Employee Application
EmployeeElect
For 2-50 Member Small Groups

anthem.com/ca

Health care plans offered by Anthem Blue Cross. 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: Social Security Numbers are required under Centers for Medicare & Medicaid (CMS) regulations.

Group no.

Purpose: ☐ New enrollment ☐ New hire ☐ Family addition ☐ Change of coverage ☐ Late enrollment ☐ COBRA ☐ Cal-COBRA ☐ Other: ________

SECTION 1: TYPE OF COVERAGE – Select from only the coverages offered by your employer

A. MEDICAL COVERAGE

Anthem Blue Cross plans

- ☐ Premier PPO $10 Copay
- ☐ Premier PPO $20 Copay
- ☐ Premier PPO $30 Copay
- ☐ PPO $20 Copay
- ☐ PPO $30 Copay
- ☐ PPO $40 Copay
- ☐ PPO 1000/$25
- ☐ PPO 1500/$35
- ☐ PPO 2000/$45
- ☐ PPO 1000/$25 (Select PPO Network)
- ☐ PPO 1500/$35 (Select PPO Network)
- ☐ PPO 2000/$45 (Select PPO Network)
- ☐ Deductible 3000 PPO
- ☐ Deductible 4000 PPO
- ☐ Deductible 3000 PPO (Select PPO Network)
- ☐ Deductible 4000 PPO (Select PPO Network)
- ☐ ACO 20[1]
- ☐ ACO 30[1]
- ☐ Lumenos HSA 1500 (80/50)[2]
- ☐ Lumenos HSA 2500 (80/50)[2]
- ☐ Lumenos HSA 3500 (80/50)[2]
- ☐ High Deductible EPO
- ☐ Other: ________
- ☐ HMO $10 100%[1]
- ☐ HMO $25 100%[1]
- ☐ Classic $20 HMO[1]
- ☐ Classic $30 HMO[1]
- ☐ Classic $40 HMO[1]
- ☐ Saver $20 HMO[1]
- ☐ Saver $30 HMO[1]
- ☐ Saver $40 HMO[1]

Anthem Blue Cross Life and Health Insurance Company plans

- ☐ PPO $25 Copay GenRx
- ☐ PPO $35 Copay GenRx
- ☐ PPO $45 Copay GenRx
- ☐ Solution 2500 PPO[5]
- ☐ Solution 3500 PPO[5]
- ☐ Solution 5000 PPO
- ☐ Elements Hospital Plus
- ☐ Elements Hospital Preferred
- ☐ Other: ________
- ☐ Lumenos HRA 3000D
- ☐ Lumenos HRA 3000C
- ☐ Lumenos HRA 5000D
- ☐ Lumenos HRA 5000C
- ☐ Lumenos HIA Plus 500[3]
- ☐ Lumenos HIA Plus 750[3]
- ☐ Elements Hospital[4]

1 For HMO or ACO, be sure to provide physician number in section 3
2 If directed by your employer, Anthem Blue Cross will facilitate the opening of a Health Savings Account in your name
3 Plan will not be available for new group sales or renewals beginning July 2012
4 Plan will not be available for new group sales or renewals beginning October 2012
5 Plan will not be available for new group sales or renewals beginning January 2013

B. DENTAL COVERAGE

Anthem Blue Cross Life and Health Insurance Company plans

- ☐ Dental Blue Silver 100-80
- ☐ Dental Blue Silver Plus 100-80
- ☐ Dental Blue Gold 100-80
- ☐ Dental Blue Gold Plus 100-80
- ☐ Dental Blue Platinum 100-80
- ☐ Dental Blue Platinum Plus 100-80
- ☐ High Option PPO
- ☐ Standard Option PPO
- ☐ Basic Option PPO
- ☐ Voluntary Dental PPO
- ☐ Other: ________

Anthem Blue Cross plans

Dental Net DHMO
- ☐ Dental Net 2000A*
- ☐ Dental Net 2000B*
- ☐ Dental Net 2000C*

Voluntary Dental Coverage

Dental Net Voluntary DHMO
- ☐ Dental Net Voluntary 2000A*
- ☐ Dental Net Voluntary 2000B*
- ☐ Dental Net Voluntary 2000C*

*For this plan, you must enter your Dental office no. → Dental office no.

C. VISION COVERAGE

☐ Blue View OR ☐ Blue View Plus ☐ Other: ________
Offered by Anthem Blue Cross Life and Health Insurance Company

Voluntary Vision Coverage
☐ Blue View OR ☐ Blue View Plus

D. LIFE COVERAGE

Optional Dependent Life Insurance (**only** if offered by your employer)
- ☐ $10,000/$1,000 ($10,000 spouse/child 6 months–26 yrs; $1,000 less than 6 months)
- ☐ $5,000/$500 ($5,000 spouse/child 6 months–26 yrs; $500 less than 6 months)

Supplemental Life Insurance (in **addition** to Term Life, if it is offered)
Amount: ☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ $100,000
Offered by Anthem Blue Cross Life and Health Insurance Company

SECTION 2: EMPLOYEE INFORMATION

Last name	First name	M.I.	Marital Status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Social Security no. (required)

Street address – P.O. box not acceptable unless rural P.O. box	City	State	ZIP code

Home phone no.	No. of dependents including spouse/DP	Email address

Employer name	Occupation/job title (required)	Employment status (required) ☐ Part time ☐ Full time

Hire date (required)	No. of hours worked per week (required)	Salary (required) $ ________ ☐ Hourly ☐ Weekly ☐ Monthly

Life insurance beneficiary last name	First name	M.I.	Social Security no.	Relationship

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.
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Social Security no. (required)

Language choice (optional): ☐ English ☐ Spanish ☐ Korean ☐ Chinese ☐ Vietnamese ☐ Tagalog ☐ Other: ____________

FOR CAL-COBRA/COBRA APPLICANTS

Cal-COBRA/COBRA effective date	Qualifying event: ☐ Termination of employment ☐ Divorce/legal separation ☐ Reduction of hours ☐ Medicare entitlement ☐ Child no longer eligible ☐ Death of employee	Qualifying event date

Cal-COBRA applicants must submit first month's premium.

SECTION 3: FAMILY INFORMATION

Eligible dependents include an employee's lawful spouse, or domestic partner, and the enrolled employee's, spouse's or domestic partner's natural child, stepchild, legally adopted child, or child for whom the employee, spouse or domestic partner has been appointed permanent legal guardian by a final court decree or order, up to the child's 26th birthday. Unmarried children age 26 and over may be covered, as specified by the plan certificate or evidence of coverage. Written proof of relationship may be required for certain enrollments. For example, an existing subscriber who is initially enrolling a dependent spouse or domestic partner must provide a 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

For family additions: Date of marriage or domestic partnership declaration: ____ Adoption date: ____

For HMO plans: provide 3- or 6-digit Primary Care Physician no. **For ACO plans**: provide 10-digit Provider no. →

	Last name / First / M.I.	Social Security no.	Height	Weight	Birthdate (MMDDYY)	Disabled	Enter a physician no. for each family member from the Provider Directory that can be found at anthem.com/ca	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: Please provide address(es) on a separate piece of paper, for any enrolling dependent(s) who do not live at the address listed in section 2 on the previous page.

SECTION 4: COVERAGE DECLINED OR REFUSED — Complete ONLY if any coverage is declined or refused by you and/or your eligible dependents

Type of coverage	Declined or refused for
Medical	☐ Self ☐ Spouse/DP ☐ Child(ren)
Dental (if offered)	☐ Self ☐ Spouse/DP ☐ Child(ren)
Vision (if offered)	☐ Self ☐ Spouse/DP ☐ Child(ren)
Life (if offered)	☐ Self ☐ Spouse/DP ☐ Child(ren)

Reason for declining or refusing coverage — Proof of coverage will be required

☐ Covered by other employer-sponsored group plan
Carrier name: ____________ ID no.: ____________
☐ Covered by an individual policy
Carrier name: ____________ ID no.: ____________
Covered by: ☐ Tricare ☐ Medicare ☐ MediCal
☐ Enrolled in any other insurance plan
Carrier name: ____________ ID no.: ____________
☐ List names of dependents to be waived: ____________
☐ Other: ____________

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 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 waiving 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 waived 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 waived 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 waiving 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.

Signature if **declining or refusing** coverage for yourself or dependents
X ____________ Date ____________

Social Security no. (required)

SECTION 5A: HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 1–10 EMPLOYEES – This confidential information will not be seen or given to your employer

If your group has 11–50 enrolling employees, **do not** complete this section; skip to section 5B.

All questions must be answered "Yes" or "No".

INCOMPLETE APPLICATIONS WILL BE RETURNED TO YOU FOR COMPLETION WHICH MAY DELAY THE EFFECTIVE DATE OF YOUR COVERAGE.

Has anyone listed on this application ever had, consulted for, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions?

1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins, or any other disorder of the heart, blood, blood vessels, hyperlipemia or arteriosclerosis? ☐ Yes ☐ No
2. Ulcer, colitis, gall stone, hernia or any other disorder of the stomach, intestines, rectum, gall bladder, or liver? ☐ Yes ☐ No
3. Cancer, cyst, or tumor? ☐ Yes ☐ No
4. Disorder of the kidneys, blood or albumin, thyroid glands, diabetes, venereal disease or any related eye disorders, urinary systems, male or female organs, or menstrual dysfunction? ☐ Yes ☐ No
5. Tuberculosis, asthma, hay fever, adenoids, pleurisy or any other disorder of the lungs or respiratory system? ☐ Yes ☐ No
6. Epilepsy, fainting spells, mental or nervous condition, paralysis or any disorder of the brain or nervous system? ☐ Yes ☐ No
   If epileptic, date of last seizure: _____/_____/_____
7. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same? ☐ Yes ☐ No
8. Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles, or bones? ☐ Yes ☐ No
9. Any physical deformity or defect? Any serious bodily injury, fracture, concussion, burn, and/or congenital problems? ☐ Yes ☐ No
10. Has any person to be covered had or been told that they had an immune deficiency disorder, AIDS, or AIDS-related complex, not including the results of HIV testing? ☐ Yes ☐ No
11. Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner? ☐ Yes ☐ No
12. 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
13. Does anyone listed on this application use tobacco products? ☐ Yes ☐ No

If you answered "Yes" to all or part of above questions 1–12b, complete the following. Insert additional sheets if necessary.

Question no.	Patient name		Question no.	Patient name	
Condition treated			Condition treated		
Treatment start date	Treatment end date	☐ Check if still under treatment	Treatment start date	Treatment end date	☐ Check if still under treatment
Treatment rendered			Treatment rendered		
Medication name		Dosage taken	Medication name		Dosage taken
Medication start date	Medication end date	☐ Check if still taking	Medication start date	Medication end date	☐ Check if still taking
Question no.	Patient name		Question no.	Patient name	
Condition treated			Condition treated		
Treatment start date	Treatment end date	☐ Check if still under treatment	Treatment start date	Treatment end date	☐ Check if still under treatment
Treatment rendered			Treatment rendered		
Medication name		Dosage taken	Medication name		Dosage taken
Medication start date	Medication end date	☐ Check if still taking	Medication start date	Medication end date	☐ Check if still taking

Note: You are **not** required to share this information with your employer. You may, at your discretion, return this completed application in a sealed envelope. Please write your name on the outside of the envelope for easy identification.

Social Security no. (required)

SECTION 5B: HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 11–50 EMPLOYEES – This confidential information will not be seen or given to your employer

If your group has 1–10 enrolling employees, **do not** complete this section; you are required to complete only the previous section 5A.

All questions must be answered "Yes" or "No".

INCOMPLETE APPLICATIONS WILL BE RETURNED TO YOU FOR COMPLETION WHICH MAY DELAY THE EFFECTIVE DATE OF YOUR COVERAGE.

Has anyone 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 answered "Yes" to all or part of above questions 1–4b, complete the following. Insert additional sheets if necessary.

Question no.	Patient name		Question no.	Patient name	
Condition treated			Condition treated		
Treatment start date	Treatment end date	☐ Check if still under treatment	Treatment start date	Treatment end date	☐ Check if still under treatment
Treatment rendered			Treatment rendered		
Medication name		Dosage taken	Medication name		Dosage taken
Medication start date	Medication end date	☐ Check if still taking	Medication start date	Medication end date	☐ Check if still taking
Question no.	Patient name		Question no.	Patient name	
Condition treated			Condition treated		
Treatment start date	Treatment end date	☐ Check if still under treatment	Treatment start date	Treatment end date	☐ Check if still under treatment
Treatment rendered			Treatment rendered		
Medication name		Dosage taken	Medication name		Dosage taken
Medication start date	Medication end date	☐ Check if still taking	Medication start date	Medication end date	☐ Check if still taking

Note: You are **not** required to share this information with your employer. You may, at your discretion, return this completed application in a sealed envelope. Please write your name on the outside of the envelope for easy identification.

Social Security no. (required)

SECTION 6: OTHER COVERAGE

1. Does anyone on this application intend to continue other Group coverage if this application is accepted? ☐ Yes ☐ No

   If yes, complete the following.

Name(s)	Insurance company name

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

   If yes, complete the following.

Name(s)	Insurance company name	
Type of coverage: ☐ Group ☐ Individual ☐ Other: ____________	Coverage begin date	Coverage end date

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

   If yes, complete the following.

Name(s)	Insurance company name	
Type of coverage: ☐ Group ☐ Individual ☐ Other: ____________	Coverage begin date	Coverage end date

4. Is anyone 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.

   Medicare Primary rates for groups under 20 employees will require proof of Medicare Parts A and B. If proof of both Medicare Parts A and B are not provided, the Medicare Secondary rates will be applied.

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 or dental coverage deduction, or
3. Copy of most recent medical or dental premium bill

GENERAL NOTICE OF PRE-EXISTING CONDITION EXCLUSION

The pre-existing condition exclusion does not apply to HMOs; pregnancy; dependent children who are enrolled in the plan within 31 days after birth, adoption, or placement for adoption; or persons under 19 years old, nor to conditions related to gender identity disorder, to the extent services received for this condition are covered under this plan. 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 pre-existing condition exclusion. That means that you might have to wait at least six months before the plan will provide coverage for that condition. 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 800-627-8797 if you have any questions regarding pre-existing conditions.

Social Security no. (required)

SECTION 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 work/worked 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.

I AM APPLYING FOR ELEMENTS HOSPITAL: I understand that the benefits of this plan are limited, with some exceptions, to inpatient hospital expenses. If I am not admitted to the hospital for inpatient treatment, this plan may not cover all my medical expenses, even if my illness is serious.

I AM APPLYING FOR ELEMENTS HOSPITAL PLUS OR ELEMENTS HOSPITAL PREFERRED: I understand that this plan is not designed to be a comprehensive medical or major medical plan. The benefits provided by this plan are limited, and may not cover all my medical expenses. Under this plan, I may have to pay substantial amounts of my own money for medical expenses, even if my illness is serious.

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.

READ CAREFULLY — Signature required

REQUIREMENT FOR BINDING ARBITRATION

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 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 AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND MEDICAL MALPRACTICE CLAIMS.

By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

Employee signature (required)	Date
X	

Submit application to:
Small Group Services
Anthem Blue Cross
P.O. Box 9062
Oxnard, CA 93031-9062

Anthem Blue Cross Life and Health Insurance Company
Notice of Language Assistance

IMPORTANT: An interpreter can be provided for you to communicate with your doctor or health plan at no cost. To get an interpreter or ask about written information in your language, please call the phone number listed on the back of your ID card or contact your group administrator.

IMPORTANTE: Se le puede brindar sin costo los servicios de un intérprete para que pueda comunicarse con su médico o plan de salud. Para obtener un intérprete o para solicitar información en su idioma, llame al número que figura en el reverso de su tarjeta de identificación o póngase en contacto con el administrador de su grupo. (Spanish)

重要提示： 您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請撥打您識別證背面的電話號碼，或聯絡您的團體行政人員。(Chinese)

CHÚ Ý QUAN TRỌNG: Quý vị có thể được thông dịch viên giúp đỡ miễn phí khi quý vị cần tiếp xúc với bác sĩ hoặc nhân viên trong chương trình bảo hiểm sức khỏe của quý vị. Để được thông dịch viên giúp đỡ hoặc được cấp thông tin, văn bản chuyển ngữ sang ngôn ngữ của quý vị, xin quý vị vui lòng gọi số điện thoại ghi phía sau thẻ hội viên của quý vị hoặc liên lạc ban quản trị chương trình bảo hiểm. (Vietnamese)

MAHALAGA: Mai-alok ang tagapagsalin sa iyo nang libre upang makipag-usap ka sa iyong doktor o planong pangkalusugan. Upang kumuha ng tagapagsalin o magtanong tungkol sa nakasulat na impurmasyon sa iyong lengguahe,paki-tawagan ang numero ng telepono na nakalista sa likod ng iyong ID card o paki-usap ang tagapangasiwa ng iyong pangkat. (Tagalog)

중요: 의사 또는 건강보험사와의 의사소통을 위하여 통역사를 무료로 이용하실 수 있습니다. 통역이나 한국어로 번역된 정보를 원하시면 가입자님의 ID 카드 뒷면에 있는 전화번호로 연락하시거나 그룹 담당자에게 요청하시기 바랍니다. (Korean)

ԿԱՐԵՎՈՐ. Ձեր բժշկի կամ առողջապահական ծրագրի հետ հաղորդակցվելու համար՝ Ձեզ անվճար թարգմանիչ կարող է մատակարարվել: Թարգմանիչ ստանալու կամ Ձեր լեզվով գրավոր տեղեկությունների մասին հարցնելու համար՝ խնդրվում է զանգահարել Ձեր ինքնության քարտի ետ§ի մասում գրված հեռախոսի համարով կամ կապվեք Ձեր խմբային կառավարչի հետ: (Armenian)

ПОМНИТЕ: Для общения с вашим врачом или представителем плана медицинского страхования вам могут предоставить бесплатные услуги переводчика. Для того, чтобы получить услуги переводчика или попросить о предоставлении информации в письменном виде на вашем языке, пожалуйста, позвоните по номеру, который указан на оборотной стороне вашей идентификационной карты (ID card), или свяжитесь с администратором вашей медицинской группы. (Russian)

重要事項： 医師、および、ヘルスプラン担当者との意思疎通には、通訳者による通訳サービスを無料で受けることが出来ます。通訳者サービス、または、あなたが話す言語で書かれた文書による情報を要請するには、あなたのIDカードの裏側に記載された電話番号に電話をするか、または、あなたの属するグループのアドバイザーに連絡をとってください。(Japanese)

ਜ਼ਰੂਰੀ ਸੂਚਨਾ: ਤੁਹਾਡੇ ਡਾਕਟਰ ਨਾਲ ਜਾਂ ਹੈਲਥ ਪਲਾਨ ਬਾਰੇ ਗੱਲਬਾਤ ਕਰਨ ਲਈ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ (ਅਨੁਵਾਦਕ) ਦੀ ਸੇਵਾ ਮੁਫਤ ਦਿੱਤੀ ਜਾ ਸਕਦੀ ਹੈ। ਦੁਭਾਸ਼ੀਆ ਲੈਣ ਲਈ ਜਾਂ ਲਿਖਤ ਜਾਣਕਾਰੀ ਪੰਜਾਬੀ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਆਈ.ਡੀ. ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਆਪਣੇ ਗਰੁੱਪ ਪ੍ਰਬੰਧਕ ਨੂੰ ਸੰਪਰਕ ਕਰੋ। (Punjabi)

សារៈសំខាន់ : យើងអាចផ្តល់អ្នកបកប្រែជូនអ្នកដោយឥតគិតថ្លៃ សំរាប់ប្រាស្រ័យទាក់ទងជាមួយនឹងគ្រូពេទ្យ ឬគំរោងសុខភាពរបស់អ្នក ។ ដើម្បីទទួលអ្នកបកប្រែ ឬសាកសួរអំពីព័ត៌មានដែលសរសេរជាភាសាខ្មែរ សូមទូរស័ព្ទទៅលេខដែលមានកត់នៅលើខ្នងអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ឬទាក់ទងអ្នកគ្រប់គ្រងក្រុមរបស់អ្នក ។ (Khmer)

هام: يمكننا توفير مترجم فوري لك للتواصل مع الطبيب الخاص بك أو بخصوص خطتك الصحية بدون مقابل. للحصول على مترجم فوري أو لطلب معلومات كتابية بلغتك، رجاء الاتصال على رقم الهاتف الموجود على ظهر بطاقة العضوية أو اتصل بمسؤول المجموعة. (Arabic)

TSEEM CEEB: Yeej nrhiav tau ib tug neeg pab txhais lus uas yuav pab koj nrog koj tus kws kho mob los sis pawg kho mob tham pub dawb rau koj. Yog xav tau ib tug neeg txhais lus los sis xav tau cov ntawv hauv koj yam lus, thov hu mus rau tus naj npawb xov tooj nram qab koj daim ID los sis hu mus rau tus neeg saib xyuas koj pawg hauj lwm. (Hmong)

Anthem Blue Cross
Language Assistance Notice

IMPORTANT: An interpreter can be provided for you to communicate with your doctor or health plan at no cost. To get an interpreter or to ask about written information in your language, please contact your group administrator.

IMPORTANTE: Se le puede brindar sin costo los servicios de un intérprete para que pueda comunicarse con su médico o plan de salud. Para obtener un intérprete o para solicitar información escrita en su idioma, comuníquese con el administrador de su grupo. (Spanish)

重要提示： 您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請聯絡您的團體行政人員。(Cantonese or Mandarin)

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CHÚ Ý QUAN TRỌNG: Quý vị có thể được thông dịch viên giúp đỡ miễn phí khi quý vị cần tiếp xúc với bác sĩ hoặc nhân viên trong chương trình bảo hiểm sức khỏe của quý vị. Để được thông dịch viên giúp đỡ hoặc được cấp thông tin, văn bản chuyển ngữ sang ngôn ngữ của quý vị, xin quý vị vui lòng liên lạc ban quản trị chương trình bảo hiểm. (Vietnamese)