# CREBP Benefit Package

Anthem Change Form

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**Member Information**

MEMBER NAME _____
LOCAL ASSOC. NAME _____
MEMBERSHIP # _____
E-MAIL ADDRESS _____

**CHANGING:** **[ ]** Add/ Delete Dependent [ ] Change Dependent Status
[ ] Name Change **[ ]** Change of Address

**COMPLETING CHANGE FORM:** **USE BLACK INK AND COMPLETE BOTH PAGES**
***DO NOT COMPLETE THE EMPLOYER SECTION***

**PLEASE FORWARD THE COMPLETED FORM:**

**U.S. MAIL:**
**Benefits Store, Inc.**
**PO Box 238, Alamo, CA 94507**

**Scan and Email:** **Operations@benefitsstore.com**

**FAX:** **(925) 855-2051**

**PROCESSING** Allow 12 business days for processing of your change, transmission to Anthem and data entry before your change will appear in Anthem's database.

**CREBPT Benefits Information**

**For all CREBP Programs - Local Realtor Association Membership must be maintained in order to preserve eligibility. Failure to maintain continuous active Association membership will result in the termination of coverage. Membership is verified any time an account change is made, and periodic audits are also performed to confirm continuous membership. CREBP programs require a qualifying event for mid-year enrollments. Please speak with a broker to discuss your situation.**

**CREBP is a special benefit 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 Inc.**


CA Insurance License No.: 0680704
Phone: 800-446-2663 Fax: 925-855-2051 Email: Operations@benefitsstore.com

# 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.

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

| **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.

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

**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<br>☐ Male ☐ Female | Birthdate (MM/DD/YYYY)<br>/ / |
|---|---|

| Primary Care Physician (PCP) name (if selecting an HMO[3] plan) | PCP ID no. (HMO only) | Existing patient<br>☐ Yes ☐ No |
|---|---|---|
| Primary Care Dentist (PCD) name (If selecting Dental net DHMO plan) | PCD ID no. | Existing patient<br>☐ Yes ☐ No |

| **Spouse/Domestic Partner** Last name | First name | M.I. | Social Security no.[1] (required)<br>/ / |
|---|---|---|---|

| Sex<br>☐ Male ☐ Female | Birthdate (MM/DD/YYYY)<br>/ / | Relationship to applicant<br>☐ Spouse ☐ Domestic Partner |
|---|---|---|

| PCP name (if selecting an HMO[3] plan) | PCP ID no. (HMO only) | Existing patient<br>☐ Yes ☐ No |
|---|---|---|
| PCD name (If selecting Dental net DHMO plan) | PCD ID no. | Existing patient<br>☐ 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)<br>/ / |
|---|---|---|---|

| Sex<br>☐ Male ☐ Female | Birthdate (MM/DD/YYYY)<br>/ / | Relationship to applicant<br>☐ Child ☐ Other[4] If other, what is relationship? _____ |
|---|---|---|

| PCP name (if selecting an HMO[3] plan) | PCP ID no. (HMO only) | Existing patient<br>☐ Yes ☐ No |
|---|---|---|
| PCD name (If selecting Dental net DHMO plan) | PCD ID no. | Existing patient<br>☐ Yes ☐ No |

Does this dependent have a different address? ☐ Yes ☐ No
If yes, full address and ZIP code: _____

| **Dependent**<br>Child Last name | First name | M.I. | Social Security no.[1] (required)<br>/ / |
|---|---|---|---|

| Sex<br>☐ Male ☐ Female | Birthdate (MM/DD/YYYY)<br>/ / | Relationship to applicant<br>☐ Child ☐ Other[4] If other, what is relationship? _____ |
|---|---|---|

| PCP name (if selecting an HMO[3] plan) | PCP ID no. (HMO only) | Existing patient<br>☐ Yes ☐ No |
|---|---|---|
| PCD name (If selecting Dental net DHMO plan) | PCD ID no. | Existing patient<br>☐ 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.

Social Security no. : _____/_____/_____

## 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. | | **Reason for declining/refusing coverage:** Select all that apply. |
|---|---|---|
| ☐ Employee | ☐ Medical | ☐ No coverage<br>☐ Covered by Spouse's/Domestic Partner's group coverage<br>☐ Spouse/Domestic Partner covered by their employer's group coverage.<br>☐ Enrolled in individual coverage<br>☐ Medicare/Medi-Cal/VA<br>☐ Enrolled in other Insurance — Please provide company name and plan: _____<br>☐ Other — please explain _____ |
| ☐ Spouse/ Domestic Partner | ☐ Medical | |
| ☐ Dependent(s) | ☐ Medical<br>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, 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<br>X | Printed name | Date (MM/DD/YYYY) / / |
|---|---|---|

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

Social Security no. : _____/_____/_____

**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<br>X | Date (MM/DD/YYYY)<br>/ / |
|---|---|---|

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