California Employee Enrollment Application For Anthem Balanced Funding, Small Groups Medical

Anthem

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. Submit this application to your employer.

Please complete in black ink only.

Case no. (if known)

Section 1: Application Type — Select one

☐ New enrollment ☐ Open enrollment ☐ Qualifying event ☐ COBRA ☐ Rehire date: ____ (MMDDYYYY)

If you select **Qualifying event** or **COBRA**, please select one event reason:
☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Divorce or legal separation ☐ Death
☐ Involuntary loss of coverage — please explain (required): _____
☐ Other — please explain (required): _____

Qualifying event or COBRA date — Required: ____ (MMDDYYYY)

Section 2: Employee information

Last name	First name	M.I.	Social Security no.[1] (required)	
Home address (P.O. Box not acceptable unless rural address)	City		State	ZIP code
County	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Employment status ☐ Full time ☐ Part time	Primary phone no.	
Employee email address				
Employer name		Occupation		
Employee's physical work address (required)	City		State	ZIP code
Date of hire (MMDDYYYY)	Date of full-time employment (MMDDYYYY)	Date waiting period begins (MMDDYYYY)	No. of hours worked per week	

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese ☐ Tagalog
☐ Other— 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 3: Medical coverage — Your employer will advise you of your plan options and contract codes.

Medical plan name	Contract code, if known

Member medical coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.

Section 4: Family information — Complete this section for yourself and all dependents. All fields required. Attach a separate sheet if necessary.

Social Security no.[1] (required)

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, children for whom you've assumed a parent-child relationship[2] (not including foster 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.	Birthdate (MMDDYYYY)
Sex: ☐ Male ☐ Female ☐ Non-binary			

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female ☐ Non-binary	Birthdate (MMDDYYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner	
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 ☐ Non-binary	Birthdate (MMDDYYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ______	
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 ☐ Non-binary	Birthdate (MMDDYYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ______	
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 ☐ Non-binary	Birthdate (MMDDYYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ______	
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 ☐ Non-binary	Birthdate (MMDDYYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ______	
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 ☐ Non-binary	Birthdate (MMDDYYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ______	
Does this dependent have a different address? ☐ Yes ☐ No If yes, full address and ZIP code: ______			

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2. As defined in CCR § 599.500(o).

Social Security no.[1] (required)

Section 5: Prior and other coverage

1. Is anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name:

Medicare ID no.	Part A effective date (MMDDYYYY)	Part B effective date (MMDDYYYY)

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date (MMDDYYYY)

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 coverage? ☐ Yes ☐ No
4. Has any person applying for coverage had health insurance coverage in the past six months? ☐ Yes ☐ No

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

Name of person covered Last name, first name, M.I.	Type (select one)	Carrier name	Policy ID no.	Dates (if applicable) (MMDDYYYY)
	☐ Individual ☐ Group ☐ Medicare			Start: End:
	☐ Individual ☐ Group ☐ Medicare			Start: End:
	☐ Individual ☐ Group ☐ Medicare			Start: End:
	☐ Individual ☐ Group ☐ Medicare			Start: End:

Section 6: Waiver/Declining coverage — Proof of coverage may be required.

Medical coverage declined for: Select all that apply: ☐ Employee ☐ Spouse/ Domestic Partner ☐ Dependent(s)
List name of dependents to be waived: _____

Reason for declining/refusing coverage: Select all that apply.

☐ No coverage
☐ Covered by Spouse's/Domestic Partner's group coverage
☐ Spouse/Domestic Partner covered by their employer's group coverage.
☐ Enrolled in other Insurance — Please provide company name and plan: _____
☐ Other — please explain: _____
☐ Enrolled in Individual coverage
☐ Medicare/Medi-Cal/VA

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, including but not limited to my employer, agent or life carrier, has tried to influence me or put any pressure on me to waive coverage. BY WAIVING 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 UNTIL THE NEXT OPEN ENROLLMENT TO BE ENROLLED IN THIS GROUP'S MEDICAL PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT. I also understand that if I wish to apply for Life coverage in the future, I may be required to provide evidence of insurability at my expense. Please note Spouse/Domestic Partner and Dependent coverage will not be available if the Employee has waived/declined coverage.

Special Open Enrollment
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.

Sign here only if you are declining coverage for yourself or dependents. DO NOT SIGN HERE IF YOU ARE APPLYING FOR COVERAGE.

Signature of applicant	Printed name	Date (MMDDYYYY)
X		

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) to collect this information.

Section 7: Terms, Conditions and Authorizations —
Please read this section carefully before signing the application.

Social Security no.[1] (required)

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. To the best of my knowledge or belief, 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 Life and Health Insurance Company 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 Blue Cross Life and Health Insurance Company reserves the right to accept or decline this application for coverage, and that no right is created by my application for coverage.

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 Blue Cross Life and Health Insurance Company and myself.

For Health Savings Account enrollees: I authorize the Health Savings Account (HSA) financial custodian (provided I am enrolling in an HSA) to provide Anthem Blue Cross Life and Health Insurance Company with information about my HSA, including account number, account balance and information regarding account activity. I understand that my authorization is required before the financial custodian may provide Anthem Blue Cross Life and Health Insurance Company with information regarding my HSA and that I may provide Anthem Blue Cross Life and Health Insurance Company with a written request to revoke my authorization at any time.

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

a. All disputes between Anthem Blue Cross Life and Health Insurance Company and Employee arising out of or related in any manner to this Agreement shall be resolved using the dispute resolution and arbitration procedures set forth below. To invoke the dispute resolution procedures in this Agreement, a Party first shall send to the other Party a written demand letter that contains a detailed description of the dispute and underlying facts. The Parties shall then meet and confer in person in a good faith effort to resolve the dispute.

b. Subject to the limitations set forth in subsection(c), any dispute that remains unresolved after the Parties met and conferred shall be resolved by final and binding arbitration conducted pursuant to the JAMS Comprehensive Arbitration Rules and Procedures. The arbitration shall take place in Los Angeles County, California.

c. Notwithstanding the provisions of subsection (b), the following disputes shall not be resolved through binding arbitration but, instead, shall be resolved through litigation filed in a court of competent jurisdiction or, where applicable, through an administrative proceeding before a state or federal regulatory authority:
   1. All disputes where the amount in controversy, exclusive of claimed interest, costs and attorneys' fees, is one million dollars ($1,000,000.00) or greater:
   2. All disputes in which a Party seeks injunctive relief;
   3. All disputes in which the Employee seeks to participate as a member of a class of claimants. For any dispute that is the subject of arbitration, the Parties waive any right to join or consolidate claims in arbitration on a class basis; and
   4. All disputes that are required by law to be resolved by a state or federal regulatory authority.

d. For disputes subject to arbitration, the dispute shall be decided by a single arbitrator selected, and replaced when required, in the manner described in the JAMS Comprehensive Arbitration Rules and Procedures. Each Party shall bear its own costs, including attorneys' fees, incurred in connection with the arbitration. Costs of the arbitration proceeding, including JAMS administrative fees and the arbitrator's fees, shall be shared equally between the Parties. Judgment upon the award rendered by the arbitrator may be entered and enforced in any court of competent jurisdiction.

Applicant signature

X

Date (MMDDYYYY)

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