CREBP Benefit Package - Medical, Dental, Life and AD&D*

w/Anthem Blue Cross - New Dental Choice - Mutual of Omaha

Member/Applicant: ______________________________

Local REALTOR® Association Name: ______________________________

Requested effective date of coverage: 1st of ______________________________

"SMART & AFFORDABLE" PLAN OPTIONS - BRONZE

Select PPO

[ ] Anthem Bronze Select PPO 40/5600/40% - New Dental Choice - Mutual of Omaha
[ ] Anthem Bronze Select PPO 65/4600/40% - New Dental Choice - Mutual of Omaha
[ ] Anthem Bronze Select PPO 70/6300/35% - New Dental Choice - Mutual of Omaha
[ ] Anthem Bronze Select PPO 6000/40% w/HSA - New Dental Choice - Mutual of Omaha
[ ] Anthem Bronze Select PPO 5000/45% w/HSA - New Dental Choice - Mutual of Omaha
[ ] Anthem Bronze Select PPO 6600/0% w/HSA - New Dental Choice - Mutual of Omaha

"BEST BALANCE & VALUE" PLAN OPTIONS - SILVER

Select PPO

[ ] Anthem Silver Select PPO 40/1500/40% - New Dental Choice - Mutual of Omaha
[ ] Anthem Silver Select PPO 55/1750/35% - New Dental Choice - Mutual of Omaha
[ ] Anthem Silver Select PPO 45/2000/20% - New Dental Choice - Mutual of Omaha
[ ] Anthem Silver Select PPO 50/2000/40% - New Dental Choice - Mutual of Omaha
[ ] Anthem Silver Select PPO 2000/25% w/HSA -RxC (Single) - New Dental Choice - Mutual of Omaha
[ ] Anthem Silver Select PPO 2000/25% w/HSA -RxC (Family) - New Dental Choice - Mutual of Omaha

Select HMO

[ ] Anthem Silver Select HMO 55 - New Dental Choice - Mutual of Omaha
[ ] Anthem Silver Select HMO 55/2250/40% - New Dental Choice - Mutual of Omaha

"BEST BENEFITS" PLAN OPTIONS - GOLD & PLATINUM

Select PPO

[ ] Anthem Platinum Select PPO 20/10% - New Dental Choice - Mutual of Omaha
[ ] Anthem Platinum Select PPO 15/10% - New Dental Choice - Mutual of Omaha
[ ] Anthem Platinum Select PPO 15/250/10% - New Dental Choice - Mutual of Omaha
[ ] Anthem Gold Select PPO 20/30% - New Dental Choice - Mutual of Omaha
[ ] Anthem Gold Select PPO 30/20% - New Dental Choice - Mutual of Omaha
[ ] Anthem Gold Select PPO 30/500/20% - New Dental Choice - Mutual of Omaha
[ ] Anthem Gold Select PPO 30/750/20% - New Dental Choice - Mutual of Omaha
[ ] Anthem Gold Select PPO 35/1000/20% - New Dental Choice - Mutual of Omaha

Select HMO

[ ] Anthem Platinum Select HMO 10 - New Dental Choice - Mutual of Omaha
[ ] Anthem Gold Select HMO 25 - New Dental Choice - Mutual of Omaha
[ ] Anthem Gold Select HMO 35 - New Dental Choice - Mutual of Omaha

***CREBP is a special benefit package available to both Affiliate and Realtor members of Local Realtor Associations. Please be advised that your Association, The Benefits Store, Inc. and their agents do not control premiums or coverage benefits provided by these plans. Rates as shown are inclusive of premiums and administration for Health/Medical, Mutual of Omaha Life Insurance with AD&D, New Dental Choice and Vision (included in certain plans). Plans are administered by The Benefits Store Insurance Services.**

Voice: (800) 446-2663

www.BenefitsStore.com
CA Insurance License No.: 0680704
Fax: (925) 855-2051

CREBP Benefit Package
ENROLLMENT INSTRUCTIONS

PROCESSING REQUIREMENT:

NOTE: Incomplete applications or applications without the correct premium included cannot be processed.

Applications Postmarked by the 15th

One (1) months premium is required with your application if enrolling for coverage beginning the 1st of the following month and postmarked by the 15th of the current month.

Applications Postmarked after the 15th

Two (2) months premium is required with your application if enrolling for coverage beginning the 1st of the following month and postmarked after the 15th of the current month.

PREMIUM PAYMENTS:

You have four (4) ways to pay your monthly premium:

- **Electronic Funds Transfer (EFT)**
- **Monthly Invoice/Check**
- **On-Line Bill Payment (through your Financial Institution)**
- **Credit Card Payment/Visa or MasterCard**

For your convenience we have included an EFT/CCA/ACH Authorization form with the Enrollment Form.

APPLICATION PROCESSING:

Allow 12 business days for the processing of your application and for you to appear in Anthem Blue Cross's database. ID Card(s) (from Anthem Blue Cross) are normally generated within 20 working days from the time we receive your application. If we do not receive your application until the 25th of the month, you may not receive your ID card(s) until the 15th of the following month. *To avoid this delay, we urge you to submit your application to us as soon as possible.*

THOSE APPLYING WITH CURRENT COVERAGE:

Remember, everyone applying during the Open Enrollment will be accepted! Coverage is guaranteed. Those of you that have paid your current coverage premiums in advance will need to request an effective date for your new coverage that will match the date when your current coverage ends. Those of you that are within the "grace period" for premium payment of your current coverage will need to verify the length of time allowed for your coverage before cancellation with your current insurer

IMPORTANT!

You should not cancel your current coverage until you are notified of your new coverage. For verification of your new coverage, E-mail: Customerservice@BenefitsStore.com

ADDITIONAL INFORMAITON – PLEASE READ

To cancel your coverage or to revoke your application, we require a written notice of your intent including your signature and your requested date of cancellation. We ask this statement be written on a copy of your billing statement and faxed to 925-855-2051 or mailed to our Membership Accounting department. Please visit our website for additional contact information. This notice must be received no later than 12 noon 1 business day (M-F) BEFORE the last business day of the month in which you wish to cancel. For example, April 29, 2017 for an effective cancellation date of April 1, 2017.

By signing your enrollment application you represent that all of the information you have included is complete and accurate, and that you accept all terms of this application and supporting documentation.

EXCLUSIVELY FOR THE MEMBERS OF THE LOCAL CALIFORNIA ASSOCIATIONS OF REALTORS®

SPECIAL PROGRAMS INCLUDED IN YOUR CREBP Benefit Package

Special Discount Dental Plan

The CREBP Special Discount Dental Plan gives you immediate, predictable and significant discounts for dental services. Because the Special Discount Dental plan is not insurance, plan members decide when to use a participating dentist, how often, and without any limit on their savings. For additional plan information and a list of providers go to www.NewDentalChoice.com.

Included Life Insurance Plan

You automatically have a $10,000 Life and AD&D Insurance policy through Mutual of Omaha Life Insurance Company included with your CREBP Benefit Package. This special life insurance benefit covers the primary insured member only, is guaranteed-issue without any exclusion for medical conditions and includes AD&D benefits.

Enhanced Benefit’s Page

The Benefits Store, Inc. **Association Benefits** CA License No. 0680704

Credit Card Authorization / Automated Clearing House (ACH) Electronic Funds Transfer (EFT) Authorization

Insured Information	**Payment Selection**
Name:	CCA [ ] EFT / ACH [ ]
Email:	

Credit Card Transaction

Credit Card Information:	**Mastercard [ ]**	**Visa [ ]**	**Discover [ ]**
Card Number:		**Exp: (MM / YY):**	
Name (as appears on the card):		**Authorization Code:**	
Address:	**City:**	**State:**	**Zip:**

Monthly Recurring Charges: I authorize the Benefits Store to charge this credit card for the monthly premium on the 20th of each month.

Yes [ ] No [ ] Initials: _____

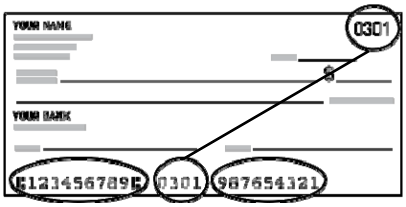
Credit Card payments will be assessed the full premium rate which includes a 2.5% administration charge.

Automated Clearing House (ACH) / Electronic Funds Transfer (EFT) Transaction

Name on Account:	**Name of Financial Institution:**
Routing Number (9 digits):	**Account Number:**
Account Holder Type: Personal [ ] Business [ ]	**Account Type: Checking [ ] Savings [ ]**

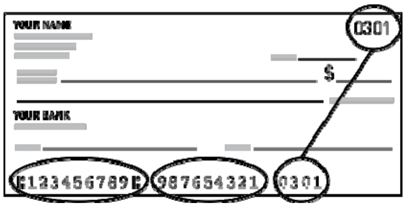
Determining your routing number:
To determine your routing number, refer to your check. The routing number is ALWAYS 9 digits long and it is enclosed by colons. The location of the routing number and account number on you company check varies depending on your bank; for example:

Bank 1



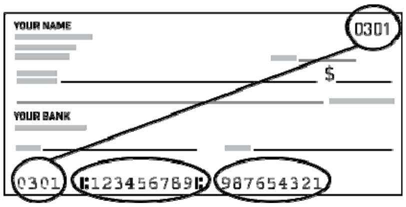
Routing # Check # Account #

Bank 2



Routing # Account # Check #

Bank 3



Check # Routing # Account #

I authorize the Benefits Store to deduct the monthly premium from this bank account.

Yes [ ] No [ ] Initials: 5th of the Month [ ] 15th of the Month [ ]

Monthly Recurring Charges (EFT)

Payment Authorization

Authorization is given to The Benefits Store, Inc. to charge my credit card or debit the banking account listed above. I will not hold The Benefits Store, Inc. responsible for delay, loss or misapplication of funds due to incorrect or incomplete information supplied by me or my depository/credit institution.

Monthly Transactions Authorization

Authorization is given to The Benefits Store, Inc. to charge my credit card or initiate debits (payments) to the financial institution indicated above. This financial institution is authorized to debit the account. This authority is to remain in full force and effect until either a 30 day revocation notice is written to The Benefits Store, Inc. or upon the termination of the coverage through The Benefits Store, Inc. Should a rate change due to policy renewal, age band change or coverage tier occur, I authorize The Benefits Store, Inc. to automatically make the adjustment to my monthly deduction.

Note: I understand and authorize a $25 service charge may be applied against my account for all denied transactions for any reason.

Authorized Signature:	Date:
Payment Amount:	$ ______________________

The Benefits Store, Inc. - PO Box 238 Alamo, CA 94507 - Membership / Accounting : 800-446-2663 - Email: CustomerService@BenefitsStore.com

BENEFITS STORE, Inc.
Association Benefits

BENEFITS STORE, Inc.
Association Benefits

BENEFITS STORE, INC.

CA Insurance License #0680704

IMPORTANT NOTICE

NEW CUSTOMER SERVICE ACCESS FOR MEMBERSHIP ACCOUNTING AND BILLING QUESTIONS

PHONE NUMBER: (888) 226-8373 **FAX: (925) 855-2051**

EMAIL: CUSTOMERSERVICE@BENEFITSSTORE.COM

MAILING ADDRESS: BENEFITS STORE/ MEMBERSHIP ACCOUNTING

PO Box 238

Alamo, CA 94507

Electronic Funds Transfer (EFT)/Automated Clearing House (ACH)

You may do a one time transaction or monthly deduction.

RELIABLE!
EFT/ACH is a method of automatically withdrawing or depositing funds to an individual's bank account.

SAFE!
All EFT/ACH transactions are tracked and governed by the Federal Reserve. Only preauthorized transactions are allowed to be processed.

EFT MONTHLY PAYMENTS!
You will never again need to worry about late payments due to mail delays, misplaced payments or forgotten payments! Your payment will always be made on time.

SIMPLE!
Once you have completed and signed the EFT authorization form, all you need to do is record the payment transaction in your checkbook or savings register on the designated payment date.

Monthly Invoice / Check
Premiums are payable in advance of the month of coverage. You will receive your monthly Premium billing on or about the first of each month

Example: Premiums for July coverage are billed on June 1st and payable (received) on or before June 20th.

Late fees are charged for payments received after the 20th.

Your full payment must be received by the 20th to avoid a late charge. We suggest that you mail your payment on or before the 12th of each month

Payments **MUST** be mailed to:

The Benefits Store, Inc.
P.O. Box 743322
Los Angeles, CA 90074-3322

To assure proper credit make sure to include the top portion of the billing statement with your payment. Also enter the full Subscriber's name in the memo field of your check.

On-Line Bill Payment
Premiums are payable in advance of the month of coverage.

To use On-Line Bill Payment, you will need to arrange for your financial institution to generate a check in payment for your coverage.

As an example, the following links will connect you with major banks for establishing this service
www.Bankofamerica.com
B of A - Online Banking Info

www.Wellsfargo.com
Wells Fargo - Online Banking Information

Your full payment must be received by the 20th to avoid a late charge. We suggest that you initiate your on-line payment on or before the 10th of each month.

Payments **MUST** be mailed to:

The Benefits Store, Inc.
P.O. Box 743322
Los Angeles, CA 90074-3322

To assure proper credit make sure to instruct your bank to show the full Subscriber's name in the memo field of your check.

Credit Card Payment Visa or MasterCard
Premiums are payable in advance of the month of coverage.

We accept Visa, MasterCard for monthly premium payments,

Credit Card payments will be assessed the full premium rate which includes a 2.5% administration charge.

The Credit Card Authorization form may be downloaded from the **Forms section** on our web site www.BenefitsStore.com

To do so, click on the "Forms" tab located in the bar crossing our home page or select the following link Credit Card Authorization Form

Your full payment must be received by the 20th to avoid a late charge. We suggest you initiate your credit card payment on or before the 17th of each month.

For processing, Credit Card Authorization forms must be faxed to (925) 855-2051

Contact us at (888) 226-8373 with any questions about completing this form.

Your Benefits Bill:
Frequently Asked Questions

The Benefits Store is committed to supporting you. Count on us to provide the products, expertise and support you need!

How do I receive my bill?

You have the option to receive a paper copy of your bill via mail, or a digital copy via email.

When will I receive my bill?

You will receive your bill on or by the first of the month.

When is my premium due?

Your premium will always be due by the 20th of each month prior to next month's coverage.

When will I see my adjustments or payments?

Any adjustments or payments made before your bill date will be reflected on your next invoice. All adjustments or payments made after your bill date will reflect on the following month's invoice.

(Example: if your bill date is on the 26th of the month, an adjustment/payment made on the 27th would reflect on the following month's invoice.)

How do I submit my payment?

There are multiple options for submitting payments.

Check

Checks must be mailed to:
The Benefits Store
PO Box 743322
Los Angeles, CA 90074-3322

Credit Card – ACH/EFT

- *if using a credit card, there is a 2.5% transaction fee added to each payment made*

If I'm on autopay, will I still receive a bill?

Yes, even if you are enrolled in automatic payments, an invoice will still be mailed to you.

My coverage was terminated for non-payment, can I get my coverage reinstated?

A reinstatement request requires the account to be paid through the most current billing cycle and is subject to review and approval from the carrier.

California Employee Enrollment Application
For Small Groups
Medical, Dental, Vision, Life and Disability

Anthem

Health care plans offered by Anthem Blue Cross (Anthem). Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company. 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. **Note:** Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect Social Security numbers.
Submit application to: your employer.

Please complete in black ink only.

Group/Case no. (if known)

Section A: Application Type — select one

☐ New enrollment ☐ Open enrollment (not applicable for Life and Disability) ☐ Qualifying event (not applicable for Life and Disability)
☐ COBRA/Cal-COBRA ☐ Rehire date (MM/DD/YYYY): ____/____ /_______

If you select **Qualifying event** or **COBRA/Cal-COBRA**, please select one event reason.
☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Divorce or legal separation ☐ Death
☐ COBRA ☐ Cal-COBRA — Cal-COBRA applicants must submit first month's premium.
☐ Involuntary loss of coverage — please explain (required): ______
☐ Other — please explain (required): ______

Qualifying event or COBRA/Cal-COBRA date — Required (MM/DD/YYYY): ____/____ /_______

Section B: Employee Information

Last name	First name	M.I.	Social Security no.[1] (required)
			/ /

Home address - Street and P.O. Box if applicable	City	State	ZIP code

County	Marital status	Employment status	Primary phone no.	Number of dependents
	☐ Single ☐ Married ☐ Domestic Partner	☐ Full time ☐ Part time		

Employee email address: ______

Applies only to Dental Net DHMO plans[2] and all Medical plans[3]: I (primary applicant) agree to receive my plan-related communications for myself and any dependents, either by email or electronically. This may include my certificate, evidence of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my plan. I agree to provide and update Anthem with my current email address. I know that at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Anthem. I (or my enrolled dependents) will update our communication preferences by going to anthem.com/ca or calling Member Services at 1-855-383-7248.

For Dental PPO[4], Vision[4], Life and Disability plans[4] Anthem will deliver plan materials and related items by mail.

Employer name	Occupation
CREBP-NORBAR	ASSOCIATION MEMBER

Date of hire (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins (MM/DD/YYYY)	No. of hours worked per week
/ /	NA / /	NA / /	40

Language choice (optional): ☐English (ENG) ☐Spanish (SPA) ☐Chinese (ZHO) ☐Korean (KOR) ☐Vietnamese (VIE) ☐Tagalog (TGL)
☐ Other (W09) — 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.

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 Dental Net DHMO plans are offered by Anthem Blue Cross and regulated by the Department of Managed Health Care.
3 Medical plans are offered by Anthem Blue Cross and regulated by the Department of Managed Health Care.
4 Dental PPO and Vision plans are offered by Anthem Blue Cross Life and Health Insurance Company and regulated by the California Department of Insurance.

Life and Disability products underwritten by Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California.
Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.

Social Security no.[1]: ______/_____/________

Section C: Type of Coverage — Select from only the coverage offered by your employer.

1. Medical Coverage – select one option 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.

	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
~~**PPO:**~~ ~~Prudent Buyer PPO Network~~	~~☐ 15/250/10%~~ ~~☐ 20/10%~~	~~☐ 20/30%~~ ~~☐ 30/500/20%~~ ~~☐ 30/750/20%~~ ~~☐ 35/1000/20%~~	~~☐ 40/1500/40%~~ ~~☐ 50/2000/40%~~ ~~☐ 55/1750/35%~~ ~~☐ 2000/25% w/HSA - RxC~~	~~☐ 40/5600/40%~~ ~~☐ 65/4600/40%~~ ~~☐ 70/6300/35%~~ ~~☐ 5000/45% w/HSA~~ ~~☐ 6600/0% w/HSA~~
PPO: Select PPO Network	☐ 15/10% ☐ 15/250/10% ☐ 20/10%	☐ 20/30% ☐ 30/20% ☐ 30/500/20% ☐ 30/750/20% ☐ 35/1000/20%	☐ 40/1500/40% ☐ 45/2000/20% ☐ 50/2000/40% ☐ 55/1750/35% ☐ 2000/25% w/HSA - RxC	☐ 40/5600/40% ☐ 65/4600/40% ☐ 70/6300/35% ☐ 5000/45% w/HSA ☐ 6000/40% w/HSA ☐ 6600/0% w/HSA
~~**EPO:**~~ ~~Prudent Buyer PPO Network~~		~~☐ 35/500/20%~~ ~~☐ 35/1700/20%~~		
~~**HMO:**~~ ~~CaliforniaCare HMO Network~~	~~☐ 10~~	~~☐ 25~~ ~~☐ 35~~	~~☐ 55~~ ~~☐ 55/2250/40%~~	
HMO: Select HMO Network	☐ 10	☐ 25 ☐ 35	☐ 55 ☐ 55/2250/40%	

☐ Medical plan name: ____ Contract code, if known: _________________________

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

~~**2. Dental Coverage** — Select from only the coverage offered by your employer.~~

~~**Dental HMO[2] and Dental PPO[3] plans do not include certified pediatric dental essential health Benefits.**~~

~~**Member dental coverage - select one:**~~
~~☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family~~

~~**Please indicate the name and contract code for the dental plan selected.** Your employer will advise you of your plan options and contract codes.~~
~~Dental plan name: ____ Dental contract code: _________________________~~

~~For all DHMO plans, you must enter your dental office no.: ____~~

~~**3. Vision Coverage** — Select from only the coverage offered by your employer. Offered by Anthem Blue Cross Life and Health Insurance Company.~~

~~**These optional vision plans do not include coverage for vision pediatric essential health benefits.**~~

~~**Member vision coverage - select one:**~~
~~☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family~~

~~**Please indicate the name and contract code for the vision plan selected.** Your employer will advise you of your plan options and contract codes.~~
~~Vision plan name: ____ Vision contract code: _________________________~~

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 Offered by Anthem Blue Cross.
3 Offered by Anthem Blue Cross Life and Health Insurance Company.

~~4. Life, Accidental Death & Dismemberment (AD&D), and Disability Coverage~~ ~~Offered by Anthem Blue Cross Life and Health Insurance Company.~~					
~~☐ Basic Life & AD&D~~ ~~☐ Basic Dependent Life~~ ~~☐ Optional Supplemental/Voluntary Life and AD&D $ ________ (Employee amount)~~ ~~☐ Optional Supplemental/Voluntary Dependent Life Spouse $ ________ (Spouse amount)~~ ~~☐ Optional Supplemental/Voluntary Dependent Life Child $ ________ (Child amount)~~				~~☐ Short Term Disability~~ ~~☐ Long Term Disability~~ ~~☐ Voluntary Short Term Disability~~ ~~☐ Voluntary Long Term Disability~~	
~~Current annual income: $~~			~~Life and Disability class no.:~~		
~~If selecting Short Term Disability coverage: Do you work in New York? ☐ Yes ☐ No Do you work in New Jersey? ☐ Yes ☐ No~~					
~~Primary Beneficiary~~ ~~— Attach a separate sheet if necessary.~~					
~~Last name~~	~~First name~~	~~M.I.~~	~~Relationship~~	~~Social Security no.~~ / /	~~Percentage~~
~~Last name~~	~~First name~~	~~M.I.~~	~~Relationship~~	~~Social Security no.~~ / /	~~Percentage~~
~~Contingent Beneficiary~~ ~~— Attach a separate sheet if necessary.~~					
~~Last name~~	~~First name~~	~~M.I.~~	~~Relationship~~	~~Social Security no.~~ / /	~~Percentage~~
~~Last name~~	~~First name~~	~~M.I.~~	~~Relationship~~	~~Social Security no.~~ / /	~~Percentage~~
~~Total percentages must add to 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.~~					
~~If an applicant's age at the time of application is 15, the applicant must submit a written statement, signed by the parent, consenting to the minor's application for coverage.~~					
~~Life and Disability - Spousal Consent for Community Property States Only (for AZ, CA, ID, LA, NM, TX, WA and WI):~~ ~~If your spouse is not named as a primary beneficiary for 50% or more of your benefit amount, then please have your spouse read and sign below. Insureds and their spouses should contact their own legal counsel for guidance pertaining to the naming of someone other than the spouse as beneficiary. Note: Anthem is not responsible for the validity of a spouse's consent for designation.~~ ~~Authorization:~~ ~~I am aware that my spouse, the Employee/Retiree named above, has designated someone else to be a primary beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive and release any and all community property rights I may have in such insurance proceeds under the applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.~~					
~~Spouse signature~~ ~~X~~		~~Spouse name~~		~~Date (MM/DD/YYYY)~~ / /	
Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.					

Section D: Coverage Information — All fields required. Attach a separate sheet if necessary. Complete this section for yourself and all dependents.
Please access *Find a Doctor* at anthem.com to determine if your physician is a participating provider.
For HMO and EPO plans: provide 3- or 6- digit Primary Care Physician no.

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.
Sex ☐ Male ☐ Female	Birthdate(MM/DD/YYYY) / /	
Primary Care Physician name (PCP) (if selecting an HMO or EPO plan)	PCP ID no. (HMO or EPO only)	Existing patient ☐ Yes ☐ No

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.[1] (required) / /
Sex ☐ Male ☐ Female	Birthdate(MM/DD/YYYY) / /	Relationship to applicant ☐ Spouse ☐ Domestic Partner	
PCP (if selecting an HMO or EPO plan)	PCP ID no. (HMO or EPO only)	Existing patient ☐ Yes ☐ No	
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	Birthdate(MM/DD/YYYY) / /	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?______________	
PCP (if selecting an HMO or EPO plan)	PCP ID no. (HMO or EPO only)	Existing patient ☐ Yes ☐ No	
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	Birthdate(MM/DD/YYYY) / /	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?______________	
PCP (if selecting an HMO or EPO plan)	PCP ID no. (HMO or EPO only)	Existing patient ☐ Yes ☐ No	
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	Birthdate(MM/DD/YYYY) / /	Relationship to applicant ☐ Child ☐ Other If other, what is relationship?______________	
PCP (if selecting an HMO or EPO plan)	PCP ID no. (HMO or EPO only)	Existing patient ☐ Yes ☐ No	
Does this dependent have a different address? ☐Yes ☐No If yes, full address and ZIP code: ______________________________			

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 As defined in 2 CCR § 599.500(o).

Section E: 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 (MM/DD/YYYY) / /	Part B effective date (MM/DD/YYYY) / /
Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date (MM/DD/YYYY) / /

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, dental, or orthodontia coverage? ☐ Yes ☐ No
4. On the day your coverage begins, will you or a family member be covered by other dental coverage? ☐ Yes ☐ No

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

Name of person covered (Last name, first, M.I.)	Type (select one)	Coverage (select all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: ____/_____/______ End: ____/_____/______

Section F: Waiver/Declining Coverage — Proof of coverage will be required. (Proof of coverage not applicable for Life and Disability.)

Type of coverage/Declined for – Select all that apply.		**Reason for declining/refusing coverage** – Select all that apply.
☐ Employee	☐ Medical ~~☐ Dental~~ ~~☐ Vision~~ ~~☐ Life/AD&D~~ ~~☐ Short Term Disability~~ ~~☐ Long Term Disability~~ ~~☐ Optional Supplemental/Voluntary Life~~ ~~☐ Voluntary Short Term Disability~~ ~~☐ Voluntary Long Term Disability~~	☐ No coverage ☐ Covered by Spouse's/Domestic Partner's group coverage ☐ Spouse/Domestic Partner covered by employer's group medical coverage ☐ Enrolled in individual coverage ☐ Medicare/Medi-Cal/VA ☐ Enrolled in other Insurance — Please provide company name and plan: ______________________________ ☐ Other — please explain: ______________________________
☐ Spouse/ Domestic Partner	☐ Medical ~~☐ Dental~~ ~~☐ Vision~~ ~~☐ Dependent Life~~ ~~☐ Optional Supplemental/Voluntary Dependent Life~~	
☐ Dependent(s)	☐ Medical ~~☐ Dental~~ ~~☐ Vision~~ ~~☐ Dependent Life~~ ~~☐ Optional Supplemental/Voluntary Dependent Life~~ ~~List name of dependents to be waived:~~ ______________________________________	

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, DENTAL, VISION, DISABILITY OR LIFE COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, VISION, DISABILITY OR LIFE 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, DENTAL, OR VISION 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.

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

Special Open Enrollment (Not applicable to Life or Disability.)

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.

Signature of applicant	Printed name	Date (MM/DD/YYYY)
X		/ /

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

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 (Anthem) 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 reserves the right to accept or decline this application for coverage (and that Anthem Blue Cross Life and Health Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage.

I also understand that I may not be covered for pre-existing conditions for Long Term Disability and Short Term Disability, if applicable. (See the policy/certificate for important information).

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 and myself.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

If applying for Life and/or Disability insurance, I represent that I have read and agree to the terms in the Life and Disability Coverage in Section 4, above.

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

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 (Not applicable to Life and Disability coverage.)

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. 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 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. 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	Applicant Signature **X**	Date (MM/DD/YYYY) / /

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

Get help in your language

Anthem. BlueCross

Language Assistance Services

Curious to know what all this says? We would be too. Here's the English version:

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the Member Services telephone number on the back of your ID card.

Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721 (TY/TDD:711T).

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese

重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید.(Y/TDD:711TT)

Hindi

महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong

TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese

重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。1-888-254-2721 (TTY/TDD: 711)

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Khmer

សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។
អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ
សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean

중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੌਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Spanish

IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Tagalog

MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai

หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese

QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It’s important we treat you fairly

That’s why we follow federal civil rights laws in our health programs and activities. We don’t discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn’t English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.