Employer Enrollment Application
For 1–100 Employee Small Groups
California

Health care plans offered by Anthem Blue Cross (Anthem). Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company (Anthem Life).
You, the employer, 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 the application.
Note: Employer Tax ID Numbers are required under Centers for Medicare & Medicaid Services (CMS) regulations.

Group/Case no. (if known)

Please complete in blue or black ink only.

Section A: Company Information

Company name			Employer tax ID no. (required)
Doing Business As (DBA)			
Company street address			
City	County	State	ZIP code
Billing address – If different from above			
City	County	State	ZIP code

Is this for coverage as a member of an association plan? ☐ Yes ☐ No
If yes, association name: ____________________

Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Limited Liability Company (LLC) ☐ Other: ____________________

SIC code – Required	Type of business (be specific)	Date business established
Company contact name	Title	
Primary phone no.	Fax no.	
Email address		
Additional company contact name	Title	

Will a third-party administrator (TPA) perform any functions for your group? ☐ Yes ☐ No If yes, complete *TPA Form*.

Do you want to enroll in Premium Only Plan (P.O.P.)? ☐ Yes ☐ No
P.O.P. is a payroll administration service offered by Wage Works, Inc. (Wage Works) (an independent company not affiliated with Anthem Blue Cross) that helps companies receive IRS Section 125 tax advantages. If you choose to enroll, download the POP application at www.anthem.com/easyrenew and complete.

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414? ☐ Yes ☐ No
If yes, please give the legal names, federal tax ID no. and number of employees employed by each.

Legal name	Federal tax ID no.	No. of employees employed

Section B: Application Type

☐ New enrollment
☐ Change(s)

Requested effective date

Life products underwritten by Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California.
Anthem Blue Cross, Anthem Blue Cross Life and Health Insurance Company and Anthem Life Insurance Company are independent licensees of the Blue Cross Association.
ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Employer tax ID no. (required)

Section C: Type of Coverage

1. Medical Coverage

Medical plans offered by Anthem Blue Cross.

Step 1 – Select a network. You may choose one PPO and/or one HMO network.

PPO: ☐ Prudent Buyer PPO ☐ Select PPO **HMO:** ☐ CaliforniaCare HMO ☐ Select HMO ☐ Priority Select HMO

Step 2 – Select the plan offering you would like for your employees.

☐ All plans – Your employees will be able to elect from all the plans offered within your selected network.

☐ Designated plans – You must select the plan designs you wish to offer your employees. Go to step 3.

Step 3 – Select one or more plan(s) designs within the network(s) you selected.

Please Note: All health plans include the required coverage for the dental and vision pediatric essential health benefits.

	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
PPO: Prudent Buyer PPO Network	☐ 200/10%/3000	☐ 20/30%/5500 ☐ 500/20%/4500 ☐ 1000/20%/4000 ☐ 2000/0%/2500 w/HSA -RxC ☐ 2000/0%/3000 w/HSA ☐ 2000/20%/4000 ☐ 2000/20%/4000 w/HRA[1]	☐ 2000/35%/6850 ☐ 2000/20%/4850 w/HSA ☐ 2000/20%/4600 w/HSA -RxC	☐ 4500/30%/6350 w/HSA ☐ 5000/30%/6850 ☐ 6000/0%/6000 w/HSA ☐ 6000/35%/6600
PPO: Select PPO Network	☐ 20/10%/4000 ☐ 200/10%/3000	☐ 20/30%/5500 ☐ 35/20%/6200 ☐ 500/20%/4500 ☐ 1000/20%/4000 ☐ 2000/0%/2500 w/HSA -RxC ☐ 2000/0%/3000 w/HSA ☐ 2000/20%/4000 ☐ 2000/20%/4000 w/HRA[1]	☐ 1500/20%/6500 ☐ 2000/35%/6850 ☐ 2000/20%/4850 w/HSA ☐ 2000/20%/4600 w/HSA -RxC	☐ 4500/30%/6350 w/HSA ☐ 5000/30%/6850 ☐ 6000/0%/6000 w/HSA ☐ 6000/35%/6600 ☐ 6000/100%/6500
HMO: CaliforniaCare HMO Network		☐ 50/30%/6850 ☐ 500/20%/5000	☐ 1750/40%/6850	
HMO: Select HMO Network	☐ 25/20%/5000	☐ 50/30%/6850 ☐ 500/20%/5000	☐ 1750/40%/6850	
HMO: Priority Select HMO Network	☐ 25/20%/5000	☐ 50/30%/6850 ☐ 500/20%/5000	☐ 1750/40%/6850	

☐ Other: ____________________

1 Deductible First – Annual HRA Employer Contribution is set to $1,000.

For HSA 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.

For 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.

Note: **PPO plans –** Prudent Buyer PPO and Select PPO network plans can only be offered alongside other plans with the same network type. (For example, plans on the Select PPO network can be offered alongside other plans on the Select PPO network, but they cannot be offered alongside plans on the Prudent Buyer PPO networks. Not all network options are available in every area.)

HMO plans – CaliforniaCare HMO, Select HMO and Priority Select 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 CaliforniaCare HMO networks. Not all network options are available in every area.)

Riders/Optional Benefits – Select additional optional benefits

☐ Infertility Benefits ☐ Women's Contraceptive Opt-out Benefits – Submit appropriate Religious Self-Certification Form. The forms can be found on the www.anthem.com/easyrenew site.

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

Contribution option 1: Traditional option – We will contribute (50% to 100%): _______% per employee _______% per dependent (optional)

Contribution option 2: Fixed Dollar Option – We will contribute (at least $100 in $5 increments): $______________

Contribution option 3: Percentage of plan option – We will contribute (50% to 100%): _______% to the following plan: ____________________

Employer tax ID no. (required)

2. Dental Coverage – You may choose one Dental Net DHMO plan and one Dental Complete PPO plan.
See bottom of section 2, for minimum enrollment/participation requirements.

Dental Net DHMO plans (employer sponsored)[1,2]	Dental Net Voluntary DHMO plans[1,2,4]
☐ Dental Net 2000A ☐ Dental Net 2000B ☐ Dental Net 2000C	☐ Dental Net Voluntary 2000A ☐ Dental Net Voluntary 2000B ☐ Dental Net Voluntary 2000C

Dental Complete PPO plans[1,3] Please choose one selection from available options for elected plan type.

Plan Type	In-network	Out-of-network	Calendar year maximum	Maximum carryover	Posterior composites & dental implants	Orthodontia coverage type	Out-of-network reimbursement
☐ Classic (employer sponsored)	☐ 100/80/50	☐ 80/60/50 ☐ 100/80/50	☐ $1,000 ☐ $1,500 ☐ $2,000	☐ Yes ☐ No	☐ Yes ☐ No	☐ Not covered ☐ Child only[5] ☐ Adult & Child[5]	☐ MAC ☐ 80th ☐ 90th
☐ Enhanced (employer sponsored)	☐ 100/90/60	☐ 100/80/50 ☐ 100/90/60	☐ $1,500 ☐ $2,000 ☐ $2,500	☐ Yes ☐ No	☐ Yes ☐ No	☐ Not covered ☐ Child only[5] ☐ Adult & Child[5]	☐ 80th ☐ 90th
☐ Voluntary[6]	☐ 100/80/50	☐ 80/60/50 ☐ 100/80/50	☐ $1,000 ☐ $1,500	N/A	N/A	☐ Not covered ☐ Child only[5]	☐ MAC ☐ 80th

☐ Other: ______________________ Contract code: ______________

1 These optional dental plans do NOT include coverage for dental pediatric essential health benefits.
2 Offered by Anthem Blue Cross.
3 Offered by Anthem Blue Cross Life and Health Insurance Company.
4 Not available in conjunction with the employer sponsored Dental Complete PPO dental plans.
5 Orthodontia coverage is only available for groups with 10 or more eligible employees.
6 These Dental Complete Voluntary dental plans can only be combined with the Dental Net Voluntary DHMO plans as long as there are five employees enrolled in each plan.

Choose your dental contribution for each month.
Employer-sponsored plans require employer to contribute between 50% and 100%.
For Voluntary plans, employers may contribute between 0% and 49%.
Traditional option – We will contribute: _______% per employee _______% per dependent (optional)

Is this plan intended to replace any existing group dental coverage? ☐ Yes ☐ No
If yes, please complete the information below for each group dental insurance plan you now have.

Insurer	Type of plan (DHMO, PPO)	Effective date	Proposed termination date

Voluntary plan participation

☐ 5–100 Eligible Employees: A minimum of five employees must enroll (there is no participation-percentage requirement for our voluntary plans). Dual Option is available for voluntary plans with a minimum of five enrollments in each plan.

Classic and Enhanced plan participation

☐ 2–4 Eligible Employees: 100% of eligible employees not covered by another dental plan (and a minimum of two employees) are required to enroll.

☐ 5–14 Eligible Employees: A minimum of 70% of employees not covered by another dental plan are required to enroll. A minimum of two employees must enroll. Dual Option (employer can select two plans to offer to employees) is available for groups with at least 10 net eligible employees. A minimum of two employees must enroll in each of the two options and the two plans offered must have a 20% premium differential.

☐ 15+ Eligible Employees: A minimum of 50% of employees not covered by another dental plan are required to enroll. A minimum of two employees must enroll. Dual Option (employer can select two plans to offer to employees) is available for groups with at least 10 net eligible employees. A minimum of two employees must enroll in each of the two options and the two plans offered must have a 20% premium differential.

☐ Medical Lock (Packaged Enrollment): All members enrolled in the Anthem medical plan must enroll in Anthem Complete PPO dental plan. The medical plan billing must be included with new group submission materials. Dental tiering must be identical on the medical and dental plans. Example: enrollees with Single medical coverage must also have Single dental coverage; enrollees with Family medical coverage must also have Family dental coverage.

Employer tax ID no. (required)

3. Vision Coverage — Choose either employer sponsored or voluntary coverage. Offered by Anthem Blue Cross Life and Health Insurance Company.

☐ **Employer-sponsored plans (available for 2–100 Employee Small Groups, a minimum of two subscribers must enroll.) Choose a maximum of two plans.**
☐ **Voluntary Vision plans (available for 2–100 Employee Small Groups, a minimum of two subscribers must enroll.) Choose a maximum of two plans.**

Full Service				Materials Only Plans
☐ Blue View Vision A1	☐ Blue View Vision B1	☐ Blue View Vision C1	☐ Blue View Vision C6	☐ Blue View Vision M01
☐ Blue View Vision A2	☐ Blue View Vision B2	☐ Blue View Vision C2	☐ Blue View Vision C7	☐ Blue View Vision M02
☐ Blue View Vision A3	☐ Blue View Vision B3	☐ Blue View Vision C3	☐ Blue View Vision C8	☐ Blue View Vision M03
☐ Blue View Vision A4	☐ Blue View Vision B4	☐ Blue View Vision C4	☐ Blue View Vision C9	☐ Blue View Vision M04
☐ Blue View Vision A5	☐ Blue View Vision B5	☐ Blue View Vision C5		☐ Blue View Vision M05
☐ Blue View Vision A6	☐ Blue View Vision B6			☐ Blue View Vision M06

☐ **Other**: ____

Choose your vision contribution for each month.

Employer-sponsored plans require employer to contribute between 50% and 100%.
For Voluntary plans, employers may contribute between 0% and 49%.

We will contribute: _______% per employee _______% per dependent (optional)

☐ Medical Lock (Packaged Enrollment): All members enrolled in the Anthem medical plan must enroll in vision. The medical plan billing must be included with new group submission materials. Vision tiering must be identical on the medical and vision plans regardless of medical carrier. Example: enrollees with Single medical coverage must also have Single vision coverage; enrollees with Family medical coverage must also have Family vision coverage.

4. Life and Disability Coverage — Check all that apply. Life benefits are available for 2–100 Employee Small Groups. A minimum of two subscribers must enroll. Offered by Anthem Blue Cross Life and Health Insurance Company.

Please check one term life option and specify the amount of Life coverage:

☐ **Schedule A**: Life/AD&D — flat amount: $____________

Groups of 2–9: $25,000, $30,000 or $50,000
Groups of 10–100: $25,000 to $350,000 in $1,000 increments

☐ **Schedule B**: Life/AD&D — class:

Class 1 description: ______________________ Class 2 description: ______________________
Class 3 description: ______________________ Class 4 description: ______________________
Class 5 description: ______________________ Class 6 description: ______________________

☐ **Schedule C**: Life/AD&D — multiple of salary:
☐ 1 x salary
☐ 2 x salary (not available for groups of 2-9)
☐ 3 x salary (not available for groups of 2-9)

☐ **Dependent life —** Must purchase Basic term life and AD&D.

Groups of 2-9:
☐ $10,000 spouse/$5,000 child age 15 days to 26 years
☐ $5,000 spouse/$2,500 child age 15 days to 26 years

Groups of 10-100:
☐ $20,000 spouse/$10,000 child age 15 days to 26 years
☐ $10,000 spouse/$5,000 child age 15 days to 26 years
☐ $5,000 spouse/$2,500 child age 15 days to 26 years

☐ **Optional life —** Available only to groups with 10 or more employees. Optional life is available in $5,000 increments from $25,000 up to $300,000.
$_______________

☐ **Optional Dependent Life —** Available when selecting Optional Life.
Spouse: ☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $50,000 Child: ☐ $5,000 ☐ $10,000 ☐ $15,000

Disability Products — for groups of 10–100 (may select one or more of the following)

☐ Short Term Disability options: ☐ Flat $200 ☐ Flat $250 ☐ 50% ☐ 60% ☐ 67% of weekly earnings
☐ Long Term Disability options: ☐ 50% ☐ 60% ☐ 67% of monthly covered payroll
☐ Voluntary Short Term Disability options: ☐ $200 ☐ $250 ☐ 50% ☐ 60% of weekly earnings
☐ Voluntary Long Term Disability options: ☐ 50% or ☐ 60% of monthly covered payroll

Life Products

Choose Life product and group contribution percentage:

☐ Life & AD&D _______% ☐ Optional/Voluntary Life* _______% ☐ Optional/Voluntary AD&D* _______%
☐ Dependent Life _______% ☐ Optional/Voluntary Dependent Life* _______% *Available for Groups of 10+

Disability Products

Choose Disability product and group contribution percentage:

☐ Short Term Disability _______% ☐ Voluntary Short Term Disability* _______%
☐ Long Term Disability _______% ☐ Voluntary Long Term Disability* _______% *Available for Groups of 10+

Employer tax ID no. (required)

4. Life and Disability Coverage – Continued

Eligibility and Waiting Period

Is the eligibility period for Life and/or Disability the same as the Anthem medical policy eligibility period? ☐ Yes ☐ No
Enter the Life and Disability eligibility period below if it differs from the Anthem medical policy eligibility period.
Eligible full-time employees must be actively at work, and must satisfy any applicable waiting period. Minimum work hours required for eligible full-time employees is 30 hours unless otherwise indicated.

The waiting period for individuals employed **on or before** the effective date will be:	The waiting period for individuals employed **on or after** the effective date will be:
☐ None	☐ None
☐ ____ days of continuous employment	☐ ____ days of continuous employment
☐ First premium due date following ____ days of continuous employment	☐ First premium due date following ____ days of continuous employment

Does any class(es) have a different waiting period? ☐ Yes ☐ No If yes, please describe: ______________________

Not Actively At Work Requirements for Life Products

The employees listed below are not presently actively-at-work and/or are not expected to be actively-at-work on the requested group effective date. Anthem Life may make an exception and assume liability, subject to Underwriting approval, for certain employees. Unless this exception is applied for and granted as indicated below, they will not be covered until they return to active work. To qualify for this exception, the following conditions must all be satisfied. 1) The employee's absence must be due to illness or injury. 2) The employee must be covered by the prior carrier on the day immediately prior to Anthem Life's effective date of coverage for your group. 3) The employee must not be eligible to have coverage continued or extended by the prior carrier after that policy/contract terminates. In no event will the actively-at work requirement be waived for coverage which provides benefits due to total disability, such as short term disability, waiver of premium or extension of benefits. In no event will any increase in coverage or any additional coverage become effective until the employee returns to work. Coverage approved below will end when your group's coverage under Anthem Life's policy ends or at the end of any time period shown below, whichever occurs first. (Attach additional sheet if necessary.)

Employee name			Amount of insurance
Date of birth	Last date worked	Reason not working	Date expected to return
Insured by prior carrier ☐ Yes ☐ No	Request actively at work waiver ☐ Yes ☐ No	Waiver request approved ☐ Yes ☐ No	Underwriter approval

Employee name			Amount of insurance
Date of birth	Last date worked	Reason not working	Date expected to return
Insured by prior carrier ☐ Yes ☐ No	Request actively at work waiver ☐ Yes ☐ No	Waiver request approved ☐ Yes ☐ No	Underwriter approval

Life and Disability Authorization – Read carefully before signing.

The undersigned employer and/or authorized representative hereby requests that it be approved for Life and/or Disability insurance coverage through Anthem Blue Cross Life and Health Insurance Company (Anthem Life). Employer understands and represents to the best of his knowledge and belief the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued;
2. To make the insurance coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed;
3. To maintain records and furnish to Anthem Life or their designated agent(s), any information required in connection with administration of the insurance coverage;
4. To provide notice of applicable conversion rights to eligible employees and eligible dependents;
5. That statements of medical history will be required of employees, and dependents, when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem Life.
6. That approval for this life and/or disability insurance may cancel any prior contracts and/or coverage with Anthem Life effective immediately preceding the effective date of the employer's coverage;
7. To pay Anthem Life by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership;
8. Employer will receive, on behalf of members, all notices delivered by Anthem Life, and immediately forward such notices to persons involved, at their last known address, including certificates of coverage;

Employer tax ID no. (required)

Life and Disability Authorization — Continued.

9. That in order for Anthem Life to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem Life, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem Life may be different than the coverage applied for herein. In that event, Anthem Life shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued;
10. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem Life by the employer. Anthem Life reserves the right to review such rates upon receipt of all individual applications and modify the rates, if the enrollment information so warrants. Any fraud or intentional misrepresentation of material fact on the employees' applications may, within the first 24 months following the issuance of the coverage, result in a material change to the group's coverage or premium rates as of the effective date of the group coverage.
11. All employees applying for coverage are employees of the employer, receive salary or wages documented on state and/or federal payroll reports, work full-time (unless otherwise approved by Anthem Life in writing) and meet any other eligibility requirements for coverage;
12. The requested coverage is not in effect unless and until this application is approved by Anthem Life, that approval of coverage shall be evidenced by issuing insurance contracts and/or policies to the employer and employer acceptance by payment of the first month's premium. An employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem Life.

Section D: Eligibility

1. Total number of employees* (including employed owners/officers):
2. Number of eligible full-time employees (minimum 30 hours per week):
3. Number of part-time employees:

   Are permanent employees who work between 20-29 hours weekly to be covered? ☐ Yes ☐ No

   If yes, number of eligible part-time enrollees:
4. Number of employees enrolling in:

   Medical: Dental: Vision:

   Life: Disability:
5. Number of eligible DECLINING employees:
6. Number of INELIGIBLE employees:
7. Waiting period for **new employees**:

   ☐ First of month after hire date

   ☐ First of month following one month from the date of hire

   ☐ First of the month following two months from date of hire, not to exceed 90 days
8. Does your business have additional employees in another state? ☐ Yes ☐ No

   If yes, specify state: ______________________
9. 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).

   California law also requires plans to offer an enrollee who has exhausted continuation coverage under COBRA the opportunity to continue coverage for up to 36 months from the date the enrollee's continuation coverage began, if the enrollee is entitled to less than 36 months of continuation coverage under COBRA.

   Number of Cal-COBRA enrollees:
10. Is your group currently subject to COBRA? ☐ Yes ☐ No

    (Employed 20 or more total employees on at least 50% of the working days in the previous calendar year)

    Number of COBRA enrollees:
11. Under the Medicare Secondary Payer rules, which one applies for your group?

    ☐ Medicare is primary (less than 20 employees)

    ☐ Anthem Blue Cross is primary (20 or more employees)

    Medicare is primary coverage for groups with less than 20 employees; Anthem Blue Cross is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.
12. Is your group currently subject to the Family Medical Leave Act of 1993 (50 or more total employees)? ☐ Yes ☐ No

Section E: 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

* A small group must have at least one eligible employee. An "employee" does not include the sole owner of a business or a spouse of the business owner.

Employer tax ID no. (required)

Section F: Certificates/EOCs

The Employer has the option to either access electronic copies or receive printed copies of the employee Certificates and/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 and/or 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 EOCs.
Employer would like to receive printed copies of the Certificates and/or EOCs.

Section G: Leaves of Absence

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

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 H: Prior Coverage

Has this group had coverage within 12 months of this application's signature date? ☐ Yes ☐ No

Will this plan replace current	If yes, carrier name	Termination date (MM/DD/YY)
Medical coverage ☐ Yes ☐ No		
Dental coverage ☐ Yes ☐ No		
Vision coverage ☐ Yes ☐ No		
Life coverage ☐ Yes ☐ No		

Section I: Workers' Compensation

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

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.

Employer tax ID no. (required)

Section J: Cal-COBRA/COBRA/FMLA Questionnaire

Cal-COBRA: For employers with 2-19 eligible employees, California law requires plans to offer continuation coverage to qualified beneficiaries under the contract when a qualifying event occurs. California law also requires plans to offer an enrollee who has exhausted continuation coverage under COBRA the opportunity to continue coverage for up to 36 months from the date the enrollee's continuation coverage began, if the enrollee is entitled to less than 36 months of continuation coverage under COBRA.

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.

1. 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		

2. 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: ______

3. 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.

***Anthem Blue Cross is required by the Internal Revenue Service and Centers for Medicare & Medicaid Services (CMS) to collect this information.**

Employer tax ID no. (required)

Section K: Electronic Access of Group Information by Agent/Producer/Broker/General Agent

We, the employer, hereby authorize the agent/producer/broker/general agent whose name is attached to this application to use the EmployerAccess system of Anthem Blue Cross (Anthem) or Anthem Blue Cross Life and Health Insurance Company (Anthem Life) to access the group's information, such as but not limited to enrollees, plan selections, and bills/invoices. Such agent/producer/broker/general agent is also hereby authorized to use the EmployerAccess system of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company to make changes to the group's information on behalf of the group, such as but not limited to adding/deleting plans, adding/deleting employees, and or changing employee demographic information. These authorizations shall terminate if the group's designated agent/producer/broker/general agent changes.

☐ Check this box **ONLY** if the group elects to opt-out of authorizing the agent/producer/broker/general agent to access and change the group's information on behalf of the group.

Section L: General Agreement

Please read this section carefully before signing the application.

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.

Employer understands and certifies the following, and if approved for coverage, agrees by payment of the required premiums, and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Anthem Blue Cross (Anthem) and/or Anthem Blue Cross Life and Health Insurance Company (Anthem Life) trust policy(ies), if applicable.
2. To make the coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Anthem or their designated agent(s), any information required in connection with administration of the coverage.
4. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.
5. To pay Anthem by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and state-mandated continued group coverage and/or conversion process, if applicable.
6. If applicable, employer will receive on behalf of members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.
7. We understand and agree that no coverage will be effective before the date determined by Anthem and/or Anthem Life, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted.
8. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. If the application is not complete, Anthem and/or Anthem Life reserve(s) the right to reject it and notify us in writing.
9. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any fraud or intentional misrepresentation of material fact on the employees' applications may, within the first 24 months following the issuance of the coverage, result in a material change to the group's coverage or premium rates as of the effective date of the group coverage.
10. The entire application for Group coverage has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
11. All employees applying for coverage are employees of the employer and receive salary or wages documented on state and/or federal payroll reports. Eligible full-time employees must work at least 30 hours per week, must be actively at work, must have satisfied any applicable eligible waiting period.
12. The requested coverage is not in effect unless and until this application is approved by Anthem, that approval of coverage shall be evidenced by issuing Group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem.
13. The broker listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.
14. This small group off-exchange product is not eligible for a premium tax credit.
15. 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 high-deductible plans are qualifying high-deductible health plans. Consultation with a tax advisor is recommended.
16. 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 and/or Anthem Life 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 and/or Anthem Life will refund these premiums after 45 days from the premium deposit date.
17. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing by Anthem and/or Anthem Life and that no agent has the right to accept this application or bind coverage.
18. If this application is accepted, it becomes a part of our contract with Anthem and/or Anthem Life.
19. If applying for Life and/or Disability insurance, the authorized representative certifies, on behalf of the employer, that it has read and agrees to the terms in the ***Life and Disability Authorization*** in Section 4.

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.

Employer tax ID no. (required)

Section L: General Agreement — Continued.

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life coverage.)

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.

Sign here	Company officer signature X		Printed name
	Title		Date (MM/DD/YYYY)

Employer tax ID no. (required)

Section M: Agent/Producer/Broker Attestation — To be completed by the agent/broker

1. To the best of my knowledge, the information on this application is complete and accurate.
2. I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.
3. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
4. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company to attribute such additions or changes to me.
5. I have advised the employer, in easy-to-understand language, that a failure to provide complete and accurate information that constitutes fraud or intentional misrepresentation of material fact may, within 24 months following the issuance of the coverage, result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Anthem Blue Cross reviews and approves the application and the employer receives a written notice from Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company. The employer understood my explanation.
6. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company shall be paid to an agent/broker/producer not appointed/approved by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company.
7. 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.
8. I understand that if I have willfully stated as true any material fact I know to be false, I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000).
9. By providing your "wet or electronic" signature below, you acknowledges that such signature is valid and binding.

Writing payable/sub-agent/producer/broker	**%**	**Second writing payable/sub-agent/producer/broker**	**%**
Agency name	Agency ID no.	Agency name	Agency ID no.
Agent/producer/broker name		Agent/producer/broker name	
Agent/producer/broker ID no.		Agent/producer/broker ID no.	
Payable/sub-agent/producer/broker ID no. if different		Payable/sub-agent/producer/broker 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 (MM/DD/YYYY)	Signature	Date (MM/DD/YYYY)

For General Agent use only

General agent	General agent ID no.		
Street address	City	State	ZIP code

Account Manager

Account manager name	Account manager ID no.

Administration kit will be sent to the 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@anthem.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.sbc.anthem.com.

ANTHEM USE ONLY	Group no.	Tracking no.	Effective date (MM/DD/YYYY)

Employer tax ID no. (required)

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