Anthem BlueCross

Anthem Blue Cross Enrollment Form

Please return the completed enrollment form to your employer.

Employer Notice: After your review of the enrollment form for completeness, please fax or mail the form to:

Anthem Blue Cross
P.O. Box 629
Woodland Hills, CA 91365-0629

Fax no.: 877-363-1077

anthem.com/ca
GC4050 Rev. 7/12

Anthem Blue Cross Enrollment Form

Reset Form | Save and Print

Effective date	Group no.

Anthem BlueCross

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

SECTION 1: TYPE OF COVERAGE — Select from only the coverages offered by your employer

MEDICAL

Anthem Blue Cross plans:

- ☐ HMO (CaliforniaCare)*
- ☐ Preferred HMO (CaliforniaCare PLUS)*
- ☐ Advantage HMO*
- ☐ Select HMO*
- ☐ Priority Select HMO*
- ☐ Other: _____
- ☐ PPO (Prudent Buyer)
- ☐ Advantage PPO
- ☐ EPO (Prudent Buyer Exclusive)
- ☐ POS (Blue Cross Plus)*
- ☐ Medicare

Anthem Blue Cross Life and Health Insurance Company plans:

- ☐ CareAdvocate PPO
- ☐ Select PPO
- ☐ BC PPO (non-California resident)
- ☐ BC Exclusive (non-California resident)
- ☐ BC CareAdvocate PPO (non-California resident)
- ☐ Lumenos®
  (select one of the following)
  ☐ H.S.A.** ☐ H.R.A.
  ☐ H.I.A. ☐ H.I.A. Plus
- ☐ ACO Flex*

* Indicate Medical Group/IPA No. in the ***Employee and Family Information*** section.
** Anthem Blue Cross will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

DENTAL

Anthem Blue Cross plans:

- ☐ Dental Net HMO*
- ☐ **Choice Dental** (select one of the following)
  ☐ Dental Net HMO* ☐ PPO Dental
- ☐ Other: _____

Anthem Blue Cross Life and Health Insurance Company plans:

- ☐ Dental Blue PPO
- ☐ PPO Dental
- ☐ Voluntary PPO Dental
- ☐ National Dental Blue PPO
- ☐ National PPO Dental
- ☐ National Voluntary PPO Dental

* Indicate Dental Office No. in the ***Employee and Family Information*** section.

☐ UniAccount (Flexible Spending account)*
(Indicate payroll deductions)
I authorize payroll deductions on the following:
☐ Health Care Account $_____
☐ Dependent Care $_____

* Anthem Blue Cross PPO, drug and dental plan enrollees, will have out-of-pocket expenses, automatically deducted from their Health Care FSA account. Automatic FSA processing is not possible for HMO enrollees and those with coverage through another health plan. Reminder: Automatic FSA processing is the equivalent of signing and submitting an FSA claim form, which states that you are eligible for FSA reimbursement and that you will not claim FSA reimbursed expenses on your income tax return.

VISION ☐ Blue View Vision (offered by Anthem Blue Cross Life and Health Insurance Company)

LIFE INSURANCE – All the coverages listed may not be offered under your plan.
To elect dependent coverage, the corresponding employee coverage must be selected.
List all life insurance beneficiaries in the ***Life Insurance Beneficiary Designation Information*** section.

Annual salary
$

Elected Benefit	Benefit Amount	Elected Benefit	Benefit Amount	Elected Benefit	Benefit Amount
☐ Basic Life (AD&D)	$_____	☐ Optional Life - Employee	$_____	☐ Optional AD&D - Employee	$_____
☐ Dependent Life - Spouse	$_____	☐ Optional Dependent Life/Spouse	$_____	☐ Optional AD&D - Spouse	$_____
☐ Dependent Life - Child	$_____	☐ Optional Dependent Life/Child	$_____	☐ Optional AD&D - Child	$_____
		☐ Short Term Disability	$_____	☐ Voluntary Short Term Disability	$_____
		☐ Long Term Disability	$_____	☐ Voluntary Long Term Disability	$_____

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

SECTION 2: APPLICANT'S PERSONAL INFORMATION

Social security numbers are required under CMS Regulations

Last name	First name	M.I.	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Social security or ID no. (required)
Street address		Apt. no.	# of dependents including spouse	Spouse/DP social security or ID no.
City		State	ZIP code	Home phone no.

Hire date/Rehire date	Employer name	Job title	Class	Dept. no.	Email address

SECTION 3: 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.	Birthdate (MM/DD/YYYY)	If children are age 26 or over you must check the appropriate boxes below	HMO, POS & ACO 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	
☐ M ☐ F					☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F					☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F					☐ 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.

Social security or ID no. (required)

SECTION 4: DECLINATION — To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependents

A. Medical coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

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

C. Vision coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

D. Life insurance coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

Reason for declining coverage – check one
☐ Covered by spouse's group coverage. Carrier name and ID no.: _____
☐ Covered by Anthem Blue Cross Individual policy
☐ Spouse covered by employer's group medical coverage. Carrier name: _____
☐ Enrolled in 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. PRE-EXISTING CONDITIONS, WHEN ENROLLED IN THIS GROUP MEDICAL PLAN, MAY NOT BE COVERED FOR SIX (6) MONTHS.**

Signature if declining coverage for employee/dependent(s)	Date
X	

SECTION 5: COBRA/CAL-COBRA COVERAGE INFORMATION — Complete only if enrolling in COBRA/Cal-COBRA

Reason for COBRA/Cal-COBRA coverage

Federal COBRA qualifying event date	Federal COBRA coverage begin date	Federal COBRA coverage end date
Cal-COBRA qualifying event date	Cal-COBRA coverage begin date	Cal-COBRA coverage end date

SECTION 6: 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
If yes, applicant/family member name(s): _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____
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.

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

SECTION 7: MEDICARE SECTION — Complete if you, your spouse or dependent child(ren) have Medicare coverage. Attach additional sheets if necessary.

Name	Part A Effective Date	Part B Effective Date	Reason for Disability if Under Age 65	Medicare Claim No.

SECTION 8: PRIOR COVERAGE FOR PPO PLANS ONLY — Attach additional sheets if necessary

Please fill out the following information to receive proper credit for **PREVIOUS COVERAGE** (if immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage, including MediCal or individual coverage). According to federal law your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.
NOTE: If this section is left blank, each applying member may experience delays in the processing of claims.

Name	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage
Employee				
Spouse/Domestic Partner				
Child				
Child				
Child				

Social security or ID no. (required)

SECTION 9: LIFE INSURANCE BENEFICIARY DESIGNATION INFORMATION

Note: Dependent Life payments are always paid to the employee.

Primary Beneficiary – First to receive payment (required) If more than one beneficiary is named, enter a % for each. If no percentage is shown, equal shares are assumed.

Name	Birthdate	Social security no.	Relationship	%
Street address		City	State	ZIP code
Name	Birthdate	Social security no.	Relationship	%
Street address		City	State	ZIP code

SECTION 10: 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, re-employment, remarriage, or otherwise, unless that other group health plan contains an exclusion or limitation for a pre-existing condition for which you are covered under your current coverage with Anthem Blue Cross. In such a case, the date on which you would lose eligibility for Continuation Coverage with Anthem Blue Cross is the date full coverage becomes available to you under the other plan, without limitations or exclusions for pre-existing conditions.

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.

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 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 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.**

Signature (Required)

Applicant	Date
X	