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Small Group Change of Coverage Application
(For Existing Enrollments Only)

INSTRUCTIONS: Before requesting a different plan, please read the Anthem Blue Cross brochure describing the plan you are thinking of choosing. **Be sure you are acquainted with the benefits, copayments, annual deductibles and the limitations and exclusions of the plan you choose.** The plan you choose must be part of your employer's Small Group benefit coverage.

1. **You, the employee, must complete this application.** You are solely responsible for its accuracy and completeness.
2. All questions must be answered in full and all signatures and dates must be included where noted; otherwise, the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
3. **Type or print clearly using blue or black ink.**

Group No. | | | | | |

1. CHOICE OF COVERAGE – Please change my coverage to:

A. MEDICAL COVERAGE SELECTION – Check only one Medical Plan:

☐ Basic PPO**	☐ Lumenos HSA 1500**	☐ Premier PPO $10 Copay*	☐ Solution 2500 PPO**	☐ Classic $30 HMO*
☐ Saver PPO**	☐ Lumenos HSA 2000**	☐ Power HealthFund 500**	☐ Solution 3500 PPO**	☐ Saver HMO*
☐ PPO $35 Copay GenRx**	☐ Lumenos HSA 3000**	☐ Power HealthFund 750**	☐ Solution 5000 PPO**	☐ Saver $30 HMO*
☐ PPO $45 Copay GenRx**	☐ Lumenos HIA Plus 3000**	☐ PPO 3500 (HSA-compatible)**	☐ HMO 100%*	☐ Power SelectHMO*
☐ PPO $30 Copay*	☐ Advantage PPO $25 Copay**	☐ PPO 2400 (HSA-compatible)**	☐ HMO $25 100%*	☐ Power $35 SelectHMO*
☐ PPO $40 Copay*	☐ Premier PPO $20 Copay*	☐ High Deductible EPO*	☐ Classic HMO*	☐ Other__________

If selecting an HMO, you must select a Primary Medical Group (PMG) or an Independent Practice Association (IPA). If you are selecting an IPA, please select a Primary Care Physician for each enrolling family member and list them by number below in Section 3A.

HMO plan PMG or IPA Medical Office Number: | | | | | Are you currently a patient of this facility? ☐ Yes ☐ No

Will Employer establish a Mellon Health Savings Account for the Lumenos plan(s)? ☐ Yes ☐ No

B. DENTAL COVERAGE SELECTION – (If group has elected Dental Coverage) – Check only one Dental Plan:

☐ Dental Blue Silver** 100-80 _ 100 _ 200 _ 300	☐ Dental Blue Platinum Plus** 100-80 _ 100 _ 200 _ 300
☐ Dental Blue Silver Plus** 100-80 _ 100 _ 200 _ 300	☐ Basic Option Dental PPO**
☐ Dental Blue Gold** 100-80 _ 100 _ 200 _ 300	☐ Standard Option Dental PPO**
☐ Dental Blue Gold Plus** 100-80 _ 100 _ 200 _ 300	☐ High Option Dental PPO**
☐ Dental Blue Platinum** 100-80 _ 100 _ 200 _ 300	☐ Dental Net*

You must select a Dental Office No. for the following plans:

☐ Dental SelectHMO*
☐ Other:__________

| | | | | | | |
Dental Office No.

Fee-for-service coverage will be substituted if member is outside of PPO service area.

Voluntary Dental Coverage

Please check below to offer one or both voluntary dental plans. *(not available in conjunction with any other dental plans):*
☐ Dental Saver SelectHMO*
☐ PPO Dental Plan**

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

C. OPTIONAL DEPENDENT LIFE INSURANCE** *(Available only if offered by employer.)* ☐Yes ☐No

Last Name	First Name	M.I.	Marital Status ☐ Single ☐ Married	Social Security or ID No.
Street Address (P.O. Box not acceptable)			# of Dependents including Spouse	Spouse's Social Security or ID No.
City	State	ZIP Code	Home Phone No. ( )	Business Phone No. ( )
Occupation		Employer Name		No. of Hours Worked Per Week

3. SUBSCRIBER / FAMILY INFORMATION – *List yourself and all eligible family members requesting a change in coverage.* ***If spouse's last name is different from yours, is he/she a domestic partner?*** ☐ **Yes** ☐ **No**

3A. HMO only – IPA
If you select an IPA you must choose a Primary Care Physician for each member of your family.

	Last Name	First Name	M. I.	Height	Weight	Birthdate Mo Day Yr	Provider Number of Primary Care Physician
10 ☐ Male 20 ☐ Female	Subscriber						
30 ☐ Male 40 ☐ Female	Spouse*						
☐ Son ☐ Daughter							
☐ Son ☐ Daughter							
☐ Son ☐ Daughter							

** Spouse includes domestic partner ONLY if your employer has elected that coverage. If coverage is available, domestic partner enrollment requires submission of a signed and notarized Domestic Partner Affidavit or, if applicable, a copy of a valid Declaration of Domestic Partnership filed with and stamped by the Secretary of State of California.*

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4. HEALTH HISTORY OF MEMBERS CURRENTLY ENROLLED:

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

Your claims history with Anthem Blue Cross will also be used in addition to the history listed on this application.

Has any enrolled family member been hospitalized, seen a physician or other health care provider or taken prescription medication within the last 6 months? ☐ Yes ☐ No *If yes, provide the required medical information below:*

Member Name	Hospital / Provider Name and Address	Condition/Illness Treated	Medication (If applicable)

5. AUTHORIZATION: ***The following Authorization is to be signed by all employees 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 further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at the 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.

Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded.

I AM APPLYING FOR PPO COVERAGE: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider. If a PPO Plan is selected and a non-participating 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 Health Savings Account (HSA) compatible EPO PLAN: I understand that the HSA compatible Plans are designed for Exclusive Provider Organization (EPO) usage, and that using non-participating 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.

ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employee Retirement Income Security Act of 1974), certain disputes may not be subject to the following arbitration provisions:

I understand that any and all disputes between myself (and/or any enrolled family member) and Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, including claims for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company are giving up the right to have any dispute decided in a court of law before a jury. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Evidence of Coverage/Certificate. If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Signature of Employee	Date *(Mo/Day/Yr)*	Signature of Employee's Spouse *(If applying for coverage)*	Date *(Mo/Day/Yr)*
X		**X**	

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.

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