

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: _____ fax: _____

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: Anthem Blue Cross

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...





Benefits from Anthem Blue Cross
Small business solutions. A package that fits.

Employer Application

Small Group Services
Anthem Blue Cross
P.O. Box 9042
Oxnard, CA 93031-9042
anthem.com/ca

BeneFits is a package of plans designed to help small businesses offer coverage for a range of unique needs. Included are health plans and options for dental, life and vision coverage from either Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company.

From Anthem Blue Cross Life and Health:

- | | |
|------------------------------------|--|
| <i>Hospital BeneFits</i> | Hospitalization only benefits |
| <i>Hospital BeneFits Plus</i> | Hospitalization plus limited doctor visit benefits |
| <i>Hospital BeneFits Preferred</i> | Hospitalization and limited doctor visit, dental & vision benefits |
| <i>PPO \$35 Copay GenRx</i> | Comprehensive PPO coverage with generic-only drug benefits |
| <i>Lumenos HSA 3000</i> | Will Employer establish a Mellon Health Savings Account? <input type="checkbox"/> Yes <input type="checkbox"/> No |

From Anthem Blue Cross: *Power Select HMO* Comprehensive HMO coverage in selected areas Other: _____

Please complete using black ink/type and return to your Anthem Blue Cross agent.

1. Please tell us about your company...			
Company Name		Group No. (For existing groups)	
Street Address	City	State	ZIP Code
Billing Address	City	State	ZIP Code
Employer is: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Other (Explain):	SIC Code	Type of Business (Be specific)	
Date Business Established (Mo/Yr)	Company Contact Person	Phone No. ()	Fax No. ()
Has company been insured by Anthem Blue Cross in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date prior Anthem Blue Cross coverage terminated:	E-mail Address	Tax ID No.	

2. How much will you contribute to employee/dependent monthly premiums?	
Employee contribution - please fill in one option or the other, not both:	
\$ _____ (\$50 or more, in \$5 increments)	OR _____ % (25% or more, in 5% increments)
Employees' dependent's contribution (optional) - please fill in one option or the other, or leave blank if not applicable:	
\$ _____ (\$50 or more, in \$5 increments)	OR _____ % (25% or more, in 5% increments)

3. Would you like to offer Dental coverage?	
Please check one or two choices below if you would like to add dental coverage. (Note: the Hospital BeneFits Preferred plan includes dental coverage). <input type="checkbox"/> Other _____	If you are adding dental coverage, please specify percentage of employer contribution to monthly premiums:
<input type="checkbox"/> Dental Blue BeneFits from Anthem Blue Cross Life and Health	Employee Dental: _____ % (50% or more in 5% increments)
<input type="checkbox"/> Dental Net from Anthem Blue Cross	Dependent Dental: _____ % (no minimum requirement)

4. Vision Coverage Preferences ... what plan choice and payment percentage would you like to select?	
Please check one or both choices if you would like to add vision coverage. (Note: the Hospital BeneFits Preferred plan includes vision coverage)	
4a. I choose to offer (vision coverage offered by Anthem Blue Cross Life and Health): <input type="checkbox"/> Blue View Vision AND/OR <input type="checkbox"/> Blue View Plus	
4b. My employee contribution will be (50-100%): _____ % per employer _____ % per dependent	

Health care plans provided by Anthem Blue Cross. Insurance plans provided by Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensees of the Blue Cross Association. ©ANTHEM is a registered trademark. ©The Blue Cross name and symbol are registered marks of the Blue Cross Association.



5. Do you want to offer Life coverage?

Yes No (By selecting \$25,000 or more of Life coverage, your group may qualify for 1% savings on medical premiums)

If Yes:

Please specify the amount, from \$15,000 to \$50,000 in \$5,000 increments: \$ _____

Please specify employer contribution (25% or more, in 5% increments): Employee Life: _____%

6. Do you want to enroll in P.O.P.?

Yes No

The first year is FREE if your group has 5+ enrolling members; otherwise the cost per year is \$125. Please read the P.O.P. brochure for complete details. If you choose to enroll please complete the enrollment form, provide a separate check (if applicable), and submit along with this application.

7. What is your requested effective date?

____/____/____ Actual effective date will be assigned if application is accepted.

8. Please tell us about your group's eligibility ...

A. Total number of employees (including owners/officers): _____

B. Number of eligible full-time employees (minimum 30 hours per week): _____

C. Are part-time employees to be covered? Yes No
If yes, check one option:
 20-29 hours weekly
 15-29 hours weekly

D. Are all eligible employees subject to withholding as on a W-2 form? Yes No
If no, please explain:

E. Number of eligible ENROLLING employees: _____

F. Number of eligible employees DECLINING coverage: _____

G. Number of INELIGIBLE employees: _____
Reason for ineligibility:

H. If this group is a class carve-out, please identify the class of employees to be covered: _____

I. Probationary period/waiting period for new employees:
 1st of month after hire date
 1 month 4 months
 2 months 5 months
 3 months 6 months

J. Under TEFRA/DEFRA:

Medicare is primary coverage for groups with <20 employees; Anthem Blue Cross is primary coverage for groups with 20+ employees (based on total number of employees during 50% of the working days in previous calendar year).

Which one applies for your group? Medicare is primary (<20)
 Anthem Blue Cross is primary (20+)

K. Is your group currently subject to Cal-COBRA? Yes No

(Employed 2-19 eligible employees on at least 50% of its working days in the previous calendar year; or if not in business during any part of the previous calendar year employed 2-19 eligible employees on at least 50% of its working days during the previous calendar quarter; and not subject to COBRA)

L. Is your group currently subject to COBRA? Yes No

(Employed 20 or more total employees on at least 50% of the working days in the previous calendar year; and not subject to Cal-COBRA)

M. Is your group subject to the Family Medical Leave Act of 1993? Yes No
(50 or more total employees)

If yes to questions K, L or M, please complete the Cal-COBRA/ COBRA/FMLA questionnaire on page 6.

** Anthem Blue Cross complies with State law requiring it to cover spouses and qualified registered domestic partners including dependents to the same extent and subject to the same terms and conditions as a spouse. To be an eligible domestic partner one must be a domestic partner registered under a valid Declaration of Domestic Partnership filed with the California Secretary of State, or an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnership.*



9. Please tell us about your group's medical coverage history ...

Has this group had group health coverage within 90 days of this application's signature date? Yes No

Will this plan replace any existing group coverage? Yes No

If yes:

Current carrier is: _____ Proposed termination date is: _____

10. What about employee Leave of Absence at your firm?

Personal: number of months employees are eligible to continue group coverage while on an employer-approved temporary personal leave of absence (maximum 3 months). None 2 Months
 1 Month 3 Months

Medical: number of months employees are eligible to continue group coverage while on an employer-approved temporary medical leave of absence (maximum 6 months). None 4 Months
 1 Month 5 Months
 2 Months 6 Months
 3 Months

11. To your knowledge, is anyone to be covered unable to work due to injury or illness?

Yes No

If yes:

Name(s) _____ Anticipated return date(s): _____

12. Please tell us about your Workers' Compensation coverage ...

Current carrier: _____ Next renewal date: _____
(mm/dd/yy)

Please list the name and job title for any medically enrolling employee under the Anthem Blue Cross coverage who is not an employee for the purpose of Workers' Compensation law or similar legislation (see the definition provided below):

Name:	Job Title:	Exempt per definition below?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Definition: Under California Labor Code Section 3351, partners, corporate officers and members of boards of directors are employees for Workers' Compensation purposes except under limited circumstances. In order for individuals holding the above-mentioned positions to fall outside the Workers' Compensation laws, they must be shareholders of the corporation, and all stock of the corporation must be held by persons who are either officers or members of the board of directors of the corporation.



13. This section is important to protect you as a small group employer ...

Please check the box that applies:

- We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employment Retirement Income Security Act of 1974), apply to obtain the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.
- We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employment Retirement Income Security Act), and therefore not subject to ERISA, apply to obtain the coverage indicated.

Rescission

We have provided a complete history of material information that is considered in the acceptance or denial of the enrollment application. Following approval of coverage, if Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company discovers that we intentionally provided incomplete or false material information or withheld material information from Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company prior to the Effective Date of the Agreement, Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company may revoke coverage. This means Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company may cancel coverage as if it never existed.

If Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company revokes our Group coverage under the Combined Evidence of Coverage and Disclosure Form, Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company will send a written notice explaining the basis for the decision and our appeal rights. We have the option to submit a new application in the future to be underwritten and considered for enrollment. We will be required to pay for any services that were covered for an employee, and Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company will refund any amounts paid by our Group except amounts already paid by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company on behalf of our employees.

We have personally read and attest to the completeness and validity of the information provided on this application for coverage. If we are accepted, this application will become part of the contract between Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and our Group.

Initials:

We understand and agree that no coverage will be effective before the date determined by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and only if we have paid our first month's contribution and this application is accepted, that we should keep prior coverage in force until notified of acceptance in writing by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and that no agent or broker has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company.

For Anthem Blue Cross Life and Health insurance coverages, we, the employer, apply to become a participating employer in the Small Group Trust to obtain the coverages indicated. We understand that the Small Group Trust and the underwriting companies may rely on the application, deciding whether to allow us to participate in the Small Group Trust. We hereby acknowledge receipt of Anthem Blue Cross Life and Health's benefit description attached to and made a part hereof. We understand and agree that: 1) no coverage will be effective before the date determined by the Small Group Trust and the underwriting companies and only if: a) we have paid for the first month's contribution; and b) this application, and any individual applications have been approved by the Small Group Trust and the underwriting companies; 2) this application, if accepted, and any subsequent amendments become our participation agreement with the Small Group Trust, and 3) the trust agreement and contracts under which we elected coverage are incorporated in and are made a part of the participation agreement. The employer agrees to comply with all provisions of the Small Group Trust. I understand and agree to all of the above. I understand that it is required to submit a DECLINATION of coverage any time that an employee and/or dependent is/or becomes eligible for coverage, but does NOT enroll.

ARBITRATION AGREEMENT:

If we are enrolled as an administrator of an Employee Welfare Benefit Plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) we understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, we further understand that any dispute we may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process has been completed.

WE UNDERSTAND THAT ANY AND ALL DISPUTES, BETWEEN US AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THIS MEANS THAT WE AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING OUR RIGHTS TO A JURY TRIAL. UNDER THIS COVERAGE, ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AND WE ARE GIVING UP THE RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST EACH OTHER.

WE UNDERSTAND THAT ANY AND ALL DISPUTES, BETWEEN US AND ANTHEM BLUE CROSS AND ITS AFFILIATES, INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THIS MEANS THAT WE AND ANTHEM BLUE CROSS ARE WAIVING OUR RIGHTS TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS AND ANY OTHER DISPUTES. UNDER THIS COVERAGE, ANTHEM BLUE CROSS AND WE ARE GIVING UP THE RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST EACH OTHER.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY TRIAL.

Name of Company Officer (Please print)	Title of Company Officer
Signature of Company Officer X	Date (Month/Day/Year)



14. Please ask your agent to complete the following ...

I hereby certify:

- that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk;
- that I have advised the client not to terminate any existing coverage until receiving written notification from Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, that the coverage being applied for by this application is accepted.

WRITING AGENT	100 %
Name	Jim Barricks
Agent/Agency ID No.	LMDLPKMMSZ
Sub-Agent ID No. (if different)	
Address	13900 NW Passage #302
City, State, ZIP	Marina Del Rey, CA 90292
Phone	310-827-7286
Fax	310-827-0256
Signature	
Date	

SECOND WRITING AGENT	%
Name	
Agent/Agency ID No.	
Sub-Agent ID No. (if different)	
Address	
City, State, ZIP	
Phone	
Fax	
Signature	
Date	

FOR GENERAL AGENT USE ONLY

General Agent Name	Agent ID No.
Address	City, State, ZIP

Send Administration Kit to: Agent Group



15. Cal-COBRA/COBRA/FMLA Questionnaire ... please complete this page if any "Yes" answers to K, L or M in Section 8

Cal-COBRA: California law requires employers with 2-19 eligible qualified employees to extend health coverage programs to former employees spouses (widowed/divorced), and their dependents when a qualifying event occurs.

COBRA: The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers with 20 or more total employees to extend health coverage programs to former employees, spouses (widowed/ divorced), and their dependents when a qualifying event occurs, unless the former employee, spouse or dependent was not eligible for continuation of coverage prior to January 1, 2005.

FMLA: The Family and Medical Leave Act of 1993 requires groups with 50 or more employees to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

A. Cal-COBRA and COBRA:

Complete for each employee or family member currently on Cal-COBRA or COBRA.

Name	Birth Date	Social Security or ID No.	Type	Qualifying Event	
				Description	Date
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		

B. Cal-COBRA: Complete for each employee terminated in the last 60 days who has had a qualifying event.

COBRA: Complete for each employee terminated in the last 90 days who has had a qualifying event.

1. Name _____ Social Security or ID No. _____ Cal-COBRA COBRA If terminated, what date? _____

If qualifying event, please describe: _____

To the best of your knowledge, Will this employee/dependent exercise their Cal-COBRA option? Yes No

Is this employee/dependent presently disabled? Yes No

If yes, disabling condition: _____

2. Name _____ Social Security or ID No. _____ Cal-COBRA COBRA If terminated, what date? _____

If qualifying event, please describe: _____

To the best of your knowledge, Will this employee/dependent exercise their Cal-COBRA option? Yes No

Is this employee/dependent presently disabled? Yes No

If yes, disabling condition: _____

C. FMLA: Complete for each employee on family or medical leave.

1. Name _____ Social Security or ID No. _____ Beginning date of leave _____

To the best of your knowledge, will this employee return to work? Yes No

If no, is this employee presently disabled? Yes No

If yes, disabling condition: _____

To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA option? Yes No

2. Name _____ Social Security or ID No. _____ Beginning date of leave _____

To the best of your knowledge, will this employee return to work? Yes No

If no, is this employee presently disabled? Yes No

If yes, disabling condition: _____

To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA option? Yes No

Signature of Company Official	Title	Company Name	Date
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If additional space is needed to include all applicable employees, please use a photocopy of this page.

