California Employer Enrollment Application For Small Groups Medical, Dental, and Vision

Anthem

Health care plans offered by Anthem Blue Cross and Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company.
You, the employer, 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 the application.
Employer Tax ID Numbers are required under Centers for Medicare & Medicaid Services (CMS) regulations.

Please complete in black ink only.

Section A: Application Type

☐ New Enrollment	☐ Change(s)	Group/Case no. (if known)	Requested effective date (MM/DD/YYYY): / /

Section B: Company Information

Legal Company name	Employer tax ID no. (required)	Form 5500 ID Number (if applicable)
Doing Business As (DBA) (if applicable)		County
Company street address (principal business address[1])	City	State / ZIP code
Billing address - If different from above	City	State / ZIP code

Is this coverage as a member of an association plan? ☐ Yes ☐ No If yes, association name: _____

Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Limited Liability Company (LLC) ☐ Limited Partnership (LP)
☐ Limited Liability Partnership (LLP) ☐ Other: _____

SIC code - required	Type of business (be specific)	Date business established (MM/DD/YYYY) / /
Company's primary contact name	Title	Primary phone no.
Company's primary contact email address		
Additional company contact name	Title	Additional company contact email address

Do you want to enroll in Premium Only Plan (P.O.P.), Internal Revenue Service (IRS) Section 125? ☐ Yes ☐ No
P.O.P. is an administration service offered by HealthEquity, Inc.
If you choose to enroll, submit P.O.P. application.

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414?
☐ Yes ☐ No If yes, please give the legal names, federal tax ID no. and the number of employees employed by each.

Legal name	Federal tax ID no.	No. of employees employed

1 The principal business address means the principal business address registered with the State or, if a principal business address is not registered with the State, or is registered solely for purposes of service of process and is not a substantial worksite for the policyholder's business, the business address within the State where the greatest number of employees of such policyholder works. If, for a network plan, the group policyholder's principal business address is not within the service area of such plan, and the policyholder has employees who live, reside, or work within the service area, the principal business address for purposes of the network plan is the business address within the plan's service area where the greatest number of employees work as of the beginning of the plan year. If there is no such business address, the rating area for purposes of the network plan is the rating area that reflects where the greatest number of employees within the plan's service area live or reside as of the beginning of the plan year.

Employer tax ID no. (required): _____

Section C: Ownership

Please account for 100% of the ownership, regardless of eligibility. Insert an additional sheet if necessary.				
First name	M.I.	Last name.	Percentage of ownership (must equal 100%)	Eligible
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Section D: Type of Coverage

1. Medical Coverage — **Medical plans offered by Anthem Blue Cross.**

Please Note: All health plans include the required coverage for the dental and vision pediatric essential health benefits.

Step 1 — Select your networks below.		**Step 2** — Select one or more plan(s) you would like to offer within the networks you selected. Insert an additional sheet if necessary.	
		Medical plan name	**Contract code**
PPO:	☐ Prudent Buyer PPO		
	☐ Select PPO		
HMO:	☐ CaliforniaCare HMO		
	☐ Select HMO		
	☐ Priority Select HMO		
	☐ Vivity		

You may not offer a medical plan with Whole Health (enhanced embedded dental and vision benefits) alongside the same medical plan without Whole Health.

For employers providing a Health Savings Account (HSA) option:

☐ Yes, we request Anthem to facilitate opening an HSA account with its service provider for our employees. We understand a completed Health Savings Account questionnaire is required in order to open the HSA account. In doing so, we agree for Anthem to disclose our member's data to its banking service provider.

☐ No, we will facilitate our own HSA account.

Note: For PPO and HMO plans, not all network options are available in all areas. Please refer to Underwriting Guidelines for network options.

Enrollment in the selected plan is dependent upon the employee residing or working within a plan's geographic service area, and the network, provider, and physician availability within the geographical service area. If at the time of enrollment the network or physician/medical group is not available or an employee does not reside or work in the geographical service area of the plan the employee may be assigned to or be required to choose a different provider, network, and/or plan.

Riders/Optional Benefits – By selecting one of the below optional benefits, all employees must enroll in the selected benefit option.
Additional premiums may apply.

☐ Travel and Lodging Benefit ☐ Infertility Benefits ☐ Other: _____

☐ Contraceptive Opt-out Benefits - Religious Self-Certification Form required.

Choose your medical contribution for each month - only **one** choice is allowed.

Contribution option 1: Traditional option - We will contribute _____% per employee (50 to 100%) _____% per dependent (optional, 0% to 100%)

Contribution option 2: Fixed Dollar Option - We will contribute (at least $100 in $5 increments): $_____

Contribution option 3: Percentage of plan option - We will contribute (50% to 100%): _____% to the following plan _____

2. Dental Coverage — Indicate the contract code for the dental plan selected. The codes can be found on the proposal/quote.		
Standalone dental plans do not include Essential Health Benefits.		
	Dental plan name	**Contract code**
☐ Employer sponsored		
☐ Voluntary[1]		
Is this plan intended to replace any existing group dental coverage? ☐ Yes ☐ No If yes, please complete the information in Section G for each group dental insurance plan you now have.		

3. Vision Coverage — Indicate the contract code for the vision plan selected. The codes can be found on the proposal/quote.		
Vision plans do not include vision pediatric essential health benefits.		
	Vision plan name	**Contract code**
☐ Employer sponsored		
☐ Voluntary[2]		

1 Not available in conjunction with the employer-sponsored Dental HMO and Dental PPO plans.
2 Not available in conjunction with the employer-sponsored Vision PPO plans.

Employer tax ID no. (required): _____

Section E: Eligibility

1. Does your group meet the definition of a small employer, as defined under applicable law?[1] ☐ Yes ☐ No
2. Total number of employees (including employed owners/officers): _____
3. Number of eligible full-time employees[2] (minimum 30 hours per week): _____
4. Number of part-time employees[2]: _____
   Are permanent employees who work between 20–29 hours weekly to be covered? ☐ Yes ☐ No
   If yes, number of eligible part-time employees: _____
5. Number of employees enrolling in:
   Medical: _____ Dental: _____ Vision: _____
6. Number of eligible DECLINING employees: _____
7. Number of INELIGIBLE employees: _____
8. Waiting period for **new employees**:
   An employer may impose a bona fide employment-based orientation (affiliation) period for new employees which cannot exceed 30 days.
   If you the employer imposes an orientation period, the "date of hire" is the first day after completion of the orientation period.
   ☐ First of the month after hire date
   ☐ First of the month following one month from the date of hire
   ☐ First of the month following two months from date of hire, not to exceed 90 days
9. Does the group intend to offer coverage to employees currently in the employer waiting period for the original effective date of the group contract (i.e. one-time waiver of employer waiting period)? ☐ Yes ☐ No
10. Does your business have additional employees in another state(s)? ☐ Yes ☐ No
    If yes, specify state(s): _____
    How many employees are employed in CA: _____
    How many employees are employed in another state: _____
11. 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).
    California law also requires plans to offer an enrollee who has exhausted continuation coverage under COBRA the opportunity to continue coverage for up to 36 months from the date the enrollee's continuation coverage began. If the enrollee is entitled to less than 36 months of continuation coverage under COBRA.
    Number of Cal-COBRA enrollees: _____
12. Is your group currently subject to COBRA? ☐ Yes ☐ No
    (Employed 20 or more full time equivalent employees on at least 50% of the working days in the previous calendar year)?
    Number of COBRA enrollees: _____
13. Under the Medicare Secondary Payer rules, which one applies for your group?
    ☐ Medicare is primary for groups with less than 20 employees.
    ☐ Anthem is primary for groups that employ 20 or more employees if the employer has 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.

Section F: Leave of Absence

Medical: Number of months employees are eligible to continue group coverage while on an employer-approved temporary medical leave of absence.
☐ None ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

Personal: Number of months employees are eligible to continue group coverage while on an employer-approved temporary personal leave of absence.
☐ None ☐ 1 month ☐ 2 months ☐ 3 months

Section G: Prior Coverage

Has this group had coverage within 12 months of this application's signature date? ☐ Yes ☐ No

Will this plan replace current	If yes, carrier name		Termination Date (MM/DD/YYYY)
Medical coverage ☐ Yes ☐ No			/ /
Vision coverage ☐ Yes ☐ No			/ /
Dental coverage ☐ Yes ☐ No	Type of Plan (DHMO, EPO, PPO)	Effective Date / /	/ /

1 A small employer is defined as any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, employees; the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. For specific guidance concerning the Affordable Care Act, the Internal Revenue Code or California State laws or regulations, you should consult with your attorney, Certified Public Accountant or other authorized consultant or advisor.

2 The following do not qualify as an employee for purposes of group eligibility: (1) an individual that wholly owns the above—named company on his/her own or with his/her spouse/domestic partner; (2) the spouses/domestic partners of sole proprietors; (3) partners of a partnership and their spouses/domestic partners; (4) a 2-percent S corporation shareholder; (5) a worker described in Section 3508 of Title 26, Internal Revenue Code.; or (6) a leased employee (as defined in 26 U.S.C. § 414(n)(2)).

Employer tax ID no. (required): _____

Section H: Cal-COBRA/COBRA/Medical Leave Questionnaire —

If additional space is needed to include all applicable employees, please use a photocopy of this page.

Complete for each employee or family member currently on Cal-COBRA or COBRA or Medical Leave.
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.
Insert an additional sheet if necessary.

Last name	First name	MI	DOB	Social Security No.[1]	☐ Cal-COBRA ☐ COBRA ☐ Medical Leave
Beginning date of leave or date of qualifying event		Describe qualifying event:			

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

Section I: Access of Group Information by designated agent, producer, broker, agency, brokerage, and/or general agency

We, the employer, hereby authorize our designated agent, producer, broker, agency, brokerage, general agency, and their respective employees currently on file with Anthem (Agent) to access our health plan information, including protected health information, on behalf of our health plan through Anthem's EmployerAccess system or any other access points Anthem may offer. This information may include, but is not limited to, detail about members, plan selections and bills/invoices. Our Agent is also authorized to make changes to our information on our behalf, including but not limited to adding/deleting plans and members and changing member demographic information. We will be responsible for the activities of our Agent. If our Agent on file changes, these authorizations will apply with respect to our successor Agent. Our Agent is required to maintain original documentation and will make such documentation available to Anthem upon request.

☐ Select this box **ONLY** if the employer **DOES NOT** want to authorize the agent, producer, broker, agency, brokerage, general agency, and their respective employees currently on file with Anthem (Agent) to access and change the group's information on behalf of the group. **Do not select this box if you consent.**

Section J: Electronic Delivery of Materials

Applies only to **Medical** and **Dental Net DHMO** plans offered by Anthem Blue Cross and regulated by the Department of Managed Health Care. We, the employer, want to receive information about plan materials and related items electronically as permitted by law. These communications may include but are not limited to benefit booklets, summaries, billing statements, notices of nonpayment and cancellation and other notices. I understand we need to register on anthem.com/ca to get the most out of our plan's digital tools and will make sure Anthem has our most up-to-date email address. We understand that we can update our email address, change our communication preferences, and request a free copy of these materials at any time by going to anthem.com/ca or by contacting Anthem at 1-833-747-1190.

For **Dental PPO** and **Vision** plans offered by Anthem Blue Cross Life and Health Insurance Company and regulated by the California Department of Insurance. Anthem will deliver plan materials and related items by mail.

☐ By signing below, we, the employer want to receive information about plan-related communications electronically. This includes our certificates,evidence of coverages, explanation of benefits statements, legally required notices, or helpful information to get the most out of our plan. We understand we need to register on anthem.com/ca to get the most out of our plan's digital tools and will make sure Anthem has our most up-to-date email address. We understand that this consent is voluntary and that we may opt-out of electronic delivery. We understand that we can update our email address, change our communication preferences, and request a free copy of these materials at any time by going to anthem.com/ca or by contacting Anthem at 1-833-747-1190.

Company officer signature _____ Date _____

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

Employer tax ID no. (required): _____

Section K: General Agreements — Please read carefully before signing the application.

The standard open enrollment period is at least 31 days before the group's renewal date and 31 days after, no more often than once in any 12 consecutive months.

Please select the box that applies:

☐ Employer is not subject to the Employee Retirement Income Security Act of 1974 (ERISA) for the following reason:

- ☐ Church plan (as defined in 29 USCS § 1002(33))
- ☐ Governmental plan (as defined in 29 USCS § 1002(32))
- ☐ Other:_____

☐ Employer is subject to ERISA

If no Form 5500 ID number, reason for exemption from the Form 5500 requirement:_____

Employer, through its authorized representative below, understands and certifies, and, if approved for coverage and by payment of premiums, agrees to the following:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company trust policy(ies), if applicable.
2. To make the coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company or their designated agent(s), any information required in connection with administration of the coverage. Original source documents, including but not limited to employee/member enrollment documentation, shall be available upon Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company's request.
4. For the purpose of clinical outreach, we the Employer agree that the cell phone numbers provided in the electronic enrollment files have been freely provided by the employee and have not been obtained by a look up service or third party. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will honor Do Not Call requests for all telephone numbers collected.
5. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.
6. To pay Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and state-mandated continued group coverage and/or conversion process, if applicable.
7. We, the employer, understand that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company standard process is to issue bills (invoices) and accept premium payments online via the EmployerAccess system. We understand and agree that if we, the employer, need to opt-out of online invoices and/or payments, we must send an email with "Opt-Out" in the subject line to employeraccesssupport@anthem.com and provide the group number, contact name, email address, phone number and reason for opting out of the electronic billing and payment process.
8. If applicable, employer will receive on behalf of members, all notices delivered by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, and immediately forward such notices to persons involved, at their last known address.
9. We understand and agree that no coverage will be effective before the date determined by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted.
10. That in order for Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. If the application is not complete, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company reserve(s) the right to reject it and notify us in writing.
11. The employer understands that the coverage issued by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may be different than the coverage applied for herein. In that event, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.
12. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company by the employer. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any fraud or intentional misrepresentation of material fact on the employees' applications may, within the first 24 months following the issuance of the coverage, result in a material change to the group's coverage or premium rates as of the effective date of the group coverage.
13. The entire application for Group coverage has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.

Employer tax ID no. (required): _____

14. All employees applying for coverage are employees of the employer and receive salary or wages documented on state and/or federal payroll reports. Eligible employees must work the required amount of hours per week, must be actively at work, have satisfied any applicable eligible waiting period, and meet any other eligibility requirements for coverage.
15. The requested coverage is not in effect unless and until this application is approved by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, that approval of coverage shall be evidenced by issuing Group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
16. This small group off-exchange product is not eligible for a premium tax credit.
17. The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits. The IRS has not yet issued HSA or high--deductible health plan regulations or determined that Anthem Blue Cross high-deductible plans are qualifying high-deductible health plans. Consultation with a tax advisor is recommended.
18. If we decide to cancel our group coverage after coverage has been issued, we understand that the cancellation will become effective on the last day of the month in which Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company received the written notification of cancellation, and that no premiums will be refunded for any period between Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company's, cancellation date, we understand that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will refund these premiums after 45 days from the premium deposit date.
19. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and that no agent has the right to accept this application or bind coverage.
20. If this application is accepted, it becomes a part of our contract with Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.

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.

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, 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, MUST BE RESOLVED BY BINDING ARBITRATION, 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. For claims that exceed the jurisdiction of the small claims court that are subject to binding arbitration under this Agreement, California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard: It is understood that 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 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. YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. If your plan/policy is subject to 45 CFR 147.136, this agreement does not limit your rights to internal and external review of adverse benefit determinations as required by that law. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By signing, writing or typing your name below you agree to the terms of this agreement and acknowledge that your signed, written or typed name is a valid and binding signature.

Sign here	Company officer signature **X**	Printed name
	Title	Date (MM/DD/YYYY) / /

Employer tax ID no. (required): _____

Section L: Agent/Producer/Broker Attestation — To be completed by the agent/broker

1. To the best of my knowledge, the information on this application is complete and accurate.
2. I am not aware of any information not disclosed by the employer in this application that may have bearing on this risk.
3. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
4. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Anthem Blue Cross (Anthem) to attribute such additions or changes to me.
5. I have advised the employer, in easy-to-understand language, that a failure to provide complete and accurate information that constitutes fraud or intentional misrepresentation of material fact may, within 24 months following the issuance of the coverage, result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Anthem reviews and approves the application and the employer receives a written notice from Anthem. The employer understood my explanation.
6. I am the appointed agent/producer/broker and am receiving commissions for the submission of this employer. No portion of my commission payments from Anthem shall be paid to an agent/broker/producer not appointed/approved by Anthem.
7. I have advised the employer not to terminate any existing coverage until receiving written notification from Anthem that the coverage being applied for by this application is accepted.
8. I understand that if I have willfully stated as true any material fact I know to be false, I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000).
9. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

Electronic Enrollment — Please indicate how employee enrollment will be submitted.

☐ Simple Census ☐ 834 Electronic Eligibility Transfer (EET) ☐ Other _____

☐ Real-time ☐ Online Census Enrollment (OCE)

Writing payable/sub-agent/producer/broker			%	**Second writing payable/sub-agent/producer/broker**			%
Agency name	Agency ID no.			Agency name	Agency ID no.		
Agent/producer/broker name				Agent/producer/broker name			
Agent/producer/broker encrypted tax ID no. (SSN)				Agent/producer/broker encrypted tax ID no. (SSN)			
Payable/sub-agent/producer/broker encrypted tax ID no. (SSN) if different				Payable/sub-agent/producer/broker encrypted tax ID no. (SSN) if different			
Street address				Street address			
City	State	ZIP code		City	State	ZIP code	
Phone no.	Fax no.			Phone no.	Fax no.		
Email address				Email address			
Signature	Date (MM/DD/YYYY) / /			Signature	Date (MM/DD/YYYY) / /		

For General Agent use only

General agent		General agent ID no.	
Street address	City	State	ZIP code
Email address			

Submit new business applications to: **newsguwca@anthem.com**
Administration kit will be sent to the Group.