**Note: When completing form, enter "Tools-Typewriter" before placing cursor at each entry.

Anthem. Blue Cross

EmployeeElect (51-99) Member Application
Health care plans offered by Anthem Blue Cross
Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company

Employee Application

anthem.com/ca

Group No. 342896

Please complete using black ink/type, seal the inside pages for privacy and return to your Group Administrator. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, please answer all questions and be sure to sign and date your application.

1a. Medical Coverage - please ask your employer which Medical options are available before checking your selection:

- ☐ Premier PPO $10 Copay*
- ☐ Premier PPO $20 Copay*
- ☐ Premier PPO $30 Copay*
- ☐ PPO $20 Copay**
- ☐ PPO $30 Copay*
- ☐ PPO $40 Copay*
- ☐ PPO $25 Copay GenRx**
- ☐ PPO $35 Copay GenRx**
- ☐ PPO $45 Copay GenRx**
- ☐ Solution 2500 PPO**
- ☐ Solution 3500 PPO**
- ☐ Solution 5000 PPO**
- ☐ Elements Hospital Preferred**
- ☐ Elements Hospital Plus**
- ☐ Elements Hospital**
- ☐ Lumenos HIA Plus 750**
- ☐ Lumenos HIA Plus 500**
- ☐ Lumenos HSA 2000 (100/70)**
- ☐ Lumenos HSA 3000 (100/70)**
- ☐ Lumenos HSA 5000 (100/70)**
- ☐ Lumenos HSA 1500 (80/50)**
- ☐ Lumenos HSA 2500 (80/50)**
- ☐ Lumenos HSA 3500 (80/50)**
- ☐ HMO $10 100%*
- ☐ HMO $25 100%*
- ☐ Classic $20 HMO*
- ☐ Classic $30 HMO*
- ☐ Classic $40 HMO*
- ☐ Saver $20 HMO*
- ☐ Saver $30 HMO*
- ☐ Saver $40 HMO*
- ☐ Select $25 HMO*
- ☐ Select $35 HMO*
- †☐ Lumenos HSA 1500 (100/70)**
- †☐ Advantage PPO $25 Copay***
- †☐ Saver PPO **
- †☐ Basic PPO **
- †☐ PPO 2400 (HSA-Compatible)**
- †☐ PPO 3500 (HSA-Compatible)**
- †☐ Lumenos HIA Plus 3000**
- †☐ Power HealthFund 750**
- †☐ Power HealthFund 500**
- ☐ Other: _____

If HMO, be sure to provide physician number in section 3

**offered by Anthem Blue Cross*

***offered by Anthem Blue Cross Life and Health Insurance Company*

If directed by your employer, Anthem Blue Cross Life and Health will facilitate the opening of a Health Savings Account in your name.

† Plans may not be available at renewal beginning in 2010.

1b. Dental Coverage - please ask your employer which Dental options are available before checking your selection:

- ☐ Dental Blue Silver 1000**
- ☐ Dental Blue Gold Plus 1500**
- ☐ Dental Blue Platinum Plus 2000**
- ☐ Dental Net*
- ☐ Other: _____

For Dental Net, please select a Dental Office Number:

**offered by Anthem Blue Cross*

***offered by Anthem Blue Cross Life and Health Insurance Company*

1c. Life Coverage - please check with your employer to make sure these options are available before selecting:

Optional Dependent Life Insurance (only if offered by your employer)

- ☐ $10,000/$1,000 *($10,000 spouse/child 6 months-24 yrs; $1,000<6 months)***
- ☐ $5,000/$500 *($5,000 spouse/child 6 months-24 yrs; $500<6 months)***

***offered by Anthem Blue Cross Life and Health Insurance Company*

2. Please provide the following enrollment information (must be completed by the employee):

- ☐ New group enrollment
- ☐ Family addition
- ☐ Late enrollment
- ☐ New hire
- ☐ Change of coverage
- ☐ Other: _____
- ☐ COBRA

COBRA Effective Date:

Last Name	First Name	M.I.	Social Security or ID No.

Home Address (P.O. Box not acceptable unless rural P.O. Box)	Apt No.	Marital Status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Spouse/DP Social Security or ID No.

City	State	ZIP Code	# of Dependents including Spouse/DP	Home Phone No.
				( )

Employer Name	Occupation/Job Title	Business Phone No.
JAG Professional Services, Inc.		( )

Hire Date	☐ Part time ☐ Full time	Salary (Required) $	☐ Hourly ☐ Weekly ☐ Monthly	# of Hours Worked per Week

Life Insurance Beneficiary - *Last Name*	*First*	*M.I.*	Relationship

Spouse/DP Social Security or ID No.	Social Security or ID No.

3. Please tell us about yourself and your eligible enrolling dependents:

Eligible dependent is an employee's lawful spouse or domestic partner; a child of an employee who is the permanent legal guardian of that child and for whom a valid court order establishing guardianship has been submitted; the unmarried child(ren) of the employee or, of the employee's spouse/domestic partner who are (i) under age 19, or, (ii) age [19 to age 24] who qualify as dependents for federal income tax purposes and are full time students; or (iii) over age 19 who qualify as dependents for federal income tax purposes and incapable of self-sustaining employment due to a physically or mentally disabling injury, illness or condition. Annually, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may require written proof of student status or proof of child's continuing disability due to physical or mental illness or injury. Written proof of relationship may be required for certain enrollments. For example, an existing subscriber who is adding a dependent spouse or domestic partner must provide copy of a Marriage Certificate, Declaration of Domestic Partnership or equivalent document. For enrollment of an adopted child, legal evidence of adoption (or intent to adopt) is required.

If spouse's last name is different than yours, is he/she a domestic partner? ☐ Yes ☐ No

FAMILY ADDITION: Date of marriage or domestic partnership declaration: ____ Date of adoption: ____

Sex	Last Name	First Name	MI	Birthdate Mo. Day Year	Disabled	HMO PLANS ONLY: Primary Care Physician No. or 3-digit Medical Group/IPA No.	HMO PLANS ONLY: Current Patient
☐ Male ☐ Female	Employee				☐ Yes ☐ No		☐ Yes ☐ No
☐ Male ☐ Female	Spouse/DP				☐ Yes ☐ No		☐ Yes ☐ No
☐ Son ☐ Daughter					☐ Yes ☐ No		☐ Yes ☐ No
☐ Son ☐ Daughter					☐ Yes ☐ No		☐ Yes ☐ No
☐ Son ☐ Daughter					☐ Yes ☐ No		☐ Yes ☐ No
☐ Son ☐ Daughter					☐ Yes ☐ No		☐ Yes ☐ No

Note: Any enrolling dependent(s) who do not live at the address listed in Section 2 on previous page, please provide their address(es) on a separate piece of paper.

4. Please complete if you want to decline coverage for yourself and/or any eligible dependents:

Type of Coverage:	Declined for:	Reason for declining: *(proof of coverage may be required)*
Medical coverage	☐ Self ☐ Child(ren) ☐ Spouse/DP	☐ Covered by spouse/domestic partner's employer sponsored group plan; Carrier name:_____ ID#_____ ☐ Covered by Individual Policy; Carrier name:_____ ID#_____ ☐ Covered by Tricare ☐ Covered by Medicare o Covered by MediCal ☐ Covered by any other insurance Carrier name:_____ ID#_____ ☐ Other: _____
Dental coverage (if offered)	☐ Self ☐ Child(ren) ☐ Spouse/DP	
Life coverage (if offered)	☐ Self ☐ Child(ren) ☐ Spouse/DP	

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 has tried to influence me or put any pressure on me to decline coverage. BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP'S MEDICAL AND/OR GROUP LIFE INSURANCE PLAN, as well as a six-month pre-existing condition exclusion UNLESS ENTITLED TO A SPECIAL ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT. The twelve (12) month wait will not apply if: (1) I certify at the time of initial enrollment that the coverage under another employer health benefit plan, a state child health insurance program, or a state Medicaid plan was the reason for declining enrollment and I lose coverage under that employer health benefit plan, a state child health insurance program, or a state Medicaid plan; (2) my employer offers multiple health benefit plans and I elected a different plan during an open enrollment period; (3) a court orders that I provide coverage under this plan for a spouse or minor child or (4) if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, they may be able to be enrolled if enrollment is requested within 31 days after the marriage, birth, adoption or placement for adoption.

If I declined enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other health insurance or group health plan coverage except coverage under a state child health insurance program, or a state Medicaid plan, I must request enrollment within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

If I declined enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of coverage under a state child health insurance program, or a state Medicaid plan, I must request enrollment for this group coverage within 60 days: (a) after the date my coverage under any of these plans ends; or (b) after the date I become eligible for state premium assistance for group coverage.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

X_____ _____

Signature if declining coverage for self/dependents *Date (Month/Day/Year)*

After completion, please remove tape and fold closed to seal.

Social Security or ID No. | | | | | | | | |

5A. Health Questionnaire for Groups Enrolling 11-50 Employees - this confidential information will not be seen or given to your employer

Groups with 1-10 Enrolling Employees: **Do not complete this section; you are only required to complete the previous section.**

Has any person listed on this application:

1. Ever had, consulted for, had treatment rendered, been advised to have treatment, or received treatment or been hospitalized for any of the following conditions:

   Cardiovascular disease or heart attack; stroke; disorder of the kidney, stomach, intestines or liver; musculoskeletal conditions; mental or nervous condition; central nervous system disorders; diabetes; any disorder of the lungs or respiratory system; cancer or immune deficiency disorder, AIDS, or AIDS-related complex, not including the results of HIV testing? .... ☐ Yes ☐ No

2. During the last 24 months, had surgery or been confined in any hospital, sanitarium, convalescent facility or specialized care facility or had medical expenses more than $5,000? .... ☐ Yes ☐ No

3. Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner? .... ☐ Yes ☐ No

4. a. Is any female to be covered currently pregnant? .... ☐ Yes ☐ No
   If yes, Due Date: _____ /_____ /_____

   b. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application? .... ☐ Yes ☐ No

5. Does anyone listed on this application use tobacco products? .... ☐ Yes ☐ No

***If you answer "Yes" to all or part of the above questions 1-4b, please complete the following** (Insert additional sheets if necessary):*

Question # ___ Name of patient ______________________

Condition treated ______________________

Dates of treatment: Start ____________ End ____________

check here if still under treatment ☐

Treatment rendered ______________________

Medication and dosage taken ______________________

Dates taken: Start ____________ End ____________

check here if still taking ☐

Question # ___ Name of patient ______________________

Condition treated ______________________

Dates of treatment: Start ____________ End ____________

check here if still under treatment ☐

Treatment rendered ______________________

Medication and dosage taken ______________________

Dates taken: Start ____________ End ____________

check here if still taking ☐

Question # ___ Name of patient ______________________

Condition treated ______________________

Dates of treatment: Start ____________ End ____________

check here if still under treatment ☐

Treatment rendered ______________________

Medication and dosage taken ______________________

Dates taken: Start ____________ End ____________

check here if still taking ☐

Question # ___ Name of patient ______________________

Condition treated ______________________

Dates of treatment: Start ____________ End ____________

check here if still under treatment ☐

Treatment rendered ______________________

Medication and dosage taken ______________________

Dates taken: Start ____________ End ____________

check here if still taking ☐

Social Security or ID No.

6. Other Coverage – please be sure to complete this important information:

1. Do any persons on this application intend to continue other Group coverage if this application is accepted? ☐ Yes ☐ No

   If yes:
   Name of person: _____

   Insurance Company: _____

2. Has any person applying for coverage had health insurance coverage at any time in the past six months? ☐ Yes ☐ No

   If yes:
   Applicant/family member name(s): _____

   Type of coverage: ☐ Group ☐ Individual ☐ Other: _____

   Insurance Company: _____

   Date coverage began: _____ Date ended: _____

3. Does any person applying for coverage currently have dental insurance coverage? ☐ Yes ☐ No

   If yes:
   Applicant/family member name(s): _____

   Type of coverage: ☐ Group ☐ Individual ☐ Other: _____

   Insurance Company: _____

   Date coverage began: _____ Date ended: _____

4. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits? ☐ Yes ☐ No

   NOTE: If you are eligible for Medicare, Anthem Blue Cross may not duplicate Medicare benefits.

SUBMIT PROOF OF COVERAGE.
To comply with federal and state laws, proof of this coverage must accompany this application.

Acceptable forms of proof are:

1. Certificate of coverage from prior carrier, ***or***
2. Copy of ID card ***and*** copy of payroll stub showing medical coverage deduction, ***or***
3. Copy of most recent medical premium bill

Please note: If you or a family member have/had a medical condition before coming to our plan for which medical advice, diagnosis, care or treatment was recommended or received within the last six months and you do not advise and provide proof of prior coverage, you may be subject to a six-month preexisting condition exclusion (does not apply to HMOs). That means that you might have to wait at least six months before the plan will provide coverage for that condition (does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days after birth, adoption or placement for adoption). In some cases, the exclusion may last up to 12 months, or as long as 18 months for late enrollees. However, the length of the waiting period can be reduced by the number of days of prior "creditable coverage," which means not experiencing a break in qualified prior health coverage that lasted more than 63 days for an Individual plan or 180 days for an employer-sponsored or employer-related plan. Proof of creditable coverage is required to reduce a waiting period, including a copy of the certificate or other documentation, which we can help you obtain from a prior plan/issuer if needed. You have the right to obtain proof of creditable coverage from your prior plan/issuer. Please contact our [Small Group Enrollment & Billing Services] at [1-800-627-8797] if you have any questions regarding preexisting conditions.

Social Security or ID No.

7. Agreements and Understandings - The following Agreement is to be signed by the EMPLOYEE applying for coverage.

I AGREE: To the best of my knowledge and belief, all information on this form is correct and true. I understand that this application and any information Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company obtains prior to the effective date of coverage is the basis on which coverage may be issued under the plan. I authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at my employer's place of business in permanent employment.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and any application made by my employer have been accepted and approved by ANTHEM BLUE CROSS and/or ANTHEM BLUE CROSS LIFE and HEALTH INSURANCE COMPANY.

I AM APPLYING FOR PPO COVERAGE: I understand that I am responsible for a greater portion of my medical costs when I use a nonparticipating provider. If a PPO Plan is selected and a nonparticipating provider is used, medical payments will be based upon the lesser percentage of the negotiated fee rate and I will be responsible for any amount over that payment.

I AM APPLYING FOR HMO COVERAGE: I understand that I am responsible for paying for services rendered that are not authorized by my primary medical group.

I AM APPLYING FOR A HEALTHCARE SAVINGS ACCOUNT (HSA) COMPATIBLE EPO PLAN: I understand that the High Deductible EPO Plan is designed for Exclusive Provider Organization (EPO) usage, and that using nonparticipating providers could result in significantly higher out-of-pocket costs. I understand that having this coverage does not establish an HSA. To do so, I must contact a qualified financial institution. Also, I understand that I should consult my tax advisor.

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.

CANCELLATION OR MODIFICATION OF COVERAGE. PLEASE READ CAREFULLY.

I attest by signing below that I have reviewed the information provided on this application and accept its provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief and I understand they will be relied upon by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company in accepting this application. I understand that misstatements or failures to report new medical information prior to the effective date may result in a material change or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being cancelled. I understand that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may cancel any coverage under this application due to any of the following: (a) any material misrepresentation discovered on an application or health statement; and/or (b) an act of fraud that has been committed.

Please Read Carefully - SIGNATURE REQUIRED

REQUIREMENT FOR BINDING ARBITRATION

I understand that if my coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from Employee Retirement Income Security Act of 1974 (ERISA) or if I have a dispute that is not governed by ERISA that I will be subject to the following binding arbitration provision.

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. *It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

Signature of Employee (*Required*)	Date (*MM/DD/YY*)
X	

Small Group Services
Anthem Blue Cross
[P.O. Box 9062
Oxnard, CA 93031-9062]
anthem.com/ca

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After completion, remove tape on inside pages, fold closed to seal, and submit application to your employer.

After completion, remove tape on inside pages, fold closed to seal, and submit application to your employer.
Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.