

# Employer Application EmployeeElect

For 2-50 Member Small Groups



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: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

<input type="checkbox"/> Premier PPO \$10 Copay <sup>1</sup>	<input type="checkbox"/> Solution 2500 PPO <sup>2,5</sup>	<input type="checkbox"/> Lumenos HSA 1500 (80/50) <sup>1</sup>	<input type="checkbox"/> HMO \$10 100% <sup>1</sup>	<input type="checkbox"/> Lumenos HIA Plus 500 <sup>2,3</sup>
<input type="checkbox"/> Premier PPO \$20 Copay <sup>1</sup>	<input type="checkbox"/> Solution 3500 PPO <sup>2,5</sup>	<input type="checkbox"/> Lumenos HSA 2500 (80/50) <sup>1</sup>	<input type="checkbox"/> HMO \$25 100% <sup>1</sup>	<input type="checkbox"/> Lumenos HIA Plus 750 <sup>2,3</sup>
<input type="checkbox"/> Premier PPO \$30 Copay <sup>1</sup>	<input type="checkbox"/> Solution 5000 PPO <sup>2</sup>	<input type="checkbox"/> Lumenos HSA 3500 (80/50) <sup>1</sup>	<input type="checkbox"/> Classic \$20 HMO <sup>1</sup>	<input type="checkbox"/> Elements Hospital <sup>2,4</sup>
<input type="checkbox"/> PPO \$20 Copay <sup>1</sup>	<input type="checkbox"/> Deductible 3000 PPO <sup>1</sup>	<input type="checkbox"/> Lumenos HRA 3000D <sup>2</sup>	<input type="checkbox"/> Classic \$30 HMO <sup>1</sup>	<input type="checkbox"/> Other: _____
<input type="checkbox"/> PPO \$30 Copay <sup>1</sup>	<input type="checkbox"/> Deductible 4000 PPO <sup>1</sup>	<input type="checkbox"/> Lumenos HRA 3000C <sup>2</sup>	<input type="checkbox"/> Classic \$40 HMO <sup>1</sup>	
<input type="checkbox"/> PPO \$40 Copay <sup>1</sup>	<input type="checkbox"/> Deductible 3000 PPO <sup>1</sup> (Select PPO Network) <sup>1</sup>	<input type="checkbox"/> Lumenos HRA 5000D <sup>2</sup>	<input type="checkbox"/> Saver \$20 HMO <sup>1</sup>	
<input type="checkbox"/> PPO 1000/\$25 <sup>1</sup>	<input type="checkbox"/> Deductible 4000 PPO <sup>1</sup> (Select PPO Network) <sup>1</sup>	<input type="checkbox"/> Lumenos HRA 5000C <sup>2</sup>	<input type="checkbox"/> Saver \$30 HMO <sup>1</sup>	
<input type="checkbox"/> PPO 1500/\$35 <sup>1</sup>	<input type="checkbox"/> ACO 20 <sup>1</sup>	<input type="checkbox"/> High Deductible EPO <sup>1</sup>	<input type="checkbox"/> Saver \$40 HMO <sup>1</sup>	
<input type="checkbox"/> PPO 2000/\$45 <sup>1</sup>	<input type="checkbox"/> ACO 30 <sup>1</sup>			
<input type="checkbox"/> PPO 1000/\$25 (Select PPO Network) <sup>1</sup>	<input type="checkbox"/> Elements Hospital Plus <sup>2</sup>			
<input type="checkbox"/> PPO 1500/\$35 <sup>1</sup> (Select PPO Network) <sup>1</sup>	<input type="checkbox"/> Elements Hospital Preferred <sup>2</sup>			
<input type="checkbox"/> PPO 2000/\$45 <sup>1</sup> (Select PPO Network) <sup>1</sup>				
<input type="checkbox"/> PPO \$25 Copay GenRx <sup>2</sup>				
<input type="checkbox"/> PPO \$35 Copay GenRx <sup>2</sup>				
<input type="checkbox"/> PPO \$45 Copay GenRx <sup>2</sup>				

**For HMO plans, choose one network option:**

- Full HMO Network  
 Select HMO Network  
 Priority Select HMO Network

<sup>1</sup> Offered by Anthem Blue Cross

<sup>2</sup> Offered by Anthem Blue Cross Life and Health Insurance Company

<sup>3</sup> Plans will not be available for new group sales or renewals beginning July 2012

<sup>4</sup> Plans will not be available for new group sales or renewals beginning October 2012

<sup>5</sup> 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.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Dental Blue Silver 100-80 <sup>1</sup>      | <input type="checkbox"/> Dental Blue Platinum 100-80 <sup>1</sup>      | Dental Net DHMO <sup>2</sup>                           |
| <input type="checkbox"/> Dental Blue Silver Plus 100-80 <sup>1</sup> | <input type="checkbox"/> Dental Blue Platinum Plus 100-80 <sup>1</sup> | <input type="checkbox"/> Dental Net 2000A <sup>2</sup> |
| <input type="checkbox"/> Dental Blue Gold 100-80 <sup>1</sup>        | <input type="checkbox"/> High Option PPO <sup>1</sup>                  | <input type="checkbox"/> Dental Net 2000B <sup>2</sup> |
| <input type="checkbox"/> Dental Blue Gold Plus 100-80 <sup>1</sup>   | <input type="checkbox"/> Standard Option PPO <sup>1</sup>              | <input type="checkbox"/> Dental Net 2000C <sup>2</sup> |
|  | <input type="checkbox"/> Basic Option PPO <sup>1</sup>                 | <input type="checkbox"/> Other: _____                  |

**Voluntary Dental Coverage**

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

**Dental Net Voluntary DHMO<sup>2</sup>**

- 
- Dental Net Voluntary 2000A
- <sup>2</sup>
- 
- 
- Dental Net Voluntary 2000B
- <sup>2</sup>
- 
- 
- Dental Net Voluntary 2000C
- <sup>2</sup>

 **Voluntary Dental PPO<sup>1</sup>** Other: \_\_\_\_\_<sup>1</sup> Offered by Anthem Blue Cross Life and Health Insurance Company<sup>2</sup> Offered by Anthem Blue Cross

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
			_____%	<input type="checkbox"/> Yes <input type="checkbox"/> No
			_____%	<input type="checkbox"/> Yes <input type="checkbox"/> No
			_____%	<input type="checkbox"/> Yes <input type="checkbox"/> No
			_____%	<input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No		
Dental coverage <input type="checkbox"/> Yes <input type="checkbox"/> No		
Vision coverage <input type="checkbox"/> Yes <input type="checkbox"/> 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
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

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

**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
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		

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

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

Last name	First name	M.I.	Social Security no.	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> 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.	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> 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.	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> 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 <b>X</b>	Title	Company name	Date
---------------------------------------	-------	--------------	------

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) <b>X</b>	Printed name	Title	Date
--	--------------	-------	------

**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 acknowledge that such signature is valid and binding.

WRITING AGENT			%	SECOND WRITING AGENT			%
Name				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				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](http://www.find-sbc.com).

This page intentionally left blank.