

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



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: Application Type — select one			
<input type="checkbox"/> New enrollment		<input type="checkbox"/> Open enrollment (not applicable for Life and/or Disability)	
<input type="checkbox"/> COBRA/Cal-COBRA		<input type="checkbox"/> Qualifying event (not applicable for Life and Disability)	
<input type="checkbox"/> Rehire date: (MM/DD/YYYY) ____/____/____			
If you select Qualifying event or COBRA/Cal-COBRA , please select one event reason.			
<input type="checkbox"/> Marriage		<input type="checkbox"/> Birth of child	
<input type="checkbox"/> COBRA		<input type="checkbox"/> Adoption of child	
<input type="checkbox"/> Involuntary loss of coverage — please explain (required): _____		<input type="checkbox"/> Divorce or legal separation	
<input type="checkbox"/> Other — please explain (required): _____		<input type="checkbox"/> Death	
<input type="checkbox"/> Cal-COBRA — Cal-COBRA applicants must submit first month's premium.			
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	
		<input type="checkbox"/> Single <input type="checkbox"/> Married	
		<input type="checkbox"/> Domestic Partner (DP)	
		Employment status	
		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
		Primary phone no.	
Employer name		Occupation	
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	
Language choice (optional): <input type="checkbox"/> English (ENG) <input type="checkbox"/> Spanish (SPA) <input type="checkbox"/> Chinese (ZHO) <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.			
Employee email address:			
For Medical and all Dental Net DHMO 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.			
For Dental PPO, Vision, Life and Disability plans offered by Anthem Blue Cross Life and Health Insurance Company and regulated by the California Department of Insurance. Anthem will deliver plan materials and related items by mail.			
<input type="checkbox"/> 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 _____	
<input type="checkbox"/> 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.

Section C: Type of Coverage — Your employer will advise you of your plan options and contract codes.**1. Medical Coverage****Please Note: All health plans² include the required coverage for the dental and vision pediatric essential health benefits.**Medical plan name³: _____ Contract code, if known: _____**Member medical coverage — select one:** Employee only Employee + Spouse/Domestic Partner Employee + Child(ren) Family**2. Dental Coverage****Anthem Dental HMO² and Dental PPO⁴ plans do not include certified pediatric dental essential health benefits.****Member dental coverage — select one:** Employee only Employee + Spouse/Domestic Partner Employee + Child(ren) Family

Dental plan name: _____ Contract code, if known: _____

3. Vision Coverage**These optional vision plans⁴ 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

Vision plan name: _____ Contract code, if known: _____

4. Life⁴, Accidental Death & Dismemberment⁴ (AD&D), and Disability⁴ Coverage - These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder. Your employer will advise you of your plan options. These coverages may be subject to medical evidence underwriting and would only become effective upon approval. If you select life and/or disability coverage over the guaranteed issue amount or are a late entrant an Evidence of Insurability form may be sent to you to complete.

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

Current annual income: \$ _____ Life and/Disability class no.: _____

If an applicant's age at the time of application is 15, the applicant must submit a written statement, signed by the parent, consenting to the minor's application for coverage.

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

Beneficiary Designation — Attach a separate sheet if necessary.

Beneficiary type	Name of beneficiary	Percentage	Social Security no.	Relationship to applicant	Date of Birth
<input type="checkbox"/> Primary	Street Address	City	State	Zip Code	Phone No.
<input type="checkbox"/> Contingent					
Beneficiary type	Name of beneficiary	Percentage	Social Security no.	Relationship to applicant	Date of Birth
<input type="checkbox"/> Primary	Street Address	City	State	Zip Code	Phone No.
<input type="checkbox"/> Contingent					

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

If you live in AZ, CA, ID, LA, NM, NV, TX, WA, WI and your spouse is not 50% or more beneficiary, your spouse needs to sign below. In CA, NV, and WA, Spouse also includes your registered Domestic Partner. Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse 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.**Spouse Authorization, if applicable**

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.

Sign here to waive community property rights	Spouse signature X	Spouse name (print)	Today's date (MM/DD/YYYY) / /
---	------------------------------	----------------------------	---

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.

4 Dental PPO, Vision, and Life and Disability plans are offered by Anthem Blue Cross Life and Health Insurance Company and regulated by the California Department of Insurance.

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 relationship² (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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate (MM/DD/YYYY) / /	
Primary Care Physician (PCP) name (if selecting an HMO ³ plan)	PCP ID no. (HMO only)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Care Dentist (PCD) name (If selecting Dental net DHMO plan)	PCD ID no.	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	Birthdate (MM/DD/YYYY) / /	Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner	
PCP name (if selecting an HMO ³ plan)	PCP ID no. (HMO only)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
PCD name (If selecting Dental net DHMO plan)	PCD ID no.	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 Child Last name	First name	M.I.	Social Security no. ¹ (required) / /
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate (MM/DD/YYYY) / /	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other ⁴ If other, what is relationship? _____	
PCP name (if selecting an HMO ³ plan)	PCP ID no. (HMO only)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
PCD name (If selecting Dental net DHMO plan)	PCD ID no.	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 Child Last name	First name	M.I.	Social Security no. ¹ (required) / /
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate (MM/DD/YYYY) / /	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other ⁴ If other, what is relationship? _____	
PCP name (if selecting an HMO ³ plan)	PCP ID no. (HMO only)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No	
PCD name (If selecting Dental net DHMO plan)	PCD ID no.	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: _____			

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? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Is anyone applying for coverage covered by other health, dental, or orthodontia coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
4. On the day your coverage begins, will you or a family member be covered by other dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> 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)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Orthodontia			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"/> Orthodontia			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"/> Orthodontia			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"/> 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.
<input type="checkbox"/> Employee	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability	<input type="checkbox"/> No coverage <input type="checkbox"/> Covered by Spouse's/Domestic Partner's group coverage <input type="checkbox"/> Spouse/Domestic Partner covered by their employer's group coverage. <input type="checkbox"/> Enrolled in individual coverage <input type="checkbox"/> Medicare/Medi-Cal/VA <input type="checkbox"/> Enrolled in other Insurance — Please provide company name and plan: _____ <input type="checkbox"/> Other — please explain _____
<input type="checkbox"/> Spouse/ Domestic Partner	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Dependent Life	
<input type="checkbox"/> Dependent(s)	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Dependent Life List name of dependents to be waived: _____	

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one, including but not limited to my employer, agent or life carrier, has tried to influence me or put any pressure on me to waive coverage. BY WAIVING THIS GROUP MEDICAL, DENTAL, VISION, DISABILITY OR LIFE COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, VISION, DISABILITY OR LIFE COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT TO BE ENROLLED IN THIS GROUP'S MEDICAL, DENTAL, 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 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.

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.

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 ليساعدك 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 ե՞ք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese

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

Farsi

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

Khmer

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

Korean

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

Punjabi

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਧੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਨ 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)

It's important we treat you fairly

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