# Anthem Blue Cross Enrollment Form

Anthem BlueCross

Please return the completed enrollment form to your employer.

| Effective date (MM/DD/YY) | Group no. |
|---|---|
| | |

**Purpose:** ☐ New enrollment ☐ Re-hire ☐ Part-time to full-time ☐ Open enrollment ☐ Family addition ☐ Change ☐ COBRA ☐ Cal-COBRA

## Section 1: Type of coverage – Select from only the coverages offered by your employer.

### Medical

**Anthem Blue Cross plans:**

- ☐ HMO[1]
- ☐ Preferred HMO[1]
- ☐ Advantage HMO[1]
- ☐ Priority Select HMO[1]
- ☐ Select HMO[1]
- ☐ Vivity HMO[1]
- ☐ Clear Value
- ☐ Elements Choice (EQ) HMO[1]

**Anthem Blue Cross Life and Health Insurance Company plans:**

- ☐ PPO (Prudent Buyer)
- ☐ EPO (Prudent Buyer Exclusive)
- ☐ POS (Blue Cross Plus)[1]
- ☐ Elements Choice (EQ) PPO
- ☐ Medicare
- ☐ CareAdvocate PPO
- ☐ Select PPO
- ☐ BC PPO (non-California resident)
- ☐ BC Exclusive (non-California resident)
- ☐ BC CareAdvocate PPO
- ☐ Consumer Driven Health Plans: (select one of the following)
  - ☐ H.S.A.[2] ☐ H.R.A.
  - ☐ H.I.A. Plus
- ☐ Elements Choice (EQ) HSA (non-California resident)

☐ Other: _____

1 Indicate Medical Group/IPA No. in the ***Employee and family information*** section.
2 Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

### Dental

**Anthem Blue Cross plans:**

- ☐ Dental Net HMO[3]
- ☐ Choice Dental (select one of the following)
  - ☐ Dental Net HMO[3]
  - ☐ PPO Dental

**Anthem Blue Cross Life and Health Insurance Company plans:**

- ☐ Dental Consumer Choice
- ☐ Dental Essential Choice
- ☐ Dental Prime
- ☐ Dental Complete
- ☐ Dental Prime Voluntary
- ☐ Dental Complete Voluntary
- ☐ Dental Consumer Choice Voluntary
- ☐ Dental Essential Choice Voluntary
- ☐ Voluntary PPO Dental
- ☐ Dental Blue Complete Incentive
- ☐ Dental Blue PPO
- ☐ PPO Dental
- ☐ National Dental Blue PPO
- ☐ National PPO Dental
- ☐ National Voluntary PPO Dental

☐ Other: _____

3 Indicate Dental Office No. in ***Employee and family information*** section 3.

☐ UniAccount (Flexible Spending account)[4] (Indicate payroll deductions)
I authorize payroll deductions as follows: ☐ Health Care Account $_____ ☐ Dependent Care $_____

4 Anthem PPO, drug and dental plan enrollees, will have out-of-pocket expenses, automatically deducted from their Health Care FSA account. Automatic FSA processing is not possible for HMO enrollees and those with coverage through another health plan. Reminder: Automatic FSA processing is the equivalent of signing and submitting an FSA claim form, which states that you are eligible for FSA reimbursement and that you will not claim FSA reimbursed expenses on your income tax return.

### Vision

☐ Blue View Vision (offered by Anthem Blue Cross Life and Health Insurance Company)

### Life insurance

All the coverages listed may not be offered by your employer. To elect dependent coverage, the corresponding employee coverage must be selected. List all life insurance beneficiaries in the ***Life insurance beneficiary designation information*** section.

**Annual salary** $

| Elected benefit | Benefit amount | Elected benefit | Benefit amount | Elected benefit | Benefit amount |
|---|---|---|---|---|---|
| ☐ Basic Life (AD&D) | $_____ | ☐ Optional Life - Employee | $_____ | ☐ Optional AD&D - Employee | $_____ |
| ☐ Dependent Life - Spouse | $_____ | ☐ Optional Dependent Life - Spouse | $_____ | ☐ Optional AD&D - Spouse | $_____ |
| ☐ Dependent Life - Child | $_____ | ☐ Optional Dependent Life - Child | $_____ | ☐ Optional AD&D - Child | $_____ |
| | | ☐ Short Term Disability | $_____ | ☐ Voluntary Short Term Disability | $_____ |
| | | ☐ Long Term Disability | $_____ | ☐ Voluntary Long Term Disability | $_____ |

**Language choice (optional)** ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other – please specify: _____

## Section 2: Applicant's personal information

**Social Security no. required under CMS Regulations and by the IRS.**

| Last name | First name | M.I. | Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP) | Social Security or ID no.[5] (required) |
|---|---|---|---|---|
| | | | | |
| Mailing address | | Apt. no. | No. of dependents including spouse | Spouse/DP Social Security or ID no.[5] (required) |
| | | | | |
| City | | State | ZIP code | Home phone no. |
| | | | | |

| Hire date/Rehire date Part-time to Full-time date (MM/DD/YY) | Employer name | Job title | Class | Dept. no. | Email address |
|---|---|---|---|---|---|
| | | | | | |

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.
5 Anthem is required by the Internal Revenue Service to collect this information.

Social Security or ID no.[1] (required)

## Section 3: Employee and family information — Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

| Sex | Last Name | First Name | M.I. | Birthdate (MM/DD/YY) | Social Security or ID no.[1] (required) | Full-time student (if applicable, for non-medical plans) | If children are age 26 or over you must check the appropriate boxes below | HMO & POS ONLY IPA/Primary Care Physician code | Current MD? | Dental Net ONLY Office no. |
|---|---|---|---|---|---|---|---|---|---|---|
| ☐ M ☐ F | Employee | | | | | | | | ☐ Yes ☐ No | |
| ☐ M ☐ F | Spouse/DP | | | | | | IRS Qualified Dependent | | ☐ Yes ☐ No | |
| ☐ M ☐ F | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | | ☐ Yes ☐ No | |
| ☐ M ☐ F | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | | ☐ Yes ☐ No | |
| ☐ M ☐ F | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | | ☐ Yes ☐ No | |
| ☐ M ☐ F | | | | | | ☐ Yes ☐ No | ☐ Yes ☐ No | | ☐ Yes ☐ No | |

## Section 4: Declination — Please complete if any coverage is declined or refused by an eligible employee and/or their eligible dependents.

**A. Medical coverage declined for:**
☐ Myself ☐ Spouse/DP ☐ Child(ren)

**B. Dental coverage declined for:**
☐ Myself ☐ Spouse/DP ☐ Child(ren)

**C. Vision coverage declined for:**
☐ Myself ☐ Spouse/DP ☐ Child(ren)

**D. Life insurance coverage declined for:**
☐ Myself ☐ Spouse/DP ☐ Child(ren)

**Reason for declining coverage – check one**

☐ Covered by spouse's group coverage
Carrier name and ID no.: _____

☐ Covered by Anthem Individual policy

☐ Spouse covered by employer's group medical coverage
Carrier name: _____

☐ Enrolled in Tricare

☐ Enrolled in any other insurance carrier plan
Carrier name: _____

☐ Medicare

☐ Other (Explain): _____

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 UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN.**

| Signature if declining coverage for employee/dependent(s) | Date (MM/DD/YY) |
|---|---|
| X | |

## Section 5: COBRA/Cal-COBRA coverage information — Complete only if enrolling in COBRA/Cal-COBRA.

Reason for COBRA/Cal-COBRA coverage

| Federal COBRA qualifying event date | Federal COBRA coverage begin date | Federal COBRA coverage end date |
|---|---|---|
| Cal-COBRA qualifying event date | Cal-COBRA coverage begin date | Cal-COBRA coverage end date |

1 Anthem is required by the Internal Revenue Service to collect this information.

Social Security or ID no.[1] (required)

## Section 6: Other coverage for all enrolling employees and dependents – All questions must be answered.

A. Do any persons on this application intend to continue other group coverage if this application is accepted? ☐ Yes ☐ No

If yes, name of person(s): _____

Insurance company: _____ Policy no. _____ Phone no. _____

B. Does any person applying for coverage currently have **health** insurance coverage? ☐ Yes ☐ No

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 continuous coverage: ☐ Group ☐ Individual ☐ Other: _____

Insurance company: _____ Policy no. _____ Phone no. _____

Date coverage began: ____/____/____ Date ended: ____/____/____ (MM/DD/YY)

C. Does any person applying for coverage currently have **dental** insurance coverage? ☐ Yes ☐ No

If yes, applicant/family member name(s): _____

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____ Includes orthodontia? ☐ Yes ☐ No

Insurance company: _____ Policy no. _____ Phone no. _____

Date coverage began: ____/____/____ Date ended: ____/____/____ (MM/DD/YY)

D. Does any person applying for coverage currently have **vision** insurance coverage? ☐ Yes ☐ No

If yes, applicant/family member name(s): _____

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____

Insurance company: _____ Policy no. _____ Phone no. _____

Date coverage began: ____/____/____ Date ended: ____/____/____ (MM/DD/YY)

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

*Note: If you are eligible for Medicare, Anthem may not duplicate Medicare benefits.*

## Section 7: Medicare – Complete if you, your spouse or dependent child(ren) have Medicare coverage. Attach additional sheets if necessary.

| Name (last, first, M.I.) | Part A effective date (MM/DD/YY) | Part B effective date (MM/DD/YY) | Medicare claim no. |
|---|---|---|---|
| | | | |
| | | | |

## Section 8: Prior coverage for PPO and dental plans only – Attach additional sheets if necessary.

Please fill out the following information to receive proper credit for **previous coverage** (if immediately prior to becoming eligible for this plan, you have a dependent child(ren) over the age of 26 who cannot get a self-sustaining job due to a physical or mental condition and was covered under any public or private health care coverage, including MediCal or individual coverage). **Note**: If this section is left blank, there may be delays in the processing of claims for these dependents. If any coverage will remain in force once your dependent(s) enroll with Anthem, leave the end date blank.

| Name (last, first, M.I.) | Type (check one) | Coverage (check all that apply) | Carrier name | Carrier phone no. | Policy ID no. | Date (if applicable) (MM/DD/YY) | Reason for ending coverage (if applicable) |
|---|---|---|---|---|---|---|---|
| | ☐ Individual<br>☐ Group<br>☐ Medicare | ☐ Health<br>☐ Dental<br>☐ Orthodontia | | | | Start:<br>End: | |
| | ☐ Individual<br>☐ Group<br>☐ Medicare | ☐ Health<br>☐ Dental<br>☐ Orthodontia | | | | Start:<br>End: | |
| | ☐ Individual<br>☐ Group<br>☐ Medicare | ☐ Health<br>☐ Dental<br>☐ Orthodontia | | | | Start:<br>End: | |

1 Anthem is required by the Internal Revenue Service to collect this information.

| Social Security or ID no.[1] (required) |
|---|
| |

## Section 9: Life insurance beneficiary designation information

**Note:** Dependent Life payments are always paid to the employee.
**Primary Beneficiary – First to receive payment (required)** If two beneficiaries are named, enter a % for each. If no % is shown, equal shares are assumed.

| Name | Birthdate (MM/DD/YY) | Social Security no. | Relationship | % |
|---|---|---|---|---|
| Street address | | City | State | ZIP code |
| Name | Birthdate (MM/DD/YY) | Social Security no. | Relationship | % |
| Street address | | City | State | ZIP code |

## Section 10: Please read carefully – Signature required.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

**Deduction authorization**: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

**Non-participating provider**: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

**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.

**Effective date**: The effective date of coverage is subject to Anthem approval.

**COBRA/Cal-COBRA Continuation Coverage**

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1. The date eligibility for COBRA Continuation Coverage ends, or
2. The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3. The date your employer discontinues coverage with Anthem, or
4. The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5. The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

**Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.**

**Electronic notice:** By signing the field below labeled "Signature (Required)" I'm also consenting to get information about my benefits by email or electronically. This may include my certificate or evidence of coverage, explanation of benefits statements, required notices and helpful or personalized information to get the most out of my plan, so I will make sure Anthem has my most up to date email. These electronic communications may include specific details about me and my plan. I know I can change my mind at any time or request a free copy of specific materials by mail. I'll just contact Anthem to do either.

I certify each Social Security number listed on this application is correct.

### REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage)

**ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY (ANTHEM), 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, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: *It is understood that 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 permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, 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.* YOU AND ANTHEM AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "handwritten or electronic" signature below, you acknowledge that such signature is valid and binding.**

*Signature (Required)*

| Applicant<br>X | Date (MM/DD/YY) |
|---|---|

1 Anthem is required by the Internal Revenue Service to collect this information.