Anthem Blue Cross

2-50 Existing Small Group Employee Addition Application
For adding new employees and their eligible dependents to existing coverage

Employee Application

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

Anthem Blue Cross offers: Premier PPO plans, PPO Copay plans, High Deductible EPO, Saver HMO, Classic HMO, HMO 100%, Power Select HMO, Dental Net and Dental SelectHMO.

Anthem Blue Cross Life and Health Insurance Company offers: Basic PPO, Saver PPO, Solution Plans, PPO $35 Copay GenRx, PPO $45 Copay GenRx, Power HealthFund plans, Lumenos plans, PPO 3500, PPO 2400, Advantage PPO; all dental products except Dental Net and Dental SelectHMO; Life and AD&D plans.

INSTRUCTIONS

1. **You, the employee, must complete this application.** You are solely responsible for its accuracy and completeness.
2. All questions must be answered in full; all signatures and dates must be included where noted; otherwise, the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
3. **Type or print clearly using blue or black ink.**

Group Number: ☐☐☐☐☐☐☐

1 COVERAGE – *Please verify with your employer which plans are available.*

A. MEDICAL COVERAGE SELECTION – *Check only one Medical Plan:*

☐ Basic PPO	☐ Lumenos HSA 3000	☐ PPO 2400 (HSA-Compatible)	☐ Classic $30 HMO
☐ Saver PPO	☐ Power HealthFund 750	☐ Solution 2500 PPO	☐ Saver HMO
☐ PPO $35 Copay GenRx	☐ Lumenos HIA Plus 3000	☐ Solution 3500 PPO	☐ Saver $30 HMO
☐ PPO $45 Copay GenRx	☐ Advantage PPO $25 Copay	☐ Solution 5000 PPO	☐ Power SelectHMO
☐ PPO $30 Copay	☐ Premier PPO $20 Copay	☐ High Deductible EPO	☐ Power $35 SelectHMO
☐ PPO $40 Copay	☐ Premier PPO $10 Copay	☐ HMO 100%	☐ Other: _____
☐ Lumenos HSA 1500	☐ Power HealthFund 500	☐ HMO $25 100%	
☐ Lumenos HSA 2000	☐ PPO 3500 (HSA-Compatible)	☐ Classic HMO	

If selecting an HMO, you must select a Primary Medical Group (PMG) or an Independent Practice Association (IPA).

If you are selecting an IPA, please select a Primary Care Physician for each enrolling family member and list by number below in Section 3A.

HMO plan PMG or IPA Medical Office Number: ☐☐☐ Are you currently a patient of this facility? ☐ Yes ☐ No

B. DENTAL COVERAGE SELECTION – (If group has elected Dental Coverage) – *Check only one Dental Plan:*

☐ Dental Blue Silver	_100-80 _100 _200 _300	☐ Basic Option PPO*	
☐ Dental Blue Silver Plus	_100-80 _100 _200 _300	☐ Standard Option PPO*	
☐ Dental Blue Gold	_100-80 _100 _200 _300	☐ High Option PPO*	
☐ Dental Blue Gold Plus	_100-80 _100 _200 _300	☐ Other _____	
☐ Dental Blue Platinum	_100-80 _100 _200 _300		
☐ Dental Blue Platinum Plus	_100-80 _100 _200 _300		

**Fee-for-service dental coverage is substituted if the member is outside of PPO dental service area.*

You must select a dental office number for the following plans:

☐☐☐☐☐☐☐ Dental Office No.

☐ Dental Net
☐ Dental SelectHMO

Voluntary Dental Coverage
☐ PPO Dental Plan**
☐ Dental Saver SelectHMO – You must select a dental office number

C. OPTIONAL DEPENDENT LIFE INSURANCE – *(Available only if offered by employer.)* ☐ Yes ☐ No

D. SUPPLEMENTAL LIFE INSURANCE – *(Available only if offered by employer.)*

☐ Yes ☐ No Amount: ☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ $100,000

2 EMPLOYEE INFORMATION – *Must be completed by employee.*

☐ Family addition ☐ New hire ☐ COBRA COBRA/Cal-COBRA Effective Date: ☐☐☐☐☐☐☐☐
☐ Late enrollment ☐ Other ☐ Cal-COBRA*

**Cal-COBRA applicants must submit first month's premium.*

Last Name	First Name	M.I.	Marital Status ☐ Single ☐ Married	Social Security or ID No.
Home Address (P.O. box not acceptable unless rural P.O.) Apt No.			# of Dependents including Spouse*	Spouse's Social Security or ID No.
City		State	ZIP Code	Home Phone No. ( )

Hire Date (MM/DD/YY)	Employer Name	Occupation/Job Title	☐ Part time ☐ Full time	# of Hours Worked per Week

Business Phone No. ( )	Salary (Required) $ ☐ Hourly ☐ Weekly ☐ Monthly	Life Insurance Beneficiary – Last Name, First, M.I.	Relationship

Language Choice (Optional) ☐ English ☐ Spanish ☐ Chinese ☐ Korean

**Spouse includes domestic partner ONLY if your employer has elected that coverage. If coverage is available, domestic partner enrollment requires submission of a signed and notarized Domestic Partner Affidavit or, if applicable, a copy of a valid Declaration of Domestic Partnership filed with and stamped by the Secretary of State of California.*

3 EMPLOYEE / DEPENDENT INFORMATION — *List yourself and only those eligible dependents who are enrolling.*

Social Security or I.D. No.

An eligible "dependent" is an employee's lawful spouse or domestic partner (if employer has elected to cover domestic partners); a child (except a newborn) of an employee who is the permanent legal guardian of that child and for which a valid court order establishing guardianship has been submitted; the unmarried child(ren) of the employee or, of the employee's spouse who are under age 19, or, the unmarried child(ren) of the employee or enrolled spouse from the nineteenth (19th) to the twenty-fourth (24th) birthday who qualify as dependents for federal income tax purposes and are full time students. Anthem Blue Cross requires written proof of student status annually.

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

FAMILY ADDITION: **Date of marriage:** ____ **Date of Adoption:** ____

3A. HMO only - IPA
If you select an IPA you must choose a primary care physician for each member of your family.

Sex	Last Name	First Name	MI	Height	Weight	Disabled?	Birthday Mo. Day Year	Primary Care Physician No.
☐ Male ☐ Female	Employee					☐ Yes ☐ No		
☐ Male ☐ Female	Spouse*					☐ Yes ☐ No		
☐ Son ☐ Daughter						☐ Yes ☐ No		
☐ Son ☐ Daughter						☐ Yes ☐ No		
☐ Son ☐ Daughter						☐ Yes ☐ No		
☐ Son ☐ Daughter						☐ Yes ☐ No		

4 COVERAGE DECLINATION — *To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependents. Proof of coverage may be required.*

A. Health Plan coverage declined for:
☐ Myself ☐ Spouse*
☐ Child(ren)

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

C. Life Insurance declined for:
☐ Myself ☐ Spouse*
☐ Child(ren)

Reason for declining coverage: *(Check one)*

☐ Covered by spouse's group coverage –
Carrier name and I.D. number: _____

☐ Covered by Anthem Blue Cross Individual Policy

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

☐ Covered by 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 UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN. PREEXISTING CONDITIONS, WHEN ENROLLED IN THIS GROUP MEDICAL PLAN, MAY NOT BE COVERED FOR SIX (6) MONTHS.**

X_____ _____

Signature if declining coverage for employee/dependent(s) *Date (Month/Day/Year)*

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5 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: _____ Insurance Company: _____

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: _____ Date coverage began: _____ Date ended: _____

C. Does any person applying for coverage currently have Dental Insurance Coverage?..... ☐ Yes ☐ No

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

If Yes, Applicant/family member name(s): _____

Insurance Company: _____ Date coverage began: _____ Date ended: _____

D. 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 I.D. card ***and*** copy of payroll stub showing medical coverage deduction, ***or***
3. Copy of most recent medical premium bill or certificate of coverage from prior carrier.

Failure to advise and provide proof of coverage may subject you or a family member to a six month pre-existing conditions clause.

6 AUTHORIZATION – *The following Authorization is to be signed by ALL EMPLOYEES 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 non-participating provider. If a PPO Plan is selected and a non-participating 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 Health Savings Account (HSA) compatible EPO PLAN: I understand that the High Deductible plans are designed for Exclusive Provider Organization (EPO) usage, and that using non-participating 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.

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6 AUTHORIZATION – *Continued*

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.

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.

REQUIREMENT FOR BINDING ARBITRATION

I understand that if my coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from Employment Retirement Income Security Act of 1974 (ERISA) or if I have a disputethat 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 OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. 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 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 OR ANY OTHER ISSUES RELATED TO THE PLAN.**

All signatures and dates below are required if applying for coverage.

Signature of Employee	Date *(MM/DD/YY)*	Signature of Employee's Spouse *(If applying for coverage)*	Date *(MM/DD/YY)*
X		**X**	

see above

After completion, sign Authorization 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.