Anthem Blue Cross

Enrollment Form with Life

INSTRUCTIONS

Please read carefully and provide all applicable information.
Your signature is required.

Return the completed form to your employer.

www.anthem.com/ca

EMPLOYEE COPY - Retain the green copy of this form for your records.

GC4050 6/08

Anthem Blue Cross Enrollment Form with Life

Effective Date	Group No.

APPLICANT'S PERSONAL INFORMATION

Last Name (Print)	First Name (Print)	M.I.	☐ Male ☐ Female
Street Address	City	State	ZIP Code
Telephone No. ( ) –	Employer	Job Title	
Date of Hire	Part-time to Full-time Effective Date	Class	Dept. No.	E-mail Address

APPLICANT'S LANGUAGE PREFERENCE

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

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

EMPLOYEE & FAMILY INFORMATION – Please list yourself and all eligible family members to be enrolled. (A

	Last Name	First Name	M.I.	Sex	Birthdate Mo/Day/Yr	Age	Social Security No.
Self	Same as above	Same as above					
☐ Spouse ☐ Domestic Partner				☐ M ☐ F			
Child				☐ M ☐ F			
Child				☐ M ☐ F			
Child				☐ M ☐ F			
Child				☐ M ☐ F			

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 Sta

DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? If yes, please complete this sectio

	Name	Name and Address of Other Insurance Carrier	Effective Date Mo/Day/Yr	Group Number
Self				
☐ Spouse ☐ Domestic Partner				
Dependent No. 1 Above				
Dependent No. 2 Above				
Dependent No. 3 Above				
Dependent No. 4 Above				

DISTRIBUTION: **WHITE** – Anthem Blue Cross Membership; **CANARY** – Anthem Blue Cross Sales Office;

TYPE OF COVERAGE: ☐ New Enrollment ☐ Re-Hire ☐ Part-time to Full-time ☐ Open-enrollment

Medical

Anthem Blue Cross plans:

- ☐ HMO (CaliforniaCare)*
- ☐ Preferred HMO (CaliforniaCare PLUS)*
- ☐ Power Advantage HMO*
- ☐ Select HMO*
- ☐ PPO (Prudent Buyer)
- ☐ EPO (Prudent Buyer Exclusive)
- ☐ POS (Blue Cross Plus)*

☐ Other ____________________

Anthem Blue Cross Life and Health Insurance Company plans:

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

☐ Medicare

* Indicate Medical Group/IPA No. in the *Employee & Family Information* section below.

** 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*
- ☐ **Choice Dental** (select one of the following)
  ☐ Dental Net* ☐ PPO Dental

Anthem Blue Cross Life and Health Insurance Company plans:

- ☐ **Dental Blue** (select one of the following)
  ☐ 100 ☐ 200 ☐ 300 ☐ Complete
- ☐ PPO Dental ☐ National Dental PPO
- ☐ Voluntary PPO ☐ National Voluntary PPO
- ☐ Other ____________________

* Indicate Dental Office No. in the *Employee & Family* section

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

☐ 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.

ttach additional sheets if necessary.)

If children are age 19 or over you must check the appropriate boxes below		Coverage	Medical Group/IPA No.	Anthem Blue Cross HMO IPA Primary Care Physician Code	Is this your current MD?	Dental Office No.
		☐ Medical ☐ Dental ☐ Vision			☐ Yes ☐ No	
Qualifies as IRS Dependent	Full-time Student	☐ Medical ☐ Dental ☐ Vision			☐ Yes ☐ No	
☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision			☐ Yes ☐ No	
☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision			☐ Yes ☐ No	
☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision			☐ Yes ☐ No	
☐ Yes ☐ No	☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision			☐ Yes ☐ No	

ate 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.

n including Medicare (if applicable)

Is this yours or your dependent's primary coverage?	Does it cover?
☐ Yes ☐ No	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
☐ Yes ☐ No	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
☐ Yes ☐ No	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
☐ Yes ☐ No	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
☐ Yes ☐ No	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
☐ Yes ☐ No	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No

MEDICARE SECTION

Are you retired? . . . . ☐ Yes ☐ No

If yes Part A . . . ☐ Yes ☐ No
Part B . . . ☐ Yes ☐ No

Do you or your Dependents have Medicare? . . . . ☐ Yes ☐ No

If yes for your dependent Part A . . . ☐ Yes ☐ No
Part B . . . ☐ Yes ☐ No

Name(s) of Medicare Dependents:

____

____

If yes for Medicare for you and/or your Dependent(s), please provide your and/or their HIB number and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).

HIB No. ____________________

Entitlement Reason:
☐ Over 65 ☐ Disabled ☐ ESRD

Effective Date of Medicare: _____ /_____ /_____

Name ____________________

HIB No. ____________________

Entitlement Reason:
☐ Over 65 ☐ Disabled ☐ ESRD

Effective Date of Medicare: _____ /_____ /_____

Name ____________________

PINK – Broker/Agent; **GOLDENROD –** Employer; **GREEN –** Employee

PRIOR COVERAGE FOR PPO PLANS ONLY

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.

	Name	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage
Self					
☐ Spouse ☐ Domestic Partner					
Child					
Child					

LIFE INSURANCE

Coverage Election – Complete the boxes by checking (✓) them to indicate your Coverage Elections.
· All the coverages listed may not be offered under your plan.
· To elect Dependent coverage, the corresponding employee coverage must be selected.
· Annual Salary $ _____

	Elected	Declined	Benefit Amount
Life (AD&D)	☐	☐	$_____
Dependent Life	☐	☐	$_____
Optional Life	☐	☐	
_____ x annual earnings OR			$_____
Optional AD&D	☐	☐	$_____

	Elected	Declined
Short Term Disability	☐	☐
Long Term Disability	☐	☐
Voluntary AD&D	☐	☐
Voluntary Short Term Disability	☐	☐
Voluntary Long Term Disability	☐	☐

Beneficiary Employee Life Designation ***Note Dependent Life payments are always paid to the employee**

Primary Beneficiary – First to receive payment (required) –
If more than 1 beneficiary is named, enter a % for each. If no percentage is shown equal shares are assumed.

☐ Named Individuals (Enter the name, address, birthdate, Social Security Number and relationship to the insured for each name listed.)

Name	Birthdate	Social Security No.	Relationship	%
Address	City		State	ZIP
Name	Birthdate	Social Security No.	Relationship	%
Address	City		State	ZIP

☐ Estate of Insured ☐ Revocable or Irrevocable Trust (Enter the name of Trustee, name of Trust and complete date of Trust.)
☐ Trustee Under Insured's Will (If choosing this option DO NOT enter additional names in the Primary Beneficiary field.)

Total: 100%

Secondary Beneficiary – Second to receive payment (optional) –
If more than 1 beneficiary is named, enter a % for each. If no percentage is shown equal shares are assumed.

☐ Named Individuals (Enter the name, address, birthdate, Social Security Number and relationship to the insured for each name listed.)

Name	Birthdate	Social Security No.	Relationship	%
Address	City		State	ZIP
Name	Birthdate	Social Security No.	Relationship	%
Address	City		State	ZIP

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 dues.

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.

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

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 OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: ***"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 provided by California law, 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 FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN.**

Signature (Required)

Applicant	Date