CREBP-NORBAR Benefit Package with Anthem BlueCross, Mutual of Omaha and New Dental Choice

Member/Applicant: ______________________________
Local REALTOR® Association Name: ______________________________
Member Email Address: ______________________________
Requested Effective Date of Coverage: ______________________________
Network Selection: ______________ **Plan Name:** ______________
Plan Code: ______________
Qualifying Event: ______________ **Qualifying Event Date:** ______________

Instructions: Complete the section for the plan above (including Network and Plan Code). Before selecting a plan change, refer to the SOB (Summary of Benefits) or SBC and consult with an agent.

CREBP Member Plan Options

	Prudent Buyer/ Select PPO Small Group Network Plans		California Care/Select HMO Small Group
Anthem Platinum	6RJP – PPO 5/200/15% 6RH4 – PPO 15/40/10% 6RG6 – PPO 15/250/10%	6RJT – Select PPO 5/200/15% 6RJJ – Select PPO 15/10% 6BHY – Select PPO 15/40/10% 6RHD – Select PPO 15/250/10%	6RJ6 – HMO 20 6RHH – Select HMO 20 6RH3 – HMO 0/25 6RHW – Select HMO 0/25 6BG1 – HMO 0/30 6BGP – Select HMO 0/30
Anthem Gold	6RK1 – PPO 5/1500/30% 6RFN – PPO 25/30% 6RG9 – PPO 30/500/20% 6RGS – PPO 30/750/20% 6RGV – PPO 35/500/25% 6RH1 – PPO 35/1000/20% 6SLC/6SLE (Ind./Family) - Select PPO 1700/15% w/HSA PrevRX 6SLF/6SLD (Ind./Family) - PPO 1700/15% w/HSA PrevRX	6RJD – Select PPO 5/1500/30% 6RGD – Select PPO 25/30% 6RGH – Select PPO 25/350/20% 6RHX – Select PPO 30/500/20% 6RFP – Select PPO 30/750/20% 6RH7 – Select PPO 35/500/25% 6RFM – Select PPO 35/1000/20%	6RH8 – HMO 30 6BHZ – HMO 35 6RGA – HMO 35/500/20% 6RHC – HMO 35/1250/20% 6RJ4 – Select HMO 30 6BH0 – Select HMO 35 6RK2 – Select HMO 35/500/20% 6RJW – Select HMO 35/1250/20%
Anthem Silver	6RGX – PPO 45/1750/40% 6RK6 – PPO 50/2200/40% 6RJ0 – PPO 55/1950/35% 6RGB – PPO 55/2500/45% 6RK0/6RJ5 (Ind./Family) – PPO 2100/30% w/HSA - PrevRx 6RG5/6RH6 (Ind./Family) – PPO 2600/35% w/HSA - PrevRX 6RJ2/6RHT (Ind./Family) – Select PPO 2100/30% w/HSA - PrevRx 6RJM/6RHL (Ind./Family) – Select PPO 2600/35% w/HSA - PrevRx	6RGW – Select PPO 45/1750/40% 6RJF – Select PPO 50/2200/40% 6RFU – Select PPO 55/2500/35% 6RHJ – Select PPO 55/1950/35% 6RFY – Select PPO 55/2500/45%	6RJG – HMO 55 6RHM – HMO 60/2500/45% 6RHQ – Select HMO 55 6RHB – Select HMO 60/2500/45%
Anthem Bronze	6RJX – PPO 4600/50% 6RJN – PPO 40/6200/40% 6RK4 – PPO 60/6850/40% 6RFV – PPO 70/6600/35% 6RJ1 – PPO 75/7300/40% 6RJK – PPO 6000/45% w/HSA 6RG7 – PPO 6700/0% w/HSA	6RH9 – Select PPO 4600/50% 6RJS – Select PPO 40/6200/40% 6RHK – Select PPO 60/6850/40% 6RFR – Select PPO 70/6600/35% 6RGT – Select PPO 75/7300/40%% 6RJU – Select PPO 6000/45% w/HSA 6RJV – Select PPO 6700/0% w/HSA 6RHP – Select PPO 7000/0% w/HSA	**Vivity HMO Small Group Network Plans** 6RG8 – Anthem Link Platinum HMO 15 6RJZ – Anthem Link Gold HMO 25 6RHV – Anthem Link Gold HMO 25/500 6RGJ – Anthem Link Gold HMO 35/1000 6RK7 – Anthem Link Gold HMO 35/1850 6RG2 – Anthem Link Silver HMO 50/2650

ELIGIBILITY REQUIREMENT - In all cases, membership in a Local Realtor Association must be in effect to enroll, the membership must be maintained in order to preserve eligibility. Failure of either of these basic eligibility criteria will result in termination of coverage. Periodic audits are performed to confirm continuous Local Realtor Association membership.

Application Instructions

Please Type or Print Clearly using only Black Ink

***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**

Enrollment / Instructions

California Local Realtor Association Benefits

Effective Date of Coverage: Applications must be received in our office by the **20th** of the month prior to the effective date. You should not cancel your current coverage until you are notified of your new coverage.

Application Process Time Schedule:

- Please keep a copy of your enrollment form which serves as your temporary Anthem Blue Cross Member ID until you receive your official member ID card.
- Anthem Data Base - allow 12 business days from our receipt and processing of your enrollment
- Anthem ID Cards – allow 15 business days from our receipt and processing of your enrollment.

Applications may be sent to The Benefits Store or directly to your agent:

- Emailed to Operations@BenefitsStore.com
- Faxed to **925-855-2051**
- Mailed to: The Benefits Store - PO Box 238, Alamo CA 94507

If you send the application via email – make sure the file is encrypted to protect your HIPAA information, or ask your agent or The Benefits Store to send a secure document request.

Payment: Premium payment must be received with the application. You have options.

- Include a check for the first month's premium – make payable to **The Benefits Store Trust Account**
- Complete the CCA Payment section of the payment form (included)
- Complete the EFT/ACH Payment section of the payment form (included)

Both the CCA and EFT/ACH payment form allow for the option to set up recurring automatic monthly payments.

Monthly Premium Billing and Payment

- Premium Billing is in advance, on the 1st of each month for the following month's premium
- Premium Payment is due on the 20th of the billing month, in advance of the following month's coverage
- Example**:** You will receive July's invoice on the 1st of June – premium payment is due by June 20th for July's coverage.

Cancellation of Coverage: To cancel your coverage or revoke your application, we require a notice of your intent to be faxed to **925-855-2051** or emailed to Operations@BenefitsStore.com.

By signing your enrollment application, you represent that all the information you have included is complete and accurate, and that you accept all terms of CREBPT eligibility guidelines.

Acknowledgement Signature:____________________________________ Date: ____________________

Your California Real Estate Benefit Plan (CREBP) provides added value and protection

Enhanced Benefits

These Extra Benefits Are Included With Your CREBP Anthem Insurance!

$10,000 life insurance plan and $50,000 AD&D plan, and special Discounted Dental Plan.

Read Below for more information.

Enhanced Benefits Included

Special Discount Dental Plan

- The New Dental Choice Special Discount Pian gives you immediate, predictable and significant discounts of 60% for dental services. Plan members decide when to use a participating dentist how often, and without any limit on their savings.
- Feel confident, you have one of the largest, credentialed networks at your service. New Dental Choice contracts with thousands of general dentists and specialists. You can choose to nominate your dentist. – See Attachment A for more details

$10,000 Voluntary Life

- You automatically have a $10,000 Life Insurance policy through Mutual of Omaha Life Insurance Company included with your CREBP Anthem Blue Cross Medical plans. 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.
- **New opportunities to add more coverage. See Attachment B for more details**

$50,000 AD&D Coverage

- You automatically have $50,000 of AD&D Insurance coverage through Mutual of Omaha Life Insurance Company included in your CREBP Anthem Blue Cross Medical Plans. This special AD&D coverage benefit covers the primary insured member only, is guaranteed issue without exclusion.
- **New opportunity to add additional up to $500,000 for pennies, don't miss this! See Attachment C for more details**

Legal Club

- **New Opportunity to add Legal Protection for you and your family, also includes free annual tax filing. See Attachment D for more details**

Included In Your Plan Now

New Dental Choice is a product created by practicing dentists who see on a daily basis how the current dental care system could be improved. Their collaboration resulted in New Dental Choice, a dental savings plan designed for individuals, families and groups of all sizes.

You have the power to decide with New Dental Choice when to visit a qualified dentist and how often. There are no limitations on visits and how much money you can save. Your membership fee entitles you to savings on everything from routine checkups to major treatments. And because New Dental Choice is not insurance, you're not paying monthly premiums for services you may or may not use.

A dental plan with no surprises

Just present your New Dental Choice Membership card to any participating dentist and receive fixed, discounted fees on all dental care including cosmetic procedures and dental implants. We've eliminated the hassles. There are no waiting periods, no annual maximums, no hidden fees, and your dental history is never a factor.

Feel confident. You have one of the largest credentialed networks at your service

New Dental Choice contracts with thousands of general dentists and specialists, so it's likely your current dentist may already be participating in our network. If not, you can choose to nominate your dentist or find a new participating dentist near you. We've made every effort to make going to the dentist easy and affordable – the way it should be.

For a complete list of fees or to find a participating dentist in your area: Call us at (888) 632-3676 or visit www.newdentalchoice.com

More than 300 procedures are discounted to fixed fees at partcipating general dentists and specialists

your sample savings[1]

Procedures	Typical Price [2]	Avg Plan Fee [3]	Your Savings[4]
Oral Exams	$114	$45	61%
Cleaning	$113	$76	33%
X-Rays	$179	$82	54%
Cavity Filling	$183	$103	44%
Crown	$1,247	$838	33%
Extraction	$628	$432	31%
Root Canal	$848	$530	38%
Implant	$3,024	$1,722	43%

1 "Your Sample Savings" is based on dentist average fees in California

2 "Typical price" is the average 80th percentile of the 2013 Fairhealth fee schedule - a national profiling service

3 "Avg Plan Fee" is the average of the fixed fees for dentists in California - fees vary by provider

4 "Your Savings" is an average for dentists in California - fees vary by area

www.newdentalchoice.com

Opportunities to Enroll in Additional Life Insurance Attachment B

- You have **$10,000** of Life Insurance coverage through your membership, however that is barely enough to cover basic funeral expenses. You need to consider how much insurance your family will need to pay off your remaining debts and survive comfortably without your income
- Now is your opportunity to elect an additional $50,000 of Life Insurance with no medical questions. **Enroll Now**
- You can also enroll your Spouse for $25,000 of Life Insurance and each Child for $10,000 of Life Insurance, no medical questions required. **Enroll Now**
- *** IMPORTANT *** This is a one-time offering. If you wish to elect any life insurance coverage for you or your family going forward, you will need to complete medical forms and may not be approved for the full amount you can enroll in today.

Life Insurance premiums have been substantially discounted since you're part of CREBP. The premiums are shown on the next page.

EXAMPLE: Sara wants to enroll in $50,000 of Life Insurance for herself

At a rate of .07 per $1,000, her monthly premium would be (.07 x 50,000) / 1000 = **$3.50**

Enroll Now

LIFE INSURANCE

Opportunities to Enroll in Additional AD&D Insurance Attachment C

- You have **$50,000** of AD&D Insurance coverage through your membership, so similarly to Life Insurance you have the opportunity during this enrollment period to purchase more
- Now is your opportunity to elect an additional **$500,000** of AD&D Insurance coverage without answering a single medical question. **Enroll Now**
- You can also enroll your Spouse for **$250,000** of AD&D Insurance and each Child for **$10,000** of AD&D Insurance, no medical questions required. **Enroll Now**
- *** IMPORTANT *** This is a one-time offering. If you wish to elect any life insurance coverage for you or your family going forward, you will need to complete medical forms and may not be approved for the full amount you can enroll in today.

AD&D premiums have been substantially discounted since you're part of CREBP. No matter your age, the rate is .03 per $1,000 of benefit.

EXAMPLE: Sally wants to purchase $500,000 of AD&D coverage for herself and $250,000 for her spouse

If the Total Coverage = $750,000, then monthly premium would be (.03 x 750,000) / 1000 = **$22.50**

Enroll Now

LIFE INSURANCE

LEGAL CLUB

FAMILY PROTECTION PLAN
Attachment D

- FREE
- DEEPLY DISCOUNTED
- REDUCED HOURLY RATE

… buying or selling a home?

… speeding ticket?

… dealing with a divorce or child support?

… need an attorney to review a document?

Get your taxes done FREE!

Identity Theft is a real threat.
Do you want to protect yourself?

- *No waiting periods*
- *Low monthly premiums*
- *No exclusions or pre-existing limitations*
- *Includes eligible dependents/liberal definition of dependent*
- *Over 85,000 online legal forms*
- *ID card and guidebook delivered in about 10 business days*

Enroll in the Legal Club Family Protection Plan (FPP)

Low Premium - FPP CLASSIC	High Value - FPP
Free & Discounted Legal Care	Free & Discounted Legal Care
Online Legal Forms	Online Legal Forms
Tax Preparation & Advice Includes: Free Federal and state tax return	Tax Preparation & Advice Includes: Free Federal and state tax return
Keylogging Defense System™	Privacy Plus Software including: Data Vault, Secure Email, Virtual Private Network (VPN), and Password Manager
N/A	1-Bureau Credit Monitoring
Preventative Identity Monitoring	Preventative Identity Monitoring
N/A	Bank Account Take Over Monitoring
N/A	Sex Offender Monitoring
N/A	Social Media Monitoring (Cyberbullying)
Fully Managed Restoration	Fully Managed Restoration
Lost / Stolen Credit Card Assistance	Lost / Stolen Credit Card Assistance
$1,000,000 Insurance Policy	$1,000,000 Insurance Policy
N/A	Email Alerts
Financial Education & Credit Counseling	N/A
LifeEvents™ Telephonic Counseling	N/A
Low Premium - FPP CLASSIC **$19 per member per month**	**High Value - FPP** **$23 per member per month**
Enroll Now	**Enroll Now**

This is only an outline of benefits. For a complete description of benefits, terms and conditions, please refer to the FPP guidebook.

** Limit one per household* *** Credit Monitoring, Identity Monitoring and Insurance are limited only to the member*

California Employee Enrollment Application
For Small Groups
Medical

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/or 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 - (P.O. Box not acceptable unless rural address)	City	State	ZIP code

County	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Employment status ☐ Full-time ☐ Part-time	Primary phone no.

Employer name CREBP-NORBAR	Occupation Association Member

Employee's physical work address (required)	City	State	ZIP code

Date of hire[2] (MM/DD/YYYY) / /	Date of full-time employment (MM/DD/YYYY) / /	Date waiting period begins[2] (MM/DD/YYYY) / /	No. of hours worked per week 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.

Employee email address:

For **Medical plans** offered by Anthem Blue Cross and regulated by the Department of Managed Health care.

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 I can change my mind and request a copy of these materials (or any specific materials) at any time by mail or by contacting Anthem. I (or my enrolled dependents) will change our communication preferences by going to anthem.com/ca or calling the Member Services number on my ID card.

☐ By signing below, I (primary applicant) agree to receive my plan-related communications for myself and any dependents, either by email or electronically. This includes my certificate, evidence of coverage, explanation of benefits statements, legally 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 understand that this consent is voluntary, and that I (or my enrolled dependents) can opt out of electronic delivery at any time and receive these materials (or any specific materials) by mail, and/or change my email address by going to anthem.com/ca or calling the Member Services number on my ID card.

Applicant signature ____________________ Date ____________

☐ I do not wish to receive my plan-related communications, either by email or electronically and request to receive these items by mail.

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 If your employer imposes an orientation period for new hires, the "date of hire" is the first day after completion of the orientation period.

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.

Section C: Type of Coverage — Your employer will advise you of your plan options and contract codes.	
1. Medical Coverage	
Please Note: All health plans[2] include the required coverage for the dental and vision pediatric essential health benefits.	
Medical plan name[3]: ______________________________	Contract code, if known: ______________________________
Member medical coverage — select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family	

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 These plans are offered by Anthem Blue Cross and regulated by the Department of Managed Health Care.
3 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 you may be assigned to or be required to choose a different provider, network, and/or plan.

Section D: Family Information — Complete this section for yourself and all dependents. All fields required. Attach a separate sheet if necessary.
Please access *Find a Doctor* at anthem.com/ca to determine if your physician is a participating provider.
For HMO 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 (PCP) name (if selecting an HMO[3] plan)	PCP ID no. (HMO only)	Existing patient ☐ Yes ☐ No
Primary Care Dentist (PCD) name (If selecting Dental net DHMO plan)	PCD ID no.	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 name (if selecting an HMO[3] plan)	PCP ID no. (HMO only)	Existing patient ☐ Yes ☐ No	
PCD name (If selecting Dental net DHMO plan)	PCD ID no.	Existing patient ☐ Yes ☐ No	
Does this dependent have a different address? ☐ Yes ☐ No If yes, full address and ZIP code: ______			

Dependent Child Last name	First name	M.I.	Social Security no.[1] (required) / /
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY) / /	Relationship to applicant ☐ Child ☐ Other[4] If other, what is relationship? ______	
PCP name (if selecting an HMO[3] plan)	PCP ID no. (HMO only)	Existing patient ☐ Yes ☐ No	
PCD name (If selecting Dental net DHMO plan)	PCD ID no.	Existing patient ☐ Yes ☐ No	
Does this dependent have a different address? ☐ Yes ☐ No If yes, full address and ZIP code: ______			

Dependent Child Last name	First name	M.I.	Social Security no.[1] (required) / /
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY) / /	Relationship to applicant ☐ Child ☐ Other[4] If other, what is relationship? ______	
PCP name (if selecting an HMO[3] plan)	PCP ID no. (HMO only)	Existing patient ☐ Yes ☐ No	
PCD name (If selecting Dental net DHMO plan)	PCD ID no.	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).
3 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 you may be assigned to or be required to choose a different provider, network, and/or plan.
4 Eligibility subject to Evidence of Coverage.

Section E: Prior and Other Group 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	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 may be required. (Proof of coverage not applicable for Life and Disability.)

Type of coverage/Declined for: Select all that apply.

☐ Employee	☐ Medical
☐ Spouse/ Domestic Partner	☐ Medical
☐ Dependent(s)	☐ Medical List name of dependents to be waived: ____________

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

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

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, 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.

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		/ /

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

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.

By providing a phone number, I agree and consent that Anthem and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.

For Health Savings Account enrollees: I authorize the Health Savings Account (HSA) financial custodian (provided I am enrolling in an HSA) to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA and 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. **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.

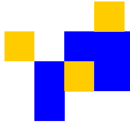
Read carefully — Signature required

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. 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	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.



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	Bank 2	Bank 3
Routing # Check # Account #	Routing # Account # Check #	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.
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

<u>Electronic Funds Transfer (EFT)/Automated Clearing House (ACH)</u>
You may do a one time transaction or monthly deduction.

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

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

<u>EFT MONTHLY PAYMENTS!</u>
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.

<u>SIMPLE!</u>
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.

<u>Monthly Invoice / Check</u>
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

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

<u>Late fees are charged for payments received after the 20th.</u>

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 **<u>MUST</u>** 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.

<u>On-Line Bill Payment</u>
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 **<u>MUST</u>** 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.

<u>Credit Card Payment Visa or MasterCard</u>
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.