

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



Health care plans offered by Anthem Blue Cross and 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. Submit application to your employer.

Please complete in black ink only.

Group/Case no. (if known)

Section A: Application Type — select one.

New enrollment Open enrollment Qualifying event
 COBRA/Cal-COBRA Rehire date (MM/DD/YYYY) / /

If you select **Qualifying event or COBRA/Cal-COBRA**, please select one event reason.

Marriage Birth of child Adoption of child Divorce or legal separation Death
 COBRA Cal-COBRA — Cal-COBRA applicants must submit first month's premium.
 Involuntary loss of coverage — please explain (required): _____
 Other — please explain (required): _____

Qualifying event or COBRA/Cal-COBRA date — Required (MM/DD/YYYY): / /

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						
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 <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Tagalog <input type="checkbox"/> Other – 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: _____						

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 name ³ :	Contract code, if known:
Member medical coverage — select one: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family	
2. Dental Coverage — Indicate the contract code for the dental plan selected. Your employer will advise you of your plan options and contract codes.	
Standalone dental plans do not include Essential Health Benefits.	
Dental plan name:	Contract code, if known:
Member dental coverage — select one: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family	
3. Vision Coverage	
These optional vision plans do not include coverage for vision pediatric essential health benefits.	
Vision plan name:	Contract code, if known:
Member vision coverage — select one: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + Spouse/Domestic Partner <input type="checkbox"/> Employee + child(ren) <input type="checkbox"/> Family	

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.

Section D: Family Information —

Complete this section for yourself and all dependents. All fields required. Attach a separate sheet if necessary.

Please access *Find Care* 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 relationship ² (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 incapacitating 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.	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.	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.	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.	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 enrolled in Medicare? Yes 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? Yes No
 3. Is anyone applying for coverage covered by other health, dental, or orthodontia coverage? Yes No
 4. On the day your coverage begins, will you or a family member be covered by other dental coverage? Yes No

If yes to any of these questions, please provide the following:

Name of Person covered (Last name, First, M.I.)	Type (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 will be required.

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"/> 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/Medicaid/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"/> Dependents	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision 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, or agent, has tried to influence me or put any pressure on me to waive coverage. BY WAIVING THIS GROUP MEDICAL, DENTAL, OR VISION COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, OR VISION 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. Please note Spouse/ Domestic Partner and Dependent coverage will not be available if the Employee has waived/declined.

Special Open Enrollment

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. DO NOT SIGN HERE IF YOU ARE APPLYING FOR COVERAGE

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: Electronic Delivery of Materials.

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 am providing my email address because I, and my enrolled dependents, want to receive information about our benefits electronically. These communications may include Identification (ID) Cards, Certificates of Coverage or Evidence of Coverage, grievance, appeals, and medical determination notifications, Explanation of Benefits, other required notices and personalized information to help get the most out of the benefits. I understand I need to register on anthem.com/ca or the Sydney Health mobile app to get the most out of my plan's digital tools and I will make sure Anthem has my most up-to-date email address. I and my enrolled dependents understand that we can update our email addresses, change our communication preferences, and request a free copy of any materials at any time by going to anthem.com/ca or calling the Member Services number on my ID card.

For **Dental PPO** and **Vision** 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.

By signing below, I and my enrolled dependents want to receive information about our benefits electronically. These communications may include Identification (ID) Cards, Certificates of Coverage, Evidence of Coverage, appeals, and medical determination notifications, Explanation of Benefits, other legally required notices, and personalized information to help get the most out of the benefits. I understand I need to register on anthem.com/ca or the Sydney Health mobile app to get the most out of my plan's digital tools, and I will make sure Anthem has my most up-to-date email address. I understand that this consent is voluntary and that I and my enrolled dependents can opt out of electronic delivery at any time. We can update our email addresses, change our communication preferences, and request a free copy of any materials at any time by going to anthem.com/ca or calling the Member Services number on my ID card.

Applicant signature _____ Date _____

Section H: 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 and/or Anthem Blue Cross Life and Health Insurance Company 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 Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company 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 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 Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and myself.

By providing a phone number, I agree and consent that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company 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 Blue Cross 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 Blue Cross with information regarding my HSA and that I may provide Anthem Blue Cross with a written request to revoke my authorization at any time.

