

### 1. Please tell us about your company:

Company Name		Group No. (For existing groups)	
Street Address	City	State	ZIP Code
Billing Address	City	State	ZIP Code
Employer is: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> Other (Explain):	SIC Code	Type of Business (Be specific)	
Date Business Established (Mo/Yr)	Company Contact Person	Phone No. ( ) ( )	Fax No. ( ) ( )
Has the company been insured by Anthem Blue Cross in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date prior Anthem Blue Cross coverage terminated: ___/___/___	E-mail Address		Federal Tax ID No.

### 2. Medical Coverage Preferences - what payment options and plan choices would you like to select?

2a. My Employer Medical Contribution each month will be:

**Traditional Option** I will contribute (50% to 100%): \_\_\_\_\_% per employee \_\_\_\_\_% per dependent

**Fixed Dollar Option** I will contribute (at least \$100 in \$5 increments): \$ \_\_\_\_\_

**Percentage and Plan Option** I will contribute (50-100%) to the following plan (excluding Basic PPO): \_\_\_\_\_  
 \_\_\_\_\_% per employee \_\_\_\_\_% per dependent

2b. I choose to offer:

**NOTE: SelectHMO plans cannot be offered along with any other non-SelectHMO plans.**

All plans OR  Designate specific plans (check as many as apply):

<input type="checkbox"/> Premier PPO \$10 Copay*	<input type="checkbox"/> Solution 2500 PPO**	<input type="checkbox"/> Lumenos HSA 2000 (100/70)**	<input type="checkbox"/> HMO \$10 100%*	<input type="checkbox"/> Lumenos HSA 1500 (100/70)**
<input type="checkbox"/> Premier PPO \$20 Copay*	<input type="checkbox"/> Solution 3500 PPO**	<input type="checkbox"/> Lumenos HSA 3000 (100/70)**	<input type="checkbox"/> HMO \$25 100%*	<input type="checkbox"/> Advantage PPO \$25 Copay**
<input type="checkbox"/> Premier PPO \$30 Copay*	<input type="checkbox"/> Solution 5000 PPO**	<input type="checkbox"/> Lumenos HSA 5000 (100/70)**	<input type="checkbox"/> Classic \$20 HMO*	<input type="checkbox"/> Saver PPO **
<input type="checkbox"/> PPO \$20 Copay**	<input type="checkbox"/> Elements Hospital Preferred**	<input type="checkbox"/> Lumenos HSA 1500 (80/50)**	<input type="checkbox"/> Classic \$30 HMO*	<input type="checkbox"/> Basic PPO **
<input type="checkbox"/> PPO \$30 Copay*	<input type="checkbox"/> Elements Hospital Plus**	<input type="checkbox"/> Lumenos HSA 2500 (80/50)**	<input type="checkbox"/> Classic \$40 HMO*	<input type="checkbox"/> PPO 2400 (HSA Compatible)**
<input type="checkbox"/> PPO \$40 Copay*	<input type="checkbox"/> Elements Hospital**	<input type="checkbox"/> Lumenos HSA 3500 (80/50)**	<input type="checkbox"/> Saver \$20 HMO*	<input type="checkbox"/> PPO 3500 (HSA Compatible)**
<input type="checkbox"/> PPO \$25 Copay GenRx**	<input type="checkbox"/> Lumenos HIA Plus 750**	<input type="checkbox"/> High Deductible EPO*	<input type="checkbox"/> Saver \$30 HMO*	<input type="checkbox"/> Lumenos HIA Plus 3000**
<input type="checkbox"/> PPO \$35 Copay GenRx**	<input type="checkbox"/> Lumenos HIA Plus 500**		<input type="checkbox"/> Saver \$40 HMO*	<input type="checkbox"/> Power HealthFund 750**
<input type="checkbox"/> PPO \$45 Copay GenRx**			<input type="checkbox"/> Select \$25 HMO*	<input type="checkbox"/> Power HealthFund 500**
			<input type="checkbox"/> Select \$35 HMO*	<input type="checkbox"/> Other _____

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

For Lumenos plans: Will Employer establish a Health Savings Account with Anthem banking partner?  Yes  No

### 3. Dental Coverage Preferences - what payment options and plan choices would you like to select?

3a. My Employer Dental Contribution each month will be:

**Traditional Option** I will contribute (at least 50%): \_\_\_\_\_% per employee \_\_\_\_\_% per dependent

**Fixed Dollar Option** I will contribute (at least \$15 in \$5 increments): \$ \_\_\_\_\_

3b. I choose to offer:

All plans OR  Designate specific plans (check as many as apply):

<input type="checkbox"/> Dental Blue Silver 100-80**	<input type="checkbox"/> Dental Blue Platinum 100-80**	<input type="checkbox"/> Basic Option PPO**
<input type="checkbox"/> Dental Blue Silver Plus 100-80**	<input type="checkbox"/> Dental Blue Platinum Plus 100-80**	<input type="checkbox"/> Dental Net*
<input type="checkbox"/> Dental Blue Gold 100-80**	<input type="checkbox"/> High Option PPO**	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Dental Blue Gold Plus 100-80**	<input type="checkbox"/> Standard Option PPO**	

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

**Voluntary Dental Coverage**

Please check below to offer one or both voluntary dental plans. (not available in conjunction with any other dental plans):

Dental PPO\*\*

Dental Saver SelectHMO\*

### 4. Vision Coverage Preferences - what plan choice and payment percentage would you like to select?

4a. I choose to offer:

Blue View AND/OR  Blue View Plus

offered by Anthem Blue Cross Life and Health Insurance Company

4b. My employer contribution will be (50-100%): \_\_\_\_\_% per employee \_\_\_\_\_% per dependent



**5. Life Coverage Selections** *[Add \$25,000 or more of Life Coverage and your group may qualify for 1% medical premium savings!]*

I choose to offer Life coverage, and my Employer Life Contributions will be (25-100%):  
 \_\_\_\_\_% per employee \_\_\_\_\_% per dependent

Please check only one schedule and specify amount of Life coverage  
 (from \$15,000 to \$250,000 in \$1,000 increments):

**Schedule A** Coverage is the same for all job titles \$ \_\_\_\_\_

**Schedule B** Coverage differs by job title:  
**Class I**, officers, managers, supervisors \$ \_\_\_\_\_  
**Class II**, all other group members \$ \_\_\_\_\_  
 (Coverage amount for Class I cannot exceed 2.5 times coverage amount for Class II)

**Schedule C** Coverage is a percentage of salary (maximum coverage \$250,000);  
 check one of the following for **all** employees:  
 EITHER  1 times annual salary, maximum Life coverage \$ \_\_\_\_\_  
 OR  2 times annual salary, maximum Life coverage \$ \_\_\_\_\_

For Schedule C, please provide list of employees & annual base salaries

I choose to offer Dependent Life coverage:

EITHER  \$10,000 spouse, \$10,000 children 6 months to 19 years (age 24 if full-time student), \$1,000 children under 6 months  
*(only available if employee Life benefit is \$20,000 or more)*

OR  \$5,000 spouse, \$5,000 children 6 months to 19 years (age 24 if full-time student), \$500 children under 6 months

I choose to make Supplemental Life coverage available;  
 Supplemental Life is 100% employee paid *(only available if other Life options are also selected)*

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

**6. Do you want to enroll in P.O.P.?**

Yes  No *Premium Only Plan (P.O.P.) is a payroll administration service [offered by Ceridian Benefit Services, Inc. (an independent company not affiliated with Anthem Blue Cross)] that helps companies receive IRS Section 125 tax advantages.*

The first year may be FREE if your group has 10+ members enrolling in both Medical and Life. Please read the P.O.P. brochure for complete details.  
 If you choose to enroll please complete the enrollment form, provide a separate check (if applicable), and submit along with this application.

**7. Please tell us about your group's eligibility:**

A. Total number of employees (including owners/officers): \_\_\_\_\_

B. Number of eligible full-time employees (working a minimum of 30 hours per week): \_\_\_\_\_

C. Are part-time employees to be covered?  Yes  No  
 If yes, check one option:  
 20-29 hours weekly  15-29 hours weekly

D. Number of eligible part-time employees: \_\_\_\_\_

E. Is this group a class carve-out?  Yes  No  
 If yes, state class of employees to be covered: \_\_\_\_\_

F. Probationary period/waiting period for new employees:  
 1<sup>st</sup> of month after hire date  3 months  5 months  
 1 month  4 months  6 months  
 2 months

G. Do you wish to offer coverage for opposite sex domestic partners\* under the age of 62 years?  Yes  No

H. Is your group currently subject to Cal-COBRA?  Yes  No  
*(Employed 2-19 eligible employees on at least 50% of its working days in the previous calendar year; or if not in business during any part of the previous calendar year, employed 2-19 eligible employees on at least 50% of its working days during the previous calendar quarter; and not subject to COBRA)*

I. Is your group currently subject to COBRA and Cal-COBRA?  Yes  No  
*(Employed 20 or more total employees on at least 50% of the working days in the previous calendar year)*

J. Is your group subject to the Family Medical Leave Act of 1993? (50 or more total employees)  Yes  No

K. Under TEFRA/DEFRA; which one applies for your group?  
 Medicare is primary (less than 20)  Anthem Blue Cross is primary (20+)  
 Medicare is primary coverage for groups with less than 20 employees; Anthem Blue Cross is primary coverage for groups with 20+ employees (based on total number of employees during 50% of the working days in previous calendar year).

\* Anthem Blue Cross complies with State law requiring it to cover spouses and qualified registered domestic partners including dependents to the same extent and subject to the same terms and conditions as a spouse. To be an eligible domestic partner one must be a domestic partner registered under a valid Declaration of Domestic Partnership filed with the California Secretary of State, or an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnership.

If yes to questions H, I or J, please complete the Cal-COBRA/COBRA/FMLA questionnaire on page 4.



**8. What is your requested effective date?**

\_\_\_\_/\_\_\_\_/\_\_\_\_ Actual effective date will be assigned if application is accepted.

**9. Please tell us if your group has had coverage within 90 days of this application's signature date:**

Will this plan replace current:	If yes, current carrier is:	Proposed termination date is:
Medical Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____

**10. What about employee Leave of Absence at your firm?**

**A. Medical:** number of months employees are eligible to continue group coverage while on an employer-approved temporary medical leave of absence (maximum 6 months).

<input type="checkbox"/> None	<input type="checkbox"/> 4 Months
<input type="checkbox"/> 1 Month	<input type="checkbox"/> 5 Months
<input type="checkbox"/> 2 Months	<input type="checkbox"/> 6 Months
<input type="checkbox"/> 3 Months	

**B. Personal:** number of months employees are eligible to continue group coverage while on an employer-approved temporary personal leave of absence (maximum 3 months).

<input type="checkbox"/> None	<input type="checkbox"/> 2 Months
<input type="checkbox"/> 1 Month	<input type="checkbox"/> 3 Months

**11. To your knowledge, is anyone to be covered unable to work due to injury or illness?**

Yes    No

If yes:  
 Name(s) \_\_\_\_\_ Anticipated return date(s) \_\_\_\_\_

**12. Please tell us about your Workers' Compensation coverage:**

Current carrier: \_\_\_\_\_ Next renewal date: \_\_\_\_\_  
(mm/dd/yy)

Please list the name and job title for any medically enrolling employee under the Anthem Blue Cross coverage who is not an employee for the purpose of Workers' Compensation law or similar legislation (see the definition provided below):

Name:	Job Title:	Exempt per definition below?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Definition: Under California Labor Code Section 3351, partners, corporate officers and members of boards of directors are employees for Workers' Compensation purposes except under limited circumstances. In order for individuals holding the above-mentioned positions to fall outside the Workers' Compensation laws, they must be shareholders of the corporation, and all stock of the corporation must be held by persons who are either officers or members of the board of directors of the corporation.

**13. Cal-COBRA/COBRA/FMLA Questionnaire - please complete this page if any "Yes" answers to H, I or J in Section 7**

Cal-COBRA: California law requires employers with 2-19 eligible qualified employees to extend health coverage programs to former employees spouses (widowed/divorced), and their dependents when a qualifying event occurs.

COBRA: The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers with 20 or more total employees to extend health coverage programs to former employees, spouses (widowed/divorced), and their dependents when a qualifying event occurs, unless the former employee, spouse or dependent was not eligible for continuation of coverage prior to January 1, 2005.

FMLA: The Family and Medical Leave Act of 1993 requires groups with 50 or more employees to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

**A. Cal-COBRA and COBRA:**

Complete for each employee or family member currently on Cal-COBRA or COBRA.

Name	Birthdate	Social Security or ID No.	Type <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	Qualifying Event	
				Description	Date
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		

**B. Cal-COBRA: Complete for each employee terminated in the last 60 days who has had a qualifying event.**

**COBRA: Complete for each employee terminated in the last 90 days who has had a qualifying event.**

1.	Name	Social Security or ID No.	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	If terminated, what date?
If qualifying event, please describe:				
To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is this employee/dependent presently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, disabling condition:				
2.	Name	Social Security or ID No.	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	If terminated, what date?
If qualifying event, please describe:				
To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is this employee/dependent presently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, disabling condition:				

**C. FMLA: Complete for each employee on family or medical leave.**

1.	Name	Social Security or ID No.	Beginning date of leave
To the best of your knowledge, will this employee return to work?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, is this employee presently disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, disabling condition: _____			
To the best of your knowledge, will this employee/dependent exercise their COBRA option?			<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Name	Social Security or ID No.	Beginning date of leave
To the best of your knowledge, will this employee return to work?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, is this employee presently disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, disabling condition: _____			
To the best of your knowledge, will this employee/dependent exercise their COBRA option?			<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of Company Official	Title	Company Name	Date
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If additional space is needed to include all applicable employees, please use a photocopy of this page.



**14. This section is important to protect you as a small group employer:**

Please check the box that applies:

- We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employee Retirement Income Security Act of 1974), apply to obtain the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.
- We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employee Retirement Income Security Act of 1974) and therefore not subject to ERISA, apply to obtain the coverage indicated.

To the best of our knowledge and belief, all information on this application is true and complete, and Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may rely on this application in deciding whether to provide coverage. If the application is not complete, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company reserve(s) the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We understand that the premium rates calculated for the employer are contingent on the accuracy of eligibility data submitted on employees and covered dependents to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company. Any misstatements on the employees' applications or failure to report new medical information prior to the employee's effective dates may result in a material change to the group's coverage or premium rates as of the effective date of the group coverage. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Anthem Blue Cross and /or Anthem Blue Cross Life and Health Insurance Company.

If a subscriber or covered dependent of a subscriber fails to elect coverage during the initial enrollment period, and then later decides to elect coverage, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may impose an exclusion from coverage for a twelve (12) month period as well as a six (6) month pre-existing condition exclusion.

**For employers offering a Health Savings Account (HSA) compatible EPO Plan:** We, the employer, understand that the High Deductible EPO Plan is designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. We understand that having this coverage does not establish an HSA.

The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits. The IRS has not yet issued HSA or high deductible health plan regulations or determined that Anthem Blue Cross high deductible plans are qualifying high deductible health plans. Consultation with a tax advisor is recommended.

**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.

**Please Read Carefully - Signature Required**

**REQUIREMENT FOR BINDING ARBITRATION**

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

The following provision does not apply to class actions:

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

Signature of Company Officer (Required)	Name of Company Officer (Please print)
X	
Title of Company Officer	Date (MM/DD/YY)



