

Employee Enrollment Application For 1-100 Employee Small Groups California



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.

Group/Case no. (if known)

Please complete in black ink only.

Section A: 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 <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		Primary phone no.		Number of dependents
Employee email address					
Employer name					
Employer street address					
City					State ZIP code
Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Disabled		Occupation			
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		
Language choice (optional): <input type="checkbox"/> English (ENG) <input type="checkbox"/> Spanish (SPA) <input type="checkbox"/> Chinese (ZHOX) (C/M) <input type="checkbox"/> Korean (KOR) <input type="checkbox"/> Vietnamese (VIE) <input type="checkbox"/> Tagalog (TGL) <input type="checkbox"/> Other (W09) – please specify: _____					
Do you read and write English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, the translator must sign and submit a Statement of Accountability/Translator's Statement.					
Section B: Application Type					
Select one: <input type="checkbox"/> New enrollment <input type="checkbox"/> Open enrollment/Qualifying event <input type="checkbox"/> COBRA/Cal-COBRA <input type="checkbox"/> Rehire date (For Life and Disability only) _____					
If you select Open enrollment/Qualifying event or COBRA/Cal-COBRA , please select one event reason. <input type="checkbox"/> Open enrollment (not applicable for life and disability) <input type="checkbox"/> Marriage <input type="checkbox"/> Birth of child <input type="checkbox"/> Adoption of child <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Death <input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA – Cal-COBRA applicants must submit first month's premium. <input type="checkbox"/> Involuntary loss of coverage – please explain (required): _____ <input type="checkbox"/> Other – please explain (required): _____					
COBRA/Cal-COBRA/Open enrollment/Qualifying event date – Required: _____ (MM/DD/YYYY)					

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

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. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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	<input type="checkbox"/> 20/10%/3000 <input type="checkbox"/> 200/10%/3000	<input type="checkbox"/> 20/30%/6500 <input type="checkbox"/> 500/20%/6500 <input type="checkbox"/> 750/20%/6500 <input type="checkbox"/> 1000/20%/6000 <input type="checkbox"/> 2000/20%/4000	<input type="checkbox"/> 1250/40%/7350 <input type="checkbox"/> 1750/35%/7350 <input type="checkbox"/> 2000/20%/6000 w/HSA – RxC <input type="checkbox"/> 2000/40%/7350	<input type="checkbox"/> 4500/35%/6550 w/HSA <input type="checkbox"/> 5000/30%/7350 <input type="checkbox"/> 5000/35%/6500 w/HSA <input type="checkbox"/> 6000/35%/7350 <input type="checkbox"/> 6500/0%/6500 w/HSA
PPO: Select PPO Network	<input type="checkbox"/> 15/10%/3350 <input type="checkbox"/> 20/10%/3000 <input type="checkbox"/> 200/10%/3000	<input type="checkbox"/> 20/30%/6500 <input type="checkbox"/> 25/20%/6000 <input type="checkbox"/> 500/20%/6500 <input type="checkbox"/> 750/20%/6500 <input type="checkbox"/> 1000/20%/6000 <input type="checkbox"/> 2000/20%/4000	<input type="checkbox"/> 1250/40%/7350 <input type="checkbox"/> 1750/35%/7350 <input type="checkbox"/> 2000/20%/6000 w/HSA – RxC <input type="checkbox"/> 2000/20%/7000 <input type="checkbox"/> 2000/40%/7350	<input type="checkbox"/> 4500/35%/6550 w/HSA <input type="checkbox"/> 4800/40%/6550 w/HSA <input type="checkbox"/> 5000/30%/7350 <input type="checkbox"/> 5000/35%/6550 w/HSA <input type="checkbox"/> 6000/35%/7350 <input type="checkbox"/> 6500/0%/6500 w/HSA
HMO: CaliforniaCare HMO Network	<input type="checkbox"/> 10/10%/2000	<input type="checkbox"/> 25/20%/5500 <input type="checkbox"/> 40/20%/4500 <input type="checkbox"/> 500/20%/5000 <input type="checkbox"/> 1000/30%/4000	<input type="checkbox"/> 1500/35%/7150 <input type="checkbox"/> 2000/40%/7350	
HMO: Select HMO Network	<input type="checkbox"/> 10/10%/2000	<input type="checkbox"/> 25/20%/5500 <input type="checkbox"/> 40/20%/4500 <input type="checkbox"/> 500/20%/5000 <input type="checkbox"/> 1000/30%/4000	<input type="checkbox"/> 1500/35%/7150 <input type="checkbox"/> 2000/40%/7350	

☐ Other: _____**Please indicate the contract code for the medical plan selected.**

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.****Anthem Dental Net DHMO², Anthem Dental Prime and Complete³ with product families including Value, Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.****Member dental coverage – select one:**☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

If you are waiving coverage for yourself and/or your eligible dependents, please complete section F.

Please indicate the name and contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.

Plan name: _____ 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

If you are waiving coverage for yourself and/or your eligible dependents, please complete section F.

Please indicate the name and contract code for the vision plan selected. Your employer will advise you of your plan options and contract codes.

Plan name: _____ Contract code: _____

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2 Offered by Anthem Blue Cross.

3 Offered by Anthem Blue Cross Life and Health Insurance Company.

**4. Life and Disability Coverage – A minimum of two employees must enroll.
Offered by Anthem Blue Cross Life and Health Insurance Company.**

- | | |
|---|--|
| <input type="checkbox"/> Basic Life and AD&D
<input type="checkbox"/> Basic Dependent Life
<input type="checkbox"/> Optional Supplemental/Voluntary Life and AD&D \$ _____ (Employee amount)
<input type="checkbox"/> Optional Supplemental/Voluntary Dependent Life Spouse \$ _____ (Spouse amount)
<input type="checkbox"/> Optional Supplemental/Voluntary Dependent Life Child \$ _____ (Child amount) | <input type="checkbox"/> Short Term Disability
<input type="checkbox"/> Long Term Disability
<input type="checkbox"/> Voluntary Short Term Disability
<input type="checkbox"/> Voluntary Long Term Disability |
|---|--|

Current annual income	Occupation	Life and Disability class no.
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Primary Beneficiary – Attach a separate sheet if necessary

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

Total percentages must add up 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.

Spousal Consent for Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse's consent for designation.)

If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under 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)
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Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

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Section D: Coverage Information — All fields required. Attach a separate sheet if necessary.Please access *Find a Doctor* at anthem.com 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, 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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)		Relationship to applicant Self	
Primary Care Physician name (PCP) (if selecting an HMO plan)				PCP ID no. (HMO only)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No

Spouse/Domestic Partner last name		First name		M.I.		Social Security no. ¹ (required)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)		Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			
PCP name (if selecting an HMO plan)				PCP ID no. (HMO only)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, full address and ZIP code: _____							

Dependent last name		First name		M.I.		Social Security no. ¹ (required)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)		Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____			
PCP name (if selecting an HMO plan)				PCP ID no. (HMO only)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, full address and ZIP code: _____							

Dependent last name		First name		M.I.		Social Security no. ¹ (required)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)		Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____			
PCP name (if selecting an HMO plan)				PCP ID no. (HMO only)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, full address and ZIP code: _____							

Dependent last name		First name		M.I.		Social Security no. ¹ (required)	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY)		Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____			
PCP name (if selecting an HMO plan)				PCP ID no. (HMO only)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If yes, full address and ZIP code: _____							

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Section E: Prior and Other Coverage1. Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If yes, give name: _____

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD: Onset date: _____
Medicare Part D ID no.	Medicare Part D carrier		Part D effective date

2. Does anyone on this application intend to continue other coverage if this application is accepted? ☐ Yes ☐ No3. Is anyone applying for coverage covered by other health, dental, or vision coverage? ☐ Yes ☐ No4. 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 (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision				Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision				Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision				Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision				Start: _____ End: _____

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Section F: Waiver/Declining Coverage – Proof of coverage will be required. (Proof of coverage not applicable to Life or Disability.)**Medical coverage declined for – check all that apply:**☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)**Dental coverage declined for – check all that apply:**☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)**Vision coverage declined for – check all that apply:**☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)***Life/AD&D coverage declined for**☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)**Dependent Life coverage declined for:**☐ Spouse/Domestic Partner and Dependents**Short Term Disability coverage declined for:**☐ Myself**Long Term Disability coverage declined for:**☐ Myself**Optional Supplemental/Voluntary coverage declined for:**☐ Myself**Optional Supplemental/Voluntary Dependent Life coverage declined for:**☐ Spouse/Domestic Partner and Dependents**Voluntary Short Term Disability coverage declined for:**☐ Myself**Voluntary Long Term Disability coverage declined for:**☐ Myself**Reason for declining coverage – check all that apply:**☐ Covered by spouse's/domestic partner's group coverage☐ Enrolled in other insurance –Please provide company name and plan:☐ Enrolled in individual coverage☐ Spouse/Domestic Partner covered by employer's group medical coverage☐ Medicare/Medicaid/VA☐ Other – please explain:☐ No coverage

List names 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 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, DISABILITY OR LIFE PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT.

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.

*I hereby certify that I have been given the opportunity to apply for the available group life and/or disability benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense. Please examine your options carefully before waiving this coverage.

Sign here only if you are declining coverage for yourself or dependents.

Signature of applicant

Printed name

Date (MM/DD/YYYY)

X

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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. 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 signing below, I (primary applicant) agree to receive my plan-related communications 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.

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.

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

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 customer service telephone number on the back of your ID card.

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)

Arabic

مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما لمساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم 1-888-254-2721 (TTY/TDD: 711).

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 مكتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

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 បើអ្នកអាចឱ្យមនុស្សណាម្នាក់អានជូនអ្នក។ អ្នកក៏អាចទទួលលិខិតនេះដោយសេរីដោយសារបង្គាប់អ្នកផងដែរ។ ដើម្បីទទួលបានជំនួយឥតគិតថ្លៃ 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 ਵੱਖੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ 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)

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)

Get help in your language

Notice of Language Assistance



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

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. (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 customer service telephone number on the back of your ID card.

Spanish

Servicios lingüísticos sin costo. Puede tener un intérprete. Puede solicitar que le lean los documentos y algunos puede recibirlos en su idioma. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener ayuda adicional, llame al Departamento de Seguros de California al 1-800-927-4357. (TTY/TDD: 711)

Arabic

يتم تقديم خدمات اللغة دون مقابل. يمكنك الاستعانة بمترجم. ويمكنك المطالبة بأن تُقرأ لك بعض المستندات وأن يُرسل بعضها بلغتك. للحصول على المساعدة، اتصل بنا على الرقم الموجود على بطاقة التعريف الخاصة بك أو على الرقم 1-888-254-2721. للحصول على مزيد من المساعدة، يُرجى الاتصال بإدارة كاليفورنيا للتأمين على الرقم 1-800-927-4357. (TTY/TDD: 711)

Armenian

Թարգմանչական անվճար ծառայություններ: Մենք կարող ենք Ձեզ թարգմանչի ծառայություններ առաջարկել Կարող ենք տրամադրել ինչ-որ մեկին, ով փաստաթղթերը կկարդա Ձեզ համար և կուղարկի դրանք Ձեր լեզվով: Օգնություն ստանալու համար զանգահարեք մեզ Ձեզ ID քարտի վրա նշված հեռախոսահամարով կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար զանգահարեք Կալիֆոռնիայի ապահովագրության նախարարություն հետևյալ հեռախոսահամարով՝ 1-800-927-4357: (TTY/TDD: 711)

Chinese

免費語言服務。您能獲得免費的譯員。您能聽到以您的語言讀出的文件內容，也能獲得以您的語言而寫的部分文件。如需協助，請撥打您的 ID 卡上的號碼或者 1-888-254-2721 聯絡我們。如需更多協助，請撥打 1-800-927-4357 聯絡 CA Dept. of Insurance。 (TTY/TDD: 711)

Farsi

خدمات رایگان زبانی. می‌توانید یک مترجم شفاهی بگیرید. می‌توانید بخوانید اسناد را برای شما بخوانند و برخی اسناد نیز به زبان خودتان برایتان ارسال شود. برای دریافت کمک، از طریق شماره فهرست شده در کارت شناسایی‌تان و یا از طریق 1-888-254-2721 با ما تماس بگیرید. برای دریافت کمکهای بیشتر با اداره بیمه کالیفرنیا به شماره 1-800-927-4357 تماس بگیرید. (TTY/TDD: 711)

Hindi

बिना लागत की भाषा सेवाएँ। आप दुभाषिया प्राप्त कर सकते हैं। आप दस्तावेज़ पढ़वा सकते हैं और कुछ दस्तावेज़ आपकी भाषा में भेजे जा सकते हैं। मदद के लिए, हमें अपने ID कार्ड पर सूचीबद्ध नंबर पर या 1-888-254-2721 पर कॉल करें। अधिक मदद के लिए 1-800-927-4357 पर CA बीमा विभाग कोकॉल करें। (TTY/TDD: 711)

Hmong

Tsis Xam Tus Nqi Cov Kev Pab Cuam Ntsig Txog Hom Lus. Koj muaj peev xwm tau txais ib tus neeg txhais lus. Koj muaj peev xwm tau txais cov ntaub ntawv nyeem ua koj hom lus rau koj mloog thiab yuav xa ib co ntaub ntawv sau ua koj hom lus tuaj rau koj. Txog rau kev pab, hu rau peb tus nab npawb xov tooj teev tseg cia nyob rau ntawm koj daim ID los sis 1-888-254-2721. Txog rau kev pab ntxiv, hu xov tooj rau Pab Kas Phais Lub Chaw Ua Hauj Lwm CA tus xov tooj 1-800-927-4357. (TTY/TDD: 711)

Japanese

無料言語サービス。通訳サービスを受けられます。希望する言語で文書を読み上げたり、文書を送るサービスも可能です。支援を受けるには、IDカードに記載された番号、または 1-888-254-2721 にお電話ください。支援の詳細は、カリフォルニア州保険局 (1-800-927-4357) にお電話ください。 (TTY/TDD: 711)

Khmer

សេវាភាសាភក្តិឥតថ្លៃ។ អ្នកអាចទទួលបានសេវាបកប្រែប្រែប្រាស់។ អ្នកអាចឱ្យគេអានឯកសារឡើងវិញឬអាន និងផ្ញើឯកសារឡើងវិញជាភាសាបកប្រែ។ ដើម្បីទទួលបានជំនួយ សូមហៅ ទូរស័ព្ទមកយើងតាមលេខដែលបានរាយនៅលើកាត ID របស់អ្នក ឬក៏លេខ 1-888-254-2721 ។ ដើម្បីទទួលបានជំនួយបន្ថែម សូមហៅទូរស័ព្ទទៅ CA Dept. of Insurance តាមលេខ 1-800-927-4357។ (TTY/TDD: 711)

Korean

무료 언어 서비스. 번역사를 이용하실 수 있습니다. 귀하의 언어로 녹음되어 작성된 문서를 받아보실 수 있습니다. 도움을 받으시려면 ID 카드에 기재된 번호 또는 1-888-254-2721로 전화하십시오. 다른 도움이 필요하시면 1-800-927-4357로 보험 CA 부서에 문의 주십시오. (TTY/TDD: 711)

Punjabi

ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਆ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਕੋਈ ਤੁਹਾਨੂੰ ਦਸਤਾਵੇਜ਼ ਪੜ੍ਹ ਕੇ ਸੁਣਾ ਸਕਦਾ ਹੈ ਅਤੇ ਕੁਝ ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਵਿੱਚ ਤੁਹਾਨੂੰ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਸਾਨੂੰ ਤੁਹਾਡੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਸੂਚੀਬੱਧ ਨੰਬਰ ਜਾਂ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। ਜ਼ਿਆਦਾ ਮਦਦ ਲਈ, ਸੀਏ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian

Бесплатные языковые услуги. Вы можете получить услуги устного переводчика. Вам могут прочитать документы или направить некоторые из них на вашем языке. Для получения помощи звоните нам по телефону, указанному на вашей идентификационной карте, или по номеру 1-888-254-2721. Для получения дополнительной помощи звоните в Департамент страхования штата Калифорния по номеру 1-800-927-4357. (TTY/TDD: 711)

Tagalog

Mga Libreng Serbisyo para sa Wika. Maaari kayong kumuha ng interpreter. Maaari ninyong ipabasa ang mga dokumento at ipadala ang ilan sa mga ito sa inyo sa wikang ginagamit ninyo. Para sa tulong, tawagan kami sa numerong nakalista sa inyong ID card o sa 1-888-254-2721. Para sa higit pang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. (TTY/TDD: 711)

Thai

ไม่มีค่าบริการเกี่ยวกับภาษา ท่านสามารถขอใช้บริการสามได้
ท่านสามารถขอให้เจ้าหน้าที่อ่านเอกสารได้ท่านฟังและเอกสารบางอย่างจะส่งถึงท่านโดยใช้ภาษาของท่าน
หากต้องการความช่วยเหลือ โปรดโทรหาเราตามหมายเลขที่ระบุอยู่บนบัตรประจำตัวของท่านหรือที่หมายเลข 1-888-254-2721
หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรติดตามแผนก CA Dept. of Insurance ที่หมายเลข 1-800-927-4357
(TTY/TDD: 711)

Vietnamese

Các Dịch Vụ Ngôn Ngữ Miễn Phí. Quý vị có thể có thông dịch viên. Quý vị có thể yêu cầu đọc tài liệu cho quý vị nghe và yêu cầu gửi một số tài liệu bằng ngôn ngữ của quý vị cho quý vị. Để được trợ giúp, hãy gọi cho số được ghi trên thẻ ID của quý vị hoặc số 1-888-254-2721. Để được giúp đỡ thêm, hãy gọi cho Sở Bảo Hiểm California (California Department of Insurance) theo số 1-800-927-4357. (TTY/TDD: 711)