complete the following (Insert additional sheets if necessary):

Question # ____ Name of patient _____
 Condition treated _____
 Dates of treatment: Start _____ End _____
 check here if still under treatment
 Treatment rendered _____
 Medication and dosage taken _____
 Dates taken: Start _____ End _____
 check here if still taking

Question # ____ Name of patient _____
 Condition treated _____
 Dates of treatment: Start _____ End _____
 check here if still under treatment
 Treatment rendered _____
 Medication and dosage taken _____
 Dates taken: Start _____ End _____
 check here if still taking

Question # ____ Name of patient _____
 Condition treated _____
 Dates of treatment: Start _____ End _____
 check here if still under treatment
 Treatment rendered _____
 Medication and dosage taken _____
 Dates taken: Start _____ End _____
 check here if still taking

Question # ____ Name of patient _____
 Condition treated _____
 Dates of treatment: Start _____ End _____
 check here if still under treatment
 Treatment rendered _____
 Medication and dosage taken _____
 Dates taken: Start _____ End _____
 check here if still taking



6. Other Coverage - please be sure to complete this important information:

1. Do any persons on this application intend to continue other Group coverage if this application is accepted?..... Yes No

If yes:
 Name of person: _____
 Insurance Company: _____

2. Has any person applying for coverage had health insurance coverage at any time in the past six months?..... Yes No

If yes:
 Applicant/family member name(s): _____
 Type of coverage: Group Individual Other: _____
 Insurance Company: _____
 Date coverage began: _____ Date ended: _____

3. Does any person applying for coverage currently have dental insurance coverage?..... Yes No

If yes:
 Applicant/family member name(s): _____
 Type of coverage: Group Individual Other: _____
 Insurance Company: _____
 Date coverage began: _____ Date ended: _____

4. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits?..... Yes No

NOTE: If you are eligible for Medicare, Anthem Blue Cross may not duplicate Medicare benefits.

SUBMIT PROOF OF COVERAGE.
To comply with federal and state laws, proof of this coverage must accompany this application.

Acceptable forms of proof are:

1. Certificate of coverage from prior carrier, *or*
2. Copy of ID card *and* copy of payroll stub showing medical coverage deduction, *or*
3. Copy of most recent medical premium bill

Please note: If you or a family member have/had a medical condition before coming to our plan for which medical advice, diagnosis, care or treatment was recommended or received within the last six months and you do not advise and provide proof of prior coverage, you may be subject to a six-month preexisting condition exclusion (does not apply to HMOs). That means that you might have to wait at least six months before the plan will provide coverage for that condition (does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption or placement for adoption). In some cases, the exclusion may last up to 12 months, or as long as 18 months for late enrollees. However, the length of the waiting period can be reduced by the number of days of prior "creditable coverage," which means not experiencing a break in qualified prior health coverage that lasted more than 63 days for an Individual plan or 180 days for an employer-sponsored or employer-related plan. Proof of creditable coverage is required to reduce a waiting period, including a copy of the certificate or other documentation, which we can help you obtain from a prior plan/issuer if needed. You have the right to obtain proof of creditable coverage from your prior plan/issuer. Please contact our [Small Group Enrollment & Billing Services] at [1-800-627-8797] if you have any questions regarding preexisting conditions.



Social Security or ID No.									

7. Agreements and Understandings - The following Agreement is to be signed by the EMPLOYEE applying for coverage.

I AGREE: To the best of my knowledge and belief, all information on this form is correct and true. I understand that this application and any information Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company obtains prior to the effective date of coverage is the basis on which coverage may be issued under the plan. I authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at my employer's place of business in permanent employment.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and any application made by my employer have been accepted and approved by ANTHEM BLUE CROSS and/or ANTHEM BLUE CROSS LIFE and HEALTH INSURANCE COMPANY.

I AM APPLYING FOR PPO COVERAGE: I understand that I am responsible for a greater portion of my medical costs when I use a nonparticipating provider. If a PPO Plan is selected and a nonparticipating provider is used, medical payments will be based upon the lesser percentage of the negotiated fee rate and I will be responsible for any amount over that payment.

I AM APPLYING FOR HMO COVERAGE: I understand that I am responsible for paying for services rendered that are not authorized by my primary medical group.

I AM APPLYING FOR A HEALTHCARE SAVINGS ACCOUNT (HSA) COMPATIBLE EPO PLAN: I understand that the High Deductible EPO Plan is designed for Exclusive Provider Organization (EPO) usage, and that using nonparticipating providers could result in significantly higher out-of-pocket costs. I understand that having this coverage does not establish an HSA. To do so, I must contact a qualified financial institution. Also, I understand that I should consult my tax advisor.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

CANCELLATION OR MODIFICATION OF COVERAGE. PLEASE READ CAREFULLY.

I attest by signing below that I have reviewed the information provided on this application and accept its 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 will be relied upon by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company in accepting this application. I understand that misstatements or failures to report new medical information prior to the effective date may result in a material change or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being cancelled. I understand that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may cancel any coverage under this application due to any of the following: (a) any material misrepresentation discovered on an application or health statement; and/or (b) an act of fraud that has been committed.

Please Read Carefully - SIGNATURE REQUIRED

REQUIREMENT FOR BINDING ARBITRATION

I understand that if my coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from Employee Retirement Income Security Act of 1974 (ERISA) or if I have a dispute that is not governed by ERISA that I will be subject to the following binding arbitration provision.

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

Signature of Employee (Required)	Date (MM/DD/YY)
X	

After completion, remove tape on inside pages, fold closed to seal, and submit application to your employer.

Small Group Services
 Anthem Blue Cross
 P.O. Box 9062
 Oxnard, CA 93031-9062
 anthem.com/ca

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After completion, remove tape on inside pages, fold closed to seal, and submit application to your employer. Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.