Anthem Blue Cross

Dental and Vision Coverage
for 2-50 Members – Small Groups

Small Group Health Coverage offered by Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company
anthem.com/ca

Employee Application

Please complete using black ink/type and return to your Group Administrator.
You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
To avoid the possibility of delay, please answer all questions and be sure to sign and date your application.

Group No.

1a. Dental Coverage ... Please ask your employer which Dental options are available before checking your selection:

☐ Dental Blue Silver*
☐ Dental Blue Silver Plus*
☐ Dental Blue Gold*
☐ Dental Blue Gold Plus*
☐ Dental Blue Platinum*
☐ Dental Blue Platinum Plus*

If you select a Dental Blue plan, you must also select a network. Please check one:

☐ 100-80 ☐ 100 ☐ 200 ☐ 300

☐ Basic Option PPO*
☐ Standard Option PPO*
☐ High Option PPO*

For above 3 PPO plans, fee-for-service coverage will be substituted if member is outside of PPO service area.

☐ Dental Net**
☐ Dental SelectHMO**

For above 2 HMO plans, you must select a Dental Office Number:

Voluntary Dental Coverage
☐ PPO Dental Plan*
☐ Dental Saver SelectHMO** – *You must select a Dental Office Number (to the left)*

☐ Other: _____

** Offered by Anthem Blue Cross Life and Health Insurance Company*
*** Offered by Anthem Blue Cross*

1b. Vision Coverage ... Please check with your employer to make sure these options are available before selecting:

☐ Blue View OR ☐ Blue View Plus *offered by Anthem Blue Cross Life and Health Insurance Company*
(not available with Hospital BeneFits Preferred)

2. 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 ☐ Single ☐ Married ☐ 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	☐ Part time ☐ Full time	Salary *(Required)* $	☐ Hourly ☐ Weekly ☐ Monthly	# of Hours Worked per Week

Language Preference *(Optional)* ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other:

Social Security or ID No.

3. 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. If the employer makes coverage available to opposite sex domestic partners under age 62, enrollees must provide a notarized *Anthem Blue Cross Affidavit of Domestic Partnership* form. 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	Birthdate Mo. Day Year
☐ Male ☐ Female	Employee			
☐ Male ☐ Female	Spouse/DP			
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				

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

4. 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)*
Dental plan (if offered)	☐ Self ☐ Child(ren) ☐ Spouse/DP	☐ Covered by another employer-sponsored group plan; carrier & ID number are: _____ ☐ Covered by Individual Policy ☐ Enrolled in any other insurance carrier plan; name: _____ ☐ Other:
Vision plan (if offered)	☐ Self ☐ Child(ren) ☐ Spouse/DP	

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 DENTAL/VISION COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP DENTAL/VISION COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE GROUP'S ANNIVERSARY DATE, WHICH MAY BE UP TO TWELVE (12) MONTHS, TO BE ENROLLED IN THIS GROUP DENTAL/VISION PLAN.**

I also acknowledge that if I am declining enrollment for myself and/or my dependent(s) (including my spouse) because of other health insurance or group health plan coverage, enrollment may still be possible if requested within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, 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.

X _____ _____

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

Social Security or ID No.

5. Dental Coverage – Please tell us about your current dental coverage ...

Does any person applying for coverage currently have Dental Insurance Coverage? ..... ☐ Yes ☐ No

If yes:
Applicant/family member name(s):_____

Type of coverage: ☐ Group ☐ Individual ☐ Other:_____

Insurance Company: _____

Date coverage began: _____ Dated ended: _____

SUBMIT PROOF OF COVERAGE. ***Proof of this coverage must accompany this application to receive prior coverage credit towards dental benefit waiting periods.***

Acceptable forms of proof are:

1. Certificate of coverage from prior carrier, ***or***
2. Copy of ID card ***and*** copy of payroll stub showing Dental coverage deduction, ***or***
3. Copy of most recent Dental premium bill or certificate of coverage from prior carrier.

Please note: If you do not advise and provide proof of prior dental coverage, you or a family member may be subject to a dental benefit waiting period.

Social Security or ID No.

6. Authorization – The following Authorization is to be signed by ALL EMPLOYEES applying for coverage.

I AGREE: To the best of my knowledge and belief, all information on this form is correct and true. I understand that this application and any information Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company obtains prior to the effective date of coverage is the basis on which coverage may be issued under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by ANTHEM BLUE CROSS and ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY.

Even if this application is approved, any intentional and fraudulent misstatements or omissions may result in future claims being denied and the policy being rescinded.

RESCISSION OF MEMBERSHIP: I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if I intentionally provided incomplete or false material information Anthem Blue Cross may revoke my coverage. This means Anthem Blue Cross will cancel membership as if it never existed. Also, after approval for membership, if material information is discovered by Anthem Blue Cross that was not provided to the Plan prior to the effective date of the policy, Anthem Blue Cross may deny coverage.

All of my dependents listed on this application who are over the age of 18 years have read this application and have provided complete and accurate information for this application. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about any children under the age of 18 listed on this application is true and complete. I understand and agree that I alone am responsible for the accuracy and completeness of this application. I understand and agree that no one listed on this application will be eligible for coverage if they provide false or incomplete information and that Anthem Blue Cross may revoke coverage if it discovers that in applying for coverage I intentionally provided incomplete or false material information to Anthem Blue Cross.

I understand that if my coverage is revoked I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for enrollment. I also understand that I will be required to pay for any services that were covered while a member and that Anthem Blue Cross will refund all amounts paid by me except amounts owed to Anthem Blue Cross.

I AM APPLYING FOR PPO COVERAGE: I understand that I am responsible for a greater portion of my costs when I use a non-participating provider. If a PPO Plan is selected and a non-participating provider is used, payments will be based upon the lesser percentage of the negotiated fee rate and I will be responsible for any amount over that payment.

I AM APPLYING FOR HMO COVERAGE: I understand that I am responsible for paying for services rendered that are not authorized by my participating HMO dental office.

ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA *(Employee Retirement Income Security Act of 1974)*, **certain disputes may not be subject to the following arbitration provisions:**

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (*Employee Retirement Income Security Act of 1974*, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I 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 is completed.

I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND ANTHEM BLUE CROSS LIFE AND HEALTH MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND ANTHEM BLUE CROSS LIFE AND HEALTH ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. ANTHEM BLUE CROSS LIFE AND HEALTH AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR CERTIFICATE.

I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND ANTHEM BLUE CROSS OR ITS AFFILIATES, INCLUDING CLAIMS FOR MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE MEMBER AND ANTHEM BLUE CROSS OR ITS AFFILIATES ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. ANTHEM BLUE CROSS OR ITS AFFILIATES AND THE MEMBER ALSO AGREE TO GIVE UP ANY RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR EVIDENCE OF COVERAGE.

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.

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

Signature of Employee	Date *(MM/DD/YY)*	Signature of Employee's Spouse/Domestic Partner *(If applying for coverage)*	Date *(MM/DD/YY)*
X		X	

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.

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