Employer Application
EmployeeElect
For 2-50 Member Small Groups

Anthem BlueCross

anthem.com/ca

Health care plans offered by Anthem Blue Cross. Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company.

SECTION 1: COMPANY INFORMATION

Company name	Employer tax ID no. (required)
Doing Business As (DBA)	Group no. (for existing group)

Street address	City	State	ZIP code
Billing address (if different from above)	City	State	ZIP code

Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ LLC ☐ Other: _____

SIC code	Type of business (be specific)	Date business established	Company contact name	Title

Phone no.	Fax no.	Email address

Has company been insured by Anthem Blue Cross in the last 12 months? ☐ Yes ☐ No If yes, enter date coverage terminated:

SECTION 2: HEALTH COVERAGE

Note: Select HMO, Priority Select HMO and Full HMO network plans can only be offered alongside other plans with the same network type. For example, plans on the Select HMO network can be offered alongside other plans on the Select HMO network, but they cannot be offered alongside plans on the Priority Select HMO or Full HMO networks. Not all network options are available in every area.

A. We choose to offer: ☐ **All plans** ☐ **Designate specific plans** – check **all** that apply.

- ☐ Premier PPO $10 Copay[1]
- ☐ Premier PPO $20 Copay[1]
- ☐ Premier PPO $30 Copay[1]
- ☐ PPO $20 Copay[1]
- ☐ PPO $30 Copay[1]
- ☐ PPO $40 Copay[1]
- ☐ PPO 1000/$25[1]
- ☐ PPO 1500/$35[1]
- ☐ PPO 2000/$45[1]
- ☐ PPO 1000/$25 (Select PPO Network)[1]
- ☐ PPO 1500/$35 (Select PPO Network)[1]
- ☐ PPO 2000/$45 (Select PPO Network)[1]
- ☐ PPO $25 Copay GenRx[2]
- ☐ PPO $35 Copay GenRx[2]
- ☐ PPO $45 Copay GenRx[2]
- ☐ Solution 2500 PPO[2, 5]
- ☐ Solution 3500 PPO[2, 5]
- ☐ Solution 5000 PPO[2]
- ☐ Deductible 3000 PPO[1]
- ☐ Deductible 4000 PPO[1]
- ☐ Deductible 3000 PPO (Select PPO Network)[1]
- ☐ Deductible 4000 PPO (Select PPO Network)[1]
- ☐ ACO 20[1]
- ☐ ACO 30[1]
- ☐ Elements Hospital Plus[2]
- ☐ Elements Hospital Preferred[2]
- ☐ Lumenos HSA 1500 (80/50)[1]
- ☐ Lumenos HSA 2500 (80/50)[1]
- ☐ Lumenos HSA 3500 (80/50)[1]
- ☐ Lumenos HRA 3000D[2]
- ☐ Lumenos HRA 3000C[2]
- ☐ Lumenos HRA 5000D[2]
- ☐ Lumenos HRA 5000C[2]
- ☐ High Deductible EPO[1]
- ☐ 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]
- ☐ Lumenos HIA Plus 500[2, 3]
- ☐ Lumenos HIA Plus 750[2, 3]
- ☐ Elements Hospital[2, 4]
- ☐ Other: _____

For HMO plans, choose one network option:
- ☐ Full HMO Network
- ☐ Select HMO Network
- ☐ Priority Select HMO Network

1 Offered by Anthem Blue Cross
2 Offered by Anthem Blue Cross Life and Health Insurance Company
3 Plans will not be available for new group sales or renewals beginning July 2012
4 Plans 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

For Lumenos HRA plans:
The selection of any HRA-compatible plan requires enrollment in the Agreement for Health Reimbursement Accounts (HRA Agreement) and submission of the Demand Debit Authorization form.

Required for Lumenos plans – Only **one** choice is allowed.
- ☐ Group will establish Health Savings Account (HSA) with Anthem facilitating with a banking services provider.
- ☐ Group will establish Health Savings Account (HSA) but does not want Anthem to facilitate in the creation of the account.

B. Choose your health contribution for each month – only **one** choice is allowed.

- ☐ **Traditional Option** We will contribute (50–100%) _____% per employee _____% per dependent
- ☐ **Fixed Dollar Option** We will contribute (at least $100 in $5 increments) $_____
- ☐ **Percentage and Plan Option** We will contribute (50–100%) to the following plan _____ _____% per employee _____% per dependent

SECTION 3: DENTAL COVERAGE

NOTE: To offer Dental Prime and/or Dental Complete plans, please use the Dental Prime and Complete employer application.

A. We choose to offer: ☐ **All plans** ☐ **Designate specific plans** – check **all** that apply.

☐ Dental Blue Silver 100-80[1]
☐ Dental Blue Silver Plus 100-80[1]
☐ Dental Blue Gold 100-80[1]
☐ Dental Blue Gold Plus 100-80[1]

☐ Dental Blue Platinum 100-80[1]
☐ Dental Blue Platinum Plus 100-80[1]
☐ High Option PPO[1]
☐ Standard Option PPO[1]
☐ Basic Option PPO[1]

Dental Net DHMO[2]
☐ Dental Net 2000A[2]
☐ Dental Net 2000B[2]
☐ Dental Net 2000C[2]
☐ Other: _____

1 Offered by Anthem Blue Cross Life and Health Insurance Company
2 Offered by Anthem Blue Cross

Voluntary Dental Coverage
Please check below to offer Voluntary Dental coverage (not available in conjunction with any other Dental plans):

Dental Net Voluntary DHMO[2]
☐ Dental Net Voluntary 2000A[2]
☐ Dental Net Voluntary 2000B[2]
☐ Dental Net Voluntary 2000C[2]

☐ **Voluntary Dental PPO**[1]
☐ Other: _____

B. Choose your dental contribution for each month – only **one** choice is allowed.

☐ **Traditional Option** We will contribute (at least 50%) _____% per employee _____% per dependent
☐ **Fixed Dollar Option** We will contribute (at least $15 in $5 increments) $_____

SECTION 4: VISION COVERAGE

Employer-sponsored plans require employer to contribute between 50% and 100%. **Note:** Hospital BeneFits Preferred plan includes vision coverage.
For Voluntary plans, employers may contribute between 0% and 49%.

A. Choose type of plan: ☐ Employer sponsored ☐ Voluntary
B. We will contribute: _____% per employee _____% per dependent
C. Choose the plan(s) you wish to offer – check all that apply: ☐ Blue View ☐ Blue View Plus ☐ Other: _____
Offered by Anthem Blue Cross Life and Health Insurance Company

SECTION 5: LIFE COVERAGE

Add $25,000 or more of Life coverage and your group may qualify for 1% medical premium savings!

☐ We choose to offer **employee** Life coverage
We will contribute (25-100%): _____% per employee _____% per dependent
Please check only one schedule and specify amount of Life coverage (from $25,000 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, provide list of employees and annual base salaries

☐ We choose to offer **dependent** Life coverage
EITHER ☐ $10,000 spouse; $10,000 children 6 months to age 26; $1,000 children under 6 months **(available only if employee Life benefit is $20,000 or more)**
OR ☐ $5,000 spouse; $5,000 children 6 months to age 26; $500 children under 6 months **(available only if employee life benefit is purchased)**

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

Offered by Anthem Blue Cross Life and Health Insurance Company

SECTION 6: PREMIUM ONLY PLAN (P.O.P.)

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 is FREE if your group has 10+ medically enrolled members; otherwise the cost per year is $125. Please read the P.O.P. brochure for complete details. If you choose to enroll please complete the P.O.P. application and provide a separate check (if applicable) along with this application. Please make checks payable to Anthem Blue Cross.

SECTION 7: ELIGIBILITY

A. Total number of employees (including employed owners/officers): _____

B. Number of eligible **ENROLLING** employees: _____

C. Number of eligible **DECLINING** employees: _____

D. Number of **INELIGIBLE** employees: _____

E. Are part-time employees to be covered? ☐ Yes ☐ No

If yes, choose one:
☐ 20-29 hours weekly ☐ 15-29 hours weekly

F. Will coverage be restricted to a certain classification of employees? ☐ Yes ☐ No

If yes, what class(es) of employees are to be covered?

_____

G. Are all eligible employees subject to withholding as on a W-2 form? ☐ Yes ☐ No

H. Probationary period/waiting period for new employees:

☐ None ☐ First of month after hire date
☐ 1 month ☐ 3 months ☐ 5 months
☐ 2 months ☐ 4 months ☐ 6 months

I. Do you want to offer coverage for opposite sex domestic partners under the age of 62 years? ☐ Yes ☐ No

J. 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)

K. Number of Cal-COBRA enrollees: _____

L. 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)

M. Number of COBRA enrollees: _____

N. Is your group currently subject to the Family Medical Leave Act of 1993? ☐ Yes ☐ No

(50 or more total employees)

O. 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).

If yes to questions J, L, or N, please complete Cal-COBRA/COBRA/FMLA questionnaire on page 5.

SECTION 8: OWNERSHIP

Please account for 100% of the ownership, regardless of eligibility. Insert an additional sheet if necessary.

Last name	First name	M.I.	Percentage of Ownership	Eligible
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No

SECTION 9: REQUESTED EFFECTIVE DATE

The actual effective date will be assigned if the application is accepted.

SECTION 10: CERTIFICATES/EOCs

The Employer has the option to either access electronic copies or receive printed copies of the employee Certificates or Combined Evidence of Coverage and Disclosure Forms (EOCs). Choose one.

☐ Yes – Employer will access electronic copies of the employee Certificates and/or Combined Evidence of Coverage and Disclosure Forms (EOCs). Information on how to access electronic EOCs are included in your Group Benefit Agreement. By marking this option, employer understands that no printed copies of the Certificates/EOCs will be mailed to its offices and agrees to comply with all applicable provisions of the Employee Retirement Income Security Act (ERISA). Employer shall also make printed copies available to its employees upon request.

☐ No – Employer will not access electronic copies of the Certificates and/or Combined Evidence of Coverage and Disclosure Forms (EOCs). Employer would like to receive printed copies of the Certificates and/or Combined Evidence of Coverage and Disclosure Forms (EOCs)

SECTION 11: PRIOR COVERAGE

Has your group had coverage within 90 days of this application's signature date? ☐ Yes ☐ No

Will this plan replace current	If yes, carrier name	Termination date
Health coverage ☐ Yes ☐ No		
Dental coverage ☐ Yes ☐ No		
Vision coverage ☐ Yes ☐ No		

SECTION 12: LEAVES OF ABSENCE

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).

☐ None ☐ 1 month 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 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).

☐ None ☐ 1 month 2 months ☐ 3 months

SECTION 13: INJURIES/ILLNESSES

To your knowledge, is anyone to be covered unable to work due to injury or illness? ☐ Yes ☐ No If yes, complete the following.

Last name	First name	M.I.	Anticipated return date

SECTION 14: WORKERS' COMPENSATION COVERAGE

Current carrier	Next renewal date

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).

Last name	First name	M.I.	Job title	Exempt per definition below
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ 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.

SECTION 15: CAL-COBRA/COBRA/FMLA QUESTIONNAIRE

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 no.	Type	Qualifying event	
				Description	Date
			☐ Cal-COBRA ☐ COBRA		
			☐ Cal-COBRA ☐ COBRA		
			☐ Cal-COBRA ☐ 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.

Last name	First name	M.I.	Social Security no.	☐ Cal-COBRA ☐ COBRA	Termination date

Describe qualifying event: ______________________________

To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? ☐ Yes ☐ No
Is this employee/dependent presently disabled? ☐ Yes ☐ No If yes, disabling condition: ______________________________

Last name	First name	M.I.	Social Security no.	☐ Cal-COBRA ☐ COBRA	Termination date

Describe qualifying event: ______________________________

To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? ☐ Yes ☐ No
Is this employee/dependent presently disabled? ☐ Yes ☐ No If yes, disabling condition: ______________________________

Last name	First name	M.I.	Social Security no.	☐ Cal-COBRA ☐ COBRA	Termination date

Describe qualifying event: ______________________________

To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? ☐ Yes ☐ No
Is this employee/dependent presently disabled? ☐ Yes ☐ No If yes, disabling condition: ______________________________

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

Last name	First name	M.I.	Social Security no.	Beginning date of leave

To the best of your knowledge, will this employee return to work? ☐ Yes ☐ No
If no, is this employee presently disabled? ☐ Yes ☐ No If yes, disabling condition: ______________________________
To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? ☐ Yes ☐ No

Last name	First name	M.I.	Social Security no.	Beginning date of leave

To the best of your knowledge, will this employee return to work? ☐ Yes ☐ No
If no, is this employee presently disabled? ☐ Yes ☐ No If yes, disabling condition: ______________________________
To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? ☐ Yes ☐ No

Last name	First name	M.I.	Social Security no.	Beginning date of leave

To the best of your knowledge, will this employee return to work? ☐ Yes ☐ No
If no, is this employee presently disabled? ☐ Yes ☐ No If yes, disabling condition: ______________________________
To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? ☐ Yes ☐ No

Company officer signature	Title	Company name	Date
X			

If additional space is needed to include all applicable employees, please use a photocopy of this page.

SECTION 16: SIGNATURE REQUIRED — Read carefully

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 we decide to cancel our group coverage after coverage has been issued, we understand that the cancellation will become effective on the last day of the month in which Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company received the written notification of cancellation, and that no premiums will be refunded for any period between Anthem's receipt of the notification and the last day of the month when the cancellation takes effect. If there are any premiums after the cancellation date, we understand that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company will refund these premiums after 45 days from the premium deposit date.

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.

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.

Company officer signature (required)	Printed name	Title	Date
X			

SECTION 17: AGENT CERTIFICATION — To be completed by the agent/broker

I hereby certify:

A. That I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.

B. That I have advised the client not to terminate any existing coverage until receiving written notification from Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, that the coverage being applied for by this application is accepted.

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

WRITING AGENT	%	SECOND WRITING AGENT	%
Name Steve Shorr		Name	
Agent/agency ID no.		Agent/agency ID no.	
Sub-agent ID no. (if different)		Sub-agent ID no. (if different)	
Street Address		Street Address	
City / State / ZIP code		City / State / ZIP code	
Phone no. / Fax no.		Phone no. / Fax no.	
Email address		Email address	
Signature / Date		Signature / Date	

FOR GENERAL AGENT/BROKER USE ONLY			
General agent name Steve Shorr	Agent ID no.		
Street address	City	State	ZIP code

Send administration kit to: ☐ Agent ☐ Group

Submit application to:

Small Group Services
Anthem Blue Cross
P.O. Box 9042
Oxnard, CA 93031-9042

New business can also be submitted by email to:

newsguwca@wellpoint.com

Employers are responsible for sending an electronic or printed copy of the summary of benefits and coverage (also called an "SBC") to plan participants and beneficiaries. To access your group's SBCs, go to www.find-sbc.com.

Anthem BlueCross

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