Anthem Blue Cross Enrollment Form

Effective date	Group no.

Anthem BlueCross

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

TYPE OF COVERAGE—Select from only the coverages offered by your employer

Medical

Anthem Blue Cross Plans:

☒ HMO (CaliforniaCare)[1]
☐ Preferred HMO (CaliforniaCare PLUS)[1]
☐ Advantage HMO[1]
☐ Priority Select HMO[1]
☐ Other: _____
☐ Select HMO[1]
☐ Vivity HMO[1]
☐ 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
☐ CardAvocate PPO
☐ Select PPO
☐ BC PPO (non-California resident)
☐ BC Exclusive (non-California resident)
☐ BC CareAdvocate PPO
☐ Lumenos®
(select one of the following)
☐ H.S.A. ☐ H.R.A.
☐ H.I.A. ☐ H.I.A. Plus
☐ Elements Choice EQ HSA

[1] Indicate Medical Group/IPA No. in the *Employee and Family Information* section.

LANGUAGE CHOICE (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other—please specify: _____

APPLICANT'S PERSONAL INFORMATION Social Security numbers are required under CMS Regulations and by the IRS

Last name	First Name	M.I.	Marital status ☐ Single ☐ Married ☐ Domestic Partner	Social Security or ID no.[3] (required)
Mailing address		Apt. No.	# of dependents including spouse	Spouse/DP Social Security or ID no.[3] (required)
City		State	Zip code	Home phone no.

Hire date/Rehire date Part-time to Full-time date	Employer name	Job title	Class	Dept. no.	Email address

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.	Birthday (MM/DD/YY)	Social Security or ID no.[3] (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	

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.[3] (required)

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 Blue Cross 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 Blue Cross, 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 Blue Cross, 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, 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.

W-9 Certification Language

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

REQUIREMENT FOR BINDING ARBITRATION

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 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. *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 permitted and as provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not be 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 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 AND PARTICIPATION IN A CLASS ACTION 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.

Applicant	Date
X	

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