Employee Enrollment Application
For 1–100 Employee Small Groups
California

Anthem BlueCross

Health care plans offered by Anthem Blue Cross (Anthem). Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company.

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Note: Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect Social Security numbers.

Submit application to: your employer.

Group/Case no. (if known)

Please complete in black ink only.

Section A: Employee Information

Last name	First name	M.I.	Social Security no.[1] (required)

Home address – Street and P.O. Box if applicable

City	State	ZIP code

County	Marital status ☐ Single ☐ Married ☐ Domestic Partner	Primary phone no.	Number of dependents

Employee email address

Employer name

Employer street address

City	State	ZIP code

Employment status ☐ Full time ☐ Part time ☐ Disabled	Occupation

Date of hire (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins (MM/DD/YYYY)	No. of hours worked per week

Language choice (optional): ☐ English (ENG) ☐ Spanish (SPA) ☐ Chinese (ZHOX) (C/M) ☐ Korean (KOR) ☐ Vietnamese (VIE) ☐ Tagalog (TGL)
☐ Other (W09) – please specify: _____

Do you read and write English? ☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability/Translator's Statement.

Section B: Application Type

Select one:
☐ New enrollment ☐ Open enrollment/Qualifying event ☐ COBRA/Cal-COBRA ☐ Rehire date (For Life and Disability only) ____

If you select **Open enrollment/Qualifying event** or **COBRA/Cal-COBRA**, please select one event reason.
☐ Open enrollment (not applicable for life and disability) ☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Divorce or legal separation ☐ Death
☐ COBRA ☐ Cal-COBRA – Cal-COBRA applicants must submit first month's premium.
☐ Involuntary loss of coverage – please explain (required): _____
☐ Other – please explain (required): _____

COBRA/Cal-COBRA/Open enrollment/Qualifying event date – Required: ____ (MM/DD/YYYY)

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Reset Form Save and Print

Social Security no.[1]

Section C: Type of Coverage – Select from only the coverage offered by your employer.

1. Medical Coverage – select one option **Medical plans offered by Anthem Blue Cross.**

Please Note: All health plans include the required coverage for the dental and vision pediatric essential health benefits.

	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
PPO: Prudent Buyer PPO Network	☐ 20/10%/3000 ☐ 200/10%/3000	☐ 20/30%/6500 ☐ 500/20%/6500 ☐ 750/20%/6500 ☐ 1000/20%/6000 ☐ 2000/20%/4000	☐ 1250/40%/7350 ☐ 1750/35%/7350 ☐ 2000/20%/6000 w/HSA – RxC ☐ 2000/40%/7350	☐ 4500/35%/6550 w/HSA ☐ 5000/30%/7350 ☐ 5000/35%/6550 w/HSA ☐ 6000/35%/7350 ☐ 6500/0%/6500 w/HSA
PPO: Select PPO Network	☐ 15/10%/3350 ☐ 20/10%/3000 ☐ 200/10%/3000	☐ 20/30%/6500 ☐ 25/20%/6000 ☐ 500/20%/6500 ☐ 750/20%/6500 ☐ 1000/20%/6000 ☐ 2000/20%/4000	☐ 1250/40%/7350 ☐ 1750/35%/7350 ☐ 2000/20%/6000 w/HSA – RxC ☐ 2000/20%/7000 ☐ 2000/40%/7350	☐ 4500/35%/6550 w/HSA ☐ 4800/40%/6550 w/HSA ☐ 5000/30%/7350 ☐ 5000/35%/6550 w/HSA ☐ 6000/35%/7350 ☐ 6500/0%/6500 w/HSA
HMO: CaliforniaCare HMO Network	☐ 10/10%/2000	☐ 25/20%/5500 ☐ 40/20%/4500 ☐ 500/20%/5000 ☐ 1000/30%/4000	☐ 1500/35%/7150 ☐ 2000/40%/7350	
HMO: Select HMO Network	☐ 10/10%/2000	☐ 25/20%/5500 ☐ 40/20%/4500 ☐ 500/20%/5000 ☐ 1000/30%/4000	☐ 1500/35%/7150 ☐ 2000/40%/7350	

☐ Other: _____

Please indicate the contract code for the medical plan selected.

Contract code, if known: _____

Member medical coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

2. Dental Coverage – Select from only the coverage offered by your employer.

Anthem Dental Net DHMO[2], Anthem Dental Prime and Complete[3] with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.

Member dental coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

If you are waiving coverage for yourself and/or your eligible dependents, please complete section F.

Please indicate the name and contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.

Plan name: _____ Contract code: _____

For all DHMO plans, you must enter your dental office no.: _____

3. Vision Coverage – Select from only the coverage offered by your employer. **Offered by Anthem Blue Cross Life and Health Insurance Company.**

These optional vision plans do not include coverage for vision pediatric essential health benefits.

Member vision coverage – select one:

☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

If you are waiving coverage for yourself and/or your eligible dependents, please complete section F.

Please indicate the name and contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.

Plan name: _____ Contract code: _____

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2 Offered by Anthem Blue Cross.
3 Offered by Anthem Blue Cross Life and Health Insurance Company.

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4. Life and Disability Coverage — A minimum of two employees must enroll. Offered by Anthem Blue Cross Life and Health Insurance Company.

☐ Basic Life and AD&D
☐ Basic Dependent Life
☐ Optional Supplemental/Voluntary Life and AD&D $ _____ (Employee amount)
☐ Optional Supplemental/Voluntary Dependent Life Spouse $ _____ (Spouse amount)
☐ Optional Supplemental/Voluntary Dependent Life Child $ _____ (Child amount)
☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income	Occupation	Life and Disability class no.

Primary Beneficiary — Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Contingent Beneficiary — Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Total percentages must add up to 100%.
If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

Spousal Consent for Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse's consent for designation.)
If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature **X**	Spouse name	Date (MM/DD/YYYY)

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

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Section D: Coverage Information — All fields required. Attach a separate sheet if necessary.
Please access *Find a Doctor* at anthem.com to determine if your physician is a participating provider.
For HMO plans: provide 3- or 6-digit Primary Care Physician no.

Dependent information must be completed for all additional dependents (if any) **to be covered under this coverage**. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26). In the case of your child, the age limit of 26 does not apply when the child is and continues to be (1) incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and (2) chiefly dependent upon the subscriber for support and maintenance. The employee will be required to submit certification by a physician of the child's condition. List all dependents beginning with the eldest.

Employee last name | First name | M.I.

Sex ☐ Male ☐ Female | Disabled ☐ Yes ☐ No | Birthdate (MM/DD/YYYY) | Relationship to applicant: Self

Primary Care Physician name (PCP) (if selecting an HMO plan) | PCP ID no. (HMO only) | Existing patient ☐ Yes ☐ No

Spouse/Domestic Partner last name | First name | M.I. | Social Security no.[1] (required)

Sex ☐ Male ☐ Female | Disabled ☐ Yes ☐ No | Birthdate (MM/DD/YYYY) | Relationship to applicant ☐ Spouse ☐ Domestic Partner

PCP name (if selecting an HMO plan) | PCP ID no. (HMO only) | Existing patient ☐ Yes ☐ No

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, full address and ZIP code: ____________________

Dependent last name | First name | M.I. | Social Security no.[1] (required)

Sex ☐ Male ☐ Female | Disabled ☐ Yes ☐ No | Birthdate (MM/DD/YYYY) | Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ____________

PCP name (if selecting an HMO plan) | PCP ID no. (HMO only) | Existing patient ☐ Yes ☐ No

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, full address and ZIP code: ____________________

Dependent last name | First name | M.I. | Social Security no.[1] (required)

Sex ☐ Male ☐ Female | Disabled ☐ Yes ☐ No | Birthdate (MM/DD/YYYY) | Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ____________

PCP name (if selecting an HMO plan) | PCP ID no. (HMO only) | Existing patient ☐ Yes ☐ No

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, full address and ZIP code: ____________________

Dependent last name | First name | M.I. | Social Security no.[1] (required)

Sex ☐ Male ☐ Female | Disabled ☐ Yes ☐ No | Birthdate (MM/DD/YYYY) | Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ____________

PCP name (if selecting an HMO plan) | PCP ID no. (HMO only) | Existing patient ☐ Yes ☐ No

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, full address and ZIP code: ____________________

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Section E: Prior and Other Coverage

1. Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No
   If yes, give name: _____

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date:
Medicare Part D ID no.	Medicare Part D carrier		Part D effective date

2. Does anyone on this application intend to continue other coverage if this application is accepted? ☐ Yes ☐ No
3. Is anyone applying for coverage covered by other health, dental, or vision coverage? ☐ Yes ☐ No
4. On the day your coverage begins, will you or a family member be covered by other dental coverage? ☐ Yes ☐ No

If yes to any of these questions, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision				Start: End:

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Section F: Waiver/Declining Coverage – Proof of coverage will be required. (Proof of coverage not applicable to Life or Disability.)

Medical coverage declined for – check all that apply:	☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Dental coverage declined for – check all that apply:	☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Vision coverage declined for – check all that apply:	☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
***Life/AD&D** coverage declined for	☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Dependent Life coverage declined for:	☐ Spouse/Domestic Partner and Dependents
Short Term Disability coverage declined for:	☐ Myself
Long Term Disability coverage declined for:	☐ Myself
Optional Supplemental/Voluntary coverage declined for:	☐ Myself
Optional Supplemental/Voluntary Dependent Life coverage declined for:	☐ Spouse/Domestic Partner and Dependents
Voluntary Short Term Disability coverage declined for:	☐ Myself
Voluntary Long Term Disability coverage declined for:	☐ Myself

Reason for declining coverage – check all that apply:

☐ Covered by spouse's/domestic partner's group coverage
☐ Enrolled in other insurance –Please provide company name and plan:

_____

☐ Enrolled in individual coverage
☐ Spouse/Domestic Partner covered by employer's group medical coverage
☐ Medicare/Medicaid/VA
☐ Other – please explain:

_____

☐ No coverage

List names of dependents to be waived: _____

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 waive coverage. BY WAIVING THIS GROUP MEDICAL, DENTAL, VISION, DISABILITY OR LIFE COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, VISION, DISABILITY OR LIFE COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT TO BE ENROLLED IN THIS GROUP'S MEDICAL, DENTAL, VISION, DISABILITY OR LIFE PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT.

Special Open Enrollment (Not applicable to Life or Disability.)
If you declined enrollment for yourself or your dependent(s) (including a spouse/domestic partner), you may be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of certain triggering events, including: (1) you or your dependent loses minimum essential coverage; (2) you gain or become a dependent; (3) you are mandated to be covered as a dependent pursuant to a valid state or federal court order; (4) you have been released from incarceration; (5) your health coverage issuer substantially violated a material provision of the health coverage contract; (6) you gain access to new health benefit plans as a result of a permanent move; (7) you were receiving services from a contracting provider under another health benefit plan, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan; (8) you are a member of the reserve forces of the United States military or a member of the California National Guard, and returning from active duty service; or (9) you demonstrate to the department that you did not enroll in a health benefit plan during the immediately preceding enrollment period because you were misinformed that you were covered under minimum essential coverage. You must request special enrollment within 60 days from the date of the triggering event to be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of a qualifying triggering event.

*I hereby certify that I have been given the opportunity to apply for the available group life and/or disability benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense. Please examine your options carefully before waiving this coverage.

Sign here only if you are declining coverage for yourself or dependents.

Signature of applicant	Printed name	Date (MM/DD/YYYY)
X		

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Section G: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to make or cause to be made a knowingly false or fraudulent material statement or material representation to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that:

I have read or have had read to me the completed application, and I realize any acts of fraud or intentional misrepresentation of material fact in the application may result in loss of coverage within 24 months following the issuance of the coverage.

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

I understand that I may not assign any payment under my Anthem Blue Cross (Anthem) program. I agree to have money taken from my wages, if necessary, to cover the premium cost for the coverage applied for.

I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application or sold case coverage documents.

I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for coverage (and that Anthem Blue Cross Life and Health Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage.

I also understand that I may not be covered for pre-existing conditions for Long Term Disability and Short Term Disability, if applicable. (See the policy/certificate for important information).

I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.

I understand that coverages will become effective on the date established by the provisions of the group policy, contract and certificates issued thereunder.

By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

By signing below, I (primary applicant) agree to receive my plan-related communications either by email or electronically. This may include my certificate, evidence of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my plan. I agree to provide and update Anthem with my current email address. I know that at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Anthem.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

If applying for Life and/or Disability insurance, I represent that I have read and agree to the terms in the *Life and Disability Coverage* in Section 4, above.

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.

Read carefully – Signature required

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, 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 BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY 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 signing, writing or typing your name below you agree to the terms of this agreement and acknowledge that your signed, written or typed name is a valid and binding signature.

Sign here	Applicant signature X	Date (MM/DD/YYYY)

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