

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.

Employee Application

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

Group No.

Please complete using black ink/type, seal the inside pages for privacy and return to your Group Administrator. To avoid the possibility of delay, please answer all questions and be sure to sign and date this application.

1. Please ask your employer which Benefits plans are offered, and check your selection:

From Anthem Blue Cross Life and Health Insurance Company:

- Hospital Benefits Hospitalization only benefits
- Hospital Benefits Plus Hospitalization plus limited doctor visit benefits
- Hospital Benefits Preferred Hospitalization and limited doctor visit, dental & vision benefits
- PPO \$35 Copay GenRx Comprehensive PPO coverage with generic-only drug benefits
- Lumenos HSA 3000 *If directed by your employer, Anthem Blue Cross will facilitate the opening of a Health Savings Account in your name.*

From Anthem Blue Cross:

- Power Select HMO Comprehensive HMO coverage in selected ZIP codes

Please select an IPA for Select HMO:

Other: _____

2. Please ask your employer if other coverage is offered ...

Dental: (Skip this section if you checked the *Hospital Benefits Preferred* plan in Section 1.) Ask your employer if the following dental coverage options are available. If so, please check one if you would like to enroll:

- From Anthem Blue Cross Life and Health: From Anthem Blue Cross:
- Dental Blue Dental Net – please select a Dental Office number:
 - Other: _____

Life: Ask your employer if Life coverage from Anthem Blue Cross Life and Health Insurance Company is offered. If not, please disregard questions in this application that pertain to Life coverage.

Vision: (Skip this section if you checked the *Hospital Benefits Preferred* plan in Section 1.) Ask your employer if the following vision coverage options are available. If so, please check one if you would like to enroll:

- Blue View Vision OR Blue View Plus
- offered by Anthem Blue Cross Life and Health*

3. Please provide the following enrollment information (must be completed by the employee):

- New group enrollment New hire COBRA COBRA/Cal-COBRA
- Family addition Change of coverage Cal-COBRA Effective Date:
- Late enrollment Other *(Cal-COBRA applicants must submit first month's premium)*

Last Name		First Name		M.I.	Social Security or ID No.
Home Address (P.O. Box not acceptable unless rural P.O. Box)			Apt No.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner (DP)	Spouse / DP Social Security or ID No.
City	State	ZIP Code	# of Dependents including Spouse/DP		Home Phone No. ()
Employer Name		Occupation/Job Title			Business Phone No. ()
Hire Date	<input type="checkbox"/> Part time <input type="checkbox"/> Full time	Salary (Required) \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		# of Hours Worked per Week
Life Insurance Beneficiary - Last Name		First	M.I.	Relationship	

When information is sent to you, we may be able to send it in a language other than English. What language would you prefer? (Optional)

- Spanish Chinese Korean Japanese Arabic Khmer Vietnamese
- Armenian Tagalog Farsi Russian Hmong Other _____



10526 2/08 RB 01



Social Security or ID No. _____

4. Please tell us about yourself and your eligible enrolling dependents ...

Eligible dependent is an employee's lawful spouse or domestic partner; a child of an employee who is the permanent legal guardian of that child and for whom a valid court order establishing guardianship has been submitted; the unmarried child(ren) of the employee or, of the employee's spouse/domestic partner who are under age 19, or, the unmarried child(ren) of the employee or enrolled spouse/domestic partner 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. Written proof of relationship may be required for certain dependent enrollments. For example, an existing subscriber who is adding a dependent spouse or domestic partner must provide copy of a Marriage Certificate, Declaration of Domestic Partnership or equivalent document. For enrollment of an adopted child, legal evidence of adoption (or intent to adopt) is required.

FAMILY ADDITION: Date of marriage or Domestic Partnership Declaration: *** _____ Date of adoption: *** _____

Sex	Last Name	First Name	MI	Height	Weight	Birthdate Mo. Day Year	Disabled	HMO Benefits only:	
								Primary Care Physician No.	Current Patient
<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse/DP						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: If any enrolling dependent(s) do not live at the address listed in Section 2 on previous page, please provide their address(es) on a separate piece of paper.

5. Please complete if you want to decline coverage for yourself and/or any eligible dependents:

Type of Coverage:	Declined for:	Reason for declining: (proof of coverage may be required)
Medical plan	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Covered by another employer-sponsored group plan; carrier name & ID number are: _____ <input type="checkbox"/> Covered by Anthem Blue Cross Individual Policy <input type="checkbox"/> Covered by Tricare
Dental plan (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Covered by Medicare <input type="checkbox"/> Covered by MediCal
Vision plan (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Enrolled in any other insurance carrier plan; name: _____
Life coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Other: _____

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'S MEDICAL AND/OR GROUP LIFE INSURANCE PLAN, as well as a six-month pre-existing condition exclusion UNLESS ENTITLED TO A SPECIAL ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT). The twelve (12) month wait will not apply if: (1) I certified at the time of initial enrollment that the coverage under another employer health benefit plan or no share-of-cost Medi-Cal coverage was the reason for declining enrollment and I lose coverage under that employer health benefit plan or no share-of-cost Medi-Cal; (2) my employer offers multiple health benefit plans and I elected a different plan during an open enrollment period; (3) a court orders that I provide coverage under this plan for a spouse or minor child or (4) if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, they may be able to be enrolled if enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption.

If I am declining enrollment for myself and/or my dependent(s) (including my spouse/Domestic Partner) because of other health insurance or group health plan coverage, I must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

X _____
Signature if declining coverage for self/dependents Date (Month/Day/Year)



After completion, please remove tape and fold closed to seal.

Social Security or ID No.

7. Other Coverage – please be sure to complete this important information:

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: _____ Dated ended: _____

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: _____

Insurance Company: _____

Date coverage began: _____ Dated 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 ID card **and** copy of payroll stub showing medical coverage deduction, **or**
3. Copy of most recent medical premium bill.

Please note that if you do not advise and provide proof of prior coverage, you or a family member may be subject to a six-month preexisting conditions exclusion.





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