Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

LOCATE THE CORRECT APP (USING PAGE 2) THEN COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department
at: 310-519-1335 fax:

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Steve Shorr Insurance

1027 W. 11th Street # 3

San Pedro, CA 90731

Please make your check payable to: Anthem Blue Cross

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 310-519-1335

Thank you for choosing...

Anthem Blue Cross

How to find the right app …

Anthem CA has four applications based on county. This pdf contains all four; please see below for the page number of this pdf for the application corresponding to the desired county:

Page 3

Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Kern, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Plumas, San Benito, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, and Yuba

Page 17

Los Angeles (North), Los Angeles (South), Orange, and San Diego.

Page 31

Fresno, Kings, Madera, Sacramento, Placer, El Dorado, Riverside, San Bernardino, Santa Clara, and Yolo

Page 45

San Fransicso

California
Individual Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Anthem Blue Cross, premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 212-1796. If you have questions about a previously submitted application, please call 1 (855) 383-7247.

Applicants must reside in one of these counties to enroll in the medical plans: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Kern, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Plumas, San Benito, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, and Yuba.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage ☐ Change plan/policy coverage Policy No._____ ☐ Add dependent(s) to current coverage Policy No._____

Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. The earliest Effective Date for the annual Open Enrollment period is the first day of the following calendar year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable premium payment.

Applications can be received during the Open Enrollment period. Outside the Open Enrollment period referenced above, the applicant may still apply for a health plan if he/she experiences a qualifying event as defined below. Following a qualifying event, an applicant has 60 days to submit an application. In the case of a future Loss of Minimum Essential Coverage or renewal of non-calendar year health plan coverage, an application may be submitted up to 60 days in advance of the qualifying event date.

No qualifying event is required to apply for new dental coverage.

For existing dental plan members, not including Dental Blue and Dental SelectHMO, dental coverage changes and/or addition of dependents may only occur at your next renewal date or if you experience a qualifying event. Following a qualifying event, an applicant has 60 days to submit an application.

Please indicate the reason you are submitting this application:

☐ Open Enrollment Period
☐ Special Enrollment Period

If Special Enrollment Period, please provide the qualifying event date, qualifying event and, if applicable, the coverage effective date:

1. **Date of the qualifying event** (which includes the date of Loss of Minimum Essential Coverage):

   _____

2. **Qualifying Event:**

   ☐ Involuntary loss of Minimum Essential Coverage (loss of minimum essential coverage includes loss of eligibility of coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of

employment, reduction in the number of hours of employment. Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan);

☐ Gain a dependent or become a dependent through marriage, domestic partnership, or appointment of domestic partnership;

☐ Gain a dependent or become a dependent through birth, adoption or placement for adoption;

☐ Mandated to be covered as a dependent pursuant to a valid state or federal court order;

☐ Release from incarceration;

☐ Death of a family member enrolled under your current coverage;

☐ Renewal of non-calendar year health plan coverage;

☐ Health coverage issuer substantially violated material provision of health coverage contract;

☐ Access to new health benefit plans due to permanent move;

☐ Loss of services from contracting provider under another health benefit plan, as defined in Sections 10965 of the Insurance Code or 1399.845 of the Health and Safety Code, for a condition described in Health and Safety Code § 1373.96(c) (an acute condition, serious chronic condition, pregnancy, terminal illness, care of newborn between birth and 36 months of age, or performance of a surgery or other procedure that has been recommended and documented by the provider) and that provider is no longer participating in the health benefit plan;

☐ Member of the Reserve Forces of the U.S. military returning from active duty or member of the California National Guard returning from active duty under Title 32 of the U.S. Code.

☐ Other Qualifying Event:_____ (Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events please indicate below).

Comments:_____

3. Coverage Effective Date:

If you are applying due to a qualifying event and your application is processed, your coverage effective date will be based on when the application is received. If the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. If the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month. **However the following qualifying events allow for different effective dates:**

- In the case of marriage, domestic partnership, appointment of domestic partnership, or Loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application.

For the following qualifying events, select one of the effective date options as described in the chart below.

- In the case of birth, or adoption, or placement for adoption; ☐A ☐B ☐C ☐D
- In the case of a mandate to be covered as a dependent pursuant to a valid state or federal court order; ☐A ☐C
- In the case of death of a family member enrolled under your current coverage; ☐B ☐C

Effective date options

A	Coverage is effective on the date of birth, or adoption, or placement for adoption, or date of valid state or federal court order.
B	First day of the month following receipt of your application.
C	Based on when the application is received. If the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. If the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month.
D	First day of the month following the date of the qualifying event.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*(required)

Home Address**			
City	State	ZIP	County

Billing Address (street and P.O. Box if applicable)		
City	State	ZIP

Marital/Domestic Partner Status	Sex	Date of Birth
☐ Single ☐ Married ☐ Domestic Partner	☐ M ☐ F	/ /

Primary Phone Number	Secondary Phone Number	E-mail***
( )	( )	

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

*** All information will be mailed to your home address, including billing, private and confidential communications as defined by California law, unless you designate a different address under the "Billing Address" field above. This will not impact rights you may have to invoke a separate Confidential Communication under the Health Insurance and Portability and Accountability Act ("HIPAA").*

****This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner
Social Security Number* (required)	Sex ☐ M ☐ F	Date of Birth / /	

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your or your spouse's or your Domestic Partner's children, including stepchildren, newborn and adopted children and any child for whom you or your spouse or domestic partner has assumed a parent-child relationship under age twenty-six 26. (List all dependents beginning with the eldest). Children over the age of twenty-six 26 may be eligible for coverage as a dependent if they are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and chiefly dependent upon the policyholder or subscriber for support and maintenance. To qualify as an overage dependent, the Dependent's disability must start before the end of the period he or she would become ineligible for coverage.

Last Name	**First Name**	**MI**	**Sex**	**Date of Birth mm/dd/yyyy**	**Social Security Number* (required)**	**Relationship to Applicant**
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Do you have a child age 26 or over who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition for whom coverage is being requested under this contract? ☐ Yes ☐ No

If YES, a separate Disabled Dependent Certification form must be submitted to determine eligibility.

☐ **Please send me a form.**

Are any of the applicants listed on the application currently incarcerated (except pending disposition of charges)? ☐ Yes ☐ No

If **YES**, who? _____

Preferred written language? (Optional)

☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Vietnamese (VIE) ☐ Spanish (SPN)
☐ English (ENG) ☐ Tagalog (TGL) ☐ Other (W09)

Preferred spoken language? (Optional)

☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Vietnamese (VIE) ☐ Spanish (SPN)
☐ English (ENG) ☐ Tagalog (TGL) ☐ Other (W09)

☐ Applicant **DOES** speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a "Statement of Accountability".

Section E – Medical Coverage

Select ONE Plan...then select ONE Individual Deductible/Coinsurance option.

Total Family Deductible is two (2) times the amount shown.

Applicants must reside in one of these counties to enroll: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Kern, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Plumas, San Benito, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, and Yuba.

Plan/Policy	Offered by Anthem Blue Cross**

PPO and Deductible/Coinsurance Options

METAL LEVEL BRONZE

- ☐ Anthem Bronze 60 D PPO $6,000/100% 1FZ4
- ☐ Anthem Bronze Pathway PPO $5,750/20% 1FZH
- ☐ Anthem Bronze Pathway PPO $5,000/25% 1FZ5
- ☐ Anthem Bronze Pathway PPO $6,600/20% 1FZL

METAL LEVEL SILVER

- ☐ Anthem Silver 70 D PPO $2,250/20% 1FZX
- ☐ Anthem Silver Pathway PPO $2,000/25% 1FZ9
- ☐ Anthem Silver Pathway PPO $1,750/30% 1FZB

METAL LEVEL GOLD

- ☐ Anthem Gold 80 D PPO $0/20% 1G09

METAL LEVEL PLATINUM

- ☐ Anthem Platinum 90 D PPO $0/10% 1G0F

Catastrophic Plans (only available for Applicants under age 30 or otherwise qualified)

- ☐ Anthem Minimum Coverage D $6,850/0% 1FZE

HSA Plans

METAL LEVEL BRONZE

- ☐ Anthem Bronze 60 D HSA PPO $4,500/40% 1FZQ

☐ **YES,** I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Anthem Blue Cross's banking partner. (Please fill in your social security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Anthem Blue Cross's banking partner.

****These products are issued by Anthem Blue Cross and are regulated by the California Department of Managed.**

Section F – Dental and Vision Coverage

Dental (Anthem is licensed to sell Dental plans in all California counties)

☐ **Yes, I wish to purchase additional dental coverage to supplement the pediatric Essential Health Benefits available to enrollees to the end of the month they turn age 19 which are included in the medical plans above.**

Select ONE Plan:

- ☐ * **Dental SelectHMO*** ** (1F3E)
- ☐ ** **Dental Blue Basic*** ** (1JZ5)
- ☐ ** **Dental Blue Enhanced*** ** (1JZ6)
- ☐ ** **Dental Prime Plan A*** ** (1RBD)
- ☐ ** **Dental Prime Plan B*** ** (1RBE)
- ☐ ** **Dental Prime Plan C*** ** (1RBF)

Select who you are enrolling (applies to individuals listed on this application only:

- ☐ Applicant only
- ☐ Applicant & Spouse or Domestic Partner only
- ☐ Applicant & all dependent children listed
- ☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

If you choose the Dental SelectHMO plan, you must choose a Primary Care Dentist for the family and enter the number of the Dental Office you have chosen.

Primary Care Dentist	Current Patient ☐ Yes ☐ No	Primary Care Dentist Number

***This product is issued by Anthem Blue Cross and is regulated by the California Department of Managed Health Care.**

**** These products are issued by Anthem Blue Cross Life and Health Insurance Company and are regulated by the California Department of Insurance.**

***** These plans do not include pediatric dental Essential Health Benefits that are required by the Affordable Care Act.**

Vision

Supplemental vision coverage is also available. In order to enroll in this coverage, you must enroll in at least one of the medical or dental coverage options in this application. If you have enrolled in one of the medical or dental plans and would like to add vision coverage, please select your plan option below.

☐ **Blue View Vision Individual*** ** (1RYD)

Select who you are enrolling (applies to individuals listed on this application only:

- ☐ Applicant only
- ☐ Applicant & Spouse or Domestic Partner only
- ☐ Applicant & all dependent children listed
- ☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

***** These plans do not include pediatric vision Essential Health Benefits that are required by the Affordable Care Act.**

Section G – Other Health and Dental Coverage

1) Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, who? _____

2) Do you or anyone applying for coverage, currently have health care coverage? ☐ Yes ☐ No

If **YES**, please provide the following for health coverage:

Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name and phone number of prior carrier(s)		
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	
Will you be terminating this health coverage if approved for Anthem Blue Cross coverage? ☐ Yes ☐ No		If **YES**, what is the termination date?

3) Do you or anyone applying for coverage, currently have dental coverage? ☐ Yes ☐ No

If **YES**, please provide the following for dental coverage:

Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name and phone number of prior carrier(s)		
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	
Will you be terminating this dental coverage if approved for Anthem Dental coverage? ☐ Yes ☐ No		If **YES**, what is the termination date?

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

All Applicants

I, the undersigned, understand that under the Anthem Blue Cross plan/policy in which I am enrolling, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician. Contact customer service at 1-855-383-7247 with any questions about the use of network providers and the financial impact of using out-of-network providers.

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.

· I understand that although Anthem Blue Cross requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Anthem Blue Cross, does not mean that coverage has been

approved. I may not assign any payment under my Anthem Blue Cross program. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, Anthem Blue Cross reserves the right, based upon eligibility requirements, to accept or decline this application. I understand that if my application is denied, my bank account or credit card will not be charged.

- I will notify Anthem Blue Cross of any changes that affect my eligibility or my dependents eligibility for coverage. This includes changes in address, marriage, divorce, dissolution of domestic partnership, death, or dependent status.
- I understand Anthem Blue Cross may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem Blue Cross automatic debit process and will only occur each time I send a check to Anthem Blue Cross. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem Blue Cross and myself.
- I understand I am applying for individual health and/or dental/vision coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- I understand that my domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem Blue Cross in accepting this application. Any act or practice that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).
- I certify each Social Security Number listed on this application is correct.

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem Blue Cross. I am acting as their agent and representative.

This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

Rescission of Membership

Every applicant age 18 or older acknowledges the following: I have provided true and complete answers to all questions in the application to the best of my knowledge and understand that all answers are important and will be considered in the acceptance or denial of this application. I understand that all information I know, that is responsive to a question on this application, must be provided in my answers consistent with California law.

The primary applicant additionally acknowledges the following: All of my dependents listed on this application who are 18 years of age or older have read this application and have provided complete and accurate information for this application to the best of my knowledge and have signed the application below. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about all applicants, including my children under the age of 18, listed on this application is true and complete.

I understand that if my plan/policy is rescinded, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be considered for benefits. I also understand that, consistent with California law, I will be required to pay for any services Anthem Blue Cross paid on my behalf and that Anthem Blue Cross will refund any premium paid by me, less my medical expenses that Anthem Blue Cross paid.

REQUIREMENT FOR BINDING ARBITRATION

YOU AND ANTHEM BLUE CROSS AGREE TO BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN /POLICY AND CLAIMS OF MEDICAL MALPRACTICE, 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. IT IS UNDERSTOOD THAT ANY DISPUTE INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY, INCLUDING 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, ANTHEM BLUE CROSS AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN YOUR OR ITS INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

SIGN HERE

Signature of Applicant* or Legal Representative X	Date
Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

Please check one of the following and complete the information below:

☐ I have not had any interactions whatsoever with this applicant either by phone, e-mail or in person and did not provide any information, advise or assist the applicant in any manner in providing answers or responses to any questions in the application.

☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code Section 1389.8(c)/Insurance Code Section 10119.3.

I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent/Broker Signature X			Date
Agent/Broker Name (please print) Steve Shorr		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No. 1027 W. 11th Street # 3	
Agent/Broker ID/TIN 550728914	Agency ID/Parent TIN	City San Pedro	State CA ZIP 90731
Agent/Broker Phone No. 310-519-1335	Agent/Broker Fax No.	Agent/Broker E-mail Steveshorr@cox.net	
GA (if applicable)		GA code (if applicable)	

Section J – Statement of Accountability

Primary Applicant's Name: _____

To be completed when the applicant cannot complete application.

NOTE: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I, _____ , personally read and completed this Individual Application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English ☐ Applicant is Limited English Proficient

☐ Other (explain):_____

I interpreted the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

☐ Applicant Or by:_____

I also interpreted and fully explained the "Application Understandings, Conditions and Agreement," the "Authorization for Use of Protected Health Information" and the "Payment Method."	
Signature of Interpreter *(Required)*	Today's Date *(Required)*
X	
I confirm that the application was interpreted on my behalf.	
Signature of Applicant *(Required)*	Today's Date *(Required)*
X	
Language interpreted (e.g. Spanish):	

Please mail this application to the following address:

Anthem Blue Cross

P.O. Box 9041

Oxnard, CA 93031-9041

Or

Fax to: 1 (800) 327-9255

Payment Methods for Individual Applications – California

Anthem BlueCross

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

☐ Monthly Automatic Premium Payment (complete Section A)

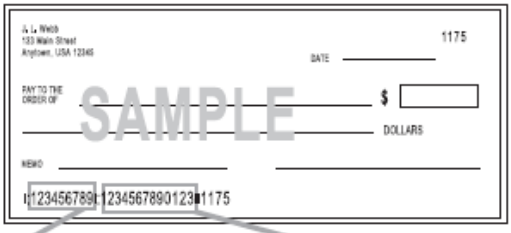
☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account

☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)



Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

As a convenience to me, I request and authorize Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") to pay and charge to my account checks drawn on that account by and made payable to the order of Anthem Blue Cross, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing Anthem a 30-day written notice. I agree that Anthem shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Anthem's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **Anthem accepts Visa ☐ and MasterCard ☐.**

Card Number:

Expiration Date:

Billing address for this Credit / Debit Card:

City:

Zip Code:

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize Anthem either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Anthem uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.

California
Individual Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Anthem Blue Cross, premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 212-1796. If you have questions about a previously submitted application, please call 1 (855) 383-7247.

Applicants must reside in one of these counties to enroll in the medical plans: Los Angeles (North), Los Angeles (South), Orange, and San Diego.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage ☐ Change plan/policy coverage Policy No._____ ☐ Add dependent(s) to current coverage Policy No._____

Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. The earliest Effective Date for the annual Open Enrollment period is the first day of the following calendar year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable premium payment.

Applications can be received during the Open Enrollment period. Outside the Open Enrollment period referenced above, the applicant may still apply for a health plan if he/she experiences a qualifying event as defined below. Following a qualifying event, an applicant has 60 days to submit an application. In the case of a future Loss of Minimum Essential Coverage or renewal of non-calendar year health plan coverage, an application may be submitted up to 60 days in advance of the qualifying event date.

No qualifying event is required to apply for new dental coverage.

For existing dental plan members, not including Dental Blue and Dental SelectHMO, dental coverage changes and/or addition of dependents may only occur at your next renewal date or if you experience a qualifying event. Following a qualifying event, an applicant has 60 days to submit an application.

Please indicate the reason you are submitting this application:

☐ Open Enrollment Period
☐ Special Enrollment Period

If Special Enrollment Period, please provide the qualifying event date, qualifying event and, if applicable, the coverage effective date:

1. **Date of the qualifying event** (which includes the date of Loss of Minimum Essential Coverage):

   _____

2. **Qualifying Event:**

   ☐ Involuntary loss of Minimum Essential Coverage (loss of minimum essential coverage includes loss of eligibility of coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment. Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause

(such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan);

☐ Gain a dependent or become a dependent through marriage, domestic partnership, or appointment of domestic partnership;

☐ Gain a dependent or become a dependent through birth, adoption or placement for adoption;

☐ Mandated to be covered as a dependent pursuant to a valid state or federal court order;

☐ Release from incarceration;

☐ Death of a family member enrolled under your current coverage;

☐ Renewal of non-calendar year health plan coverage;

☐ Health coverage issuer substantially violated material provision of health coverage contract;

☐ Access to new health benefit plans due to permanent move;

☐ Loss of services from contracting provider under another health benefit plan, as defined in Sections 10965 of the Insurance Code or 1399.845 of the Health and Safety Code, for a condition described in Health and Safety Code § 1373.96(c) (an acute condition, serious chronic condition, pregnancy, terminal illness, care of newborn between birth and 36 months of age, or performance of a surgery or other procedure that has been recommended and documented by the provider) and that provider is no longer participating in the health benefit plan;

☐ Member of the Reserve Forces of the U.S. military returning from active duty or member of the California National Guard returning from active duty under Title 32 of the U.S. Code.

☐ Other Qualifying Event:_____ (Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events please indicate below).

Comments:_____

3. Coverage Effective Date:

If you are applying due to a qualifying event and your application is processed, your coverage effective date will be based on when the application is received. If the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. If the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month. **However the following qualifying events allow for different effective dates:**

- In the case of marriage, domestic partnership, appointment of domestic partnership, or Loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application.

For the following qualifying events, select one of the effective date options as described in the chart below.

- In the case of birth, or adoption, or placement for adoption; ☐ A ☐ B ☐ C ☐ D
- In the case of a mandate to be covered as a dependent pursuant to a valid state or federal court order; ☐ A ☐ C
- In the case of death of a family member enrolled under your current coverage; ☐ B ☐ C

Effective date options

A	Coverage is effective on the date of birth, or adoption, or placement for adoption, or date of valid state or federal court order.
B	First day of the month following receipt of your application.
C	Based on when the application is received. If the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. If the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month.
D	First day of the month following the date of the qualifying event.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*(required)

Home Address**			
City	State	ZIP	County

Billing Address (street and P.O. Box if applicable)		
City	State	ZIP

Marital/Domestic Partner Status	Sex	Date of Birth
☐ Single ☐ Married ☐ Domestic Partner	☐ M ☐ F	/ /

Primary Phone Number	Secondary Phone Number	E-mail***
( )	( )	

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

*** All information will be mailed to your home address, including billing, private and confidential communications as defined by California law, unless you designate a different address under the "Billing Address" field above. This will not impact rights you may have to invoke a separate Confidential Communication under the Health Insurance and Portability and Accountability Act ("HIPAA").*

****This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner
Social Security Number* (required)	Sex ☐ M ☐ F	Date of Birth / /	

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your or your spouse's or your Domestic Partner's children, including stepchildren, newborn and adopted children and any child for whom you or your spouse or domestic partner has assumed a parent-child relationship under age twenty-six 26. (List all dependents beginning with the eldest). Children over the age of twenty-six 26 may be eligible for coverage as a dependent if they are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and chiefly dependent upon the policyholder or subscriber for support and maintenance. To qualify as an overage dependent, the Dependent's disability must start before the end of the period he or she would become ineligible for coverage.

Last Name	**First Name**	**MI**	**Sex**	**Date of Birth mm/dd/yyyy**	**Social Security Number* (required)**	**Relationship to Applicant**
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____
			M F ☐ ☐	/ /		☐ Child ☐ Other:_____

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Do you have a child age 26 or over who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition for whom coverage is being requested under this contract? ☐ Yes ☐ No

If YES, a separate Disabled Dependent Certification form must be submitted to determine eligibility.

☐ **Please send me a form.**

Are any of the applicants listed on the application currently incarcerated (except pending disposition of charges)? ☐ Yes ☐ No

If **YES**, who? _____

Preferred written language? (Optional)

☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Vietnamese (VIE) ☐ Spanish (SPN)
☐ English (ENG) ☐ Tagalog (TGL) ☐ Other (W09)

Preferred spoken language? (Optional)

☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Vietnamese (VIE) ☐ Spanish (SPN)
☐ English (ENG) ☐ Tagalog (TGL) ☐ Other (W09)

☐ Applicant **DOES** speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a "Statement of Accountability".

Section E – Medical Coverage

Select ONE Plan….then select ONE Individual Deductible/Coinsurance option.

Total Family Deductible is two (2) times the amount shown.

Applicants must reside in one of these counties to enroll: Los Angeles (North), Los Angeles (South), Orange, and San Diego.

Plan/Policy	Offered by Anthem Blue Cross**

PPO and Deductible/Coinsurance Options

METAL LEVEL BRONZE

- ☐ Anthem Bronze 60 D PPO (a Tiered PPO Plan) $6,000/100% 1X5E
- ☐ Anthem Bronze Pathway PPO (a Tiered PPO Plan) $5,750/20% 1X5J
- ☐ Anthem Bronze Pathway PPO (a Tiered PPO Plan) $5,000/25% 1X5H
- ☐ Anthem Bronze Pathway PPO (a Tiered PPO Plan) $6,600/20% 1X5K

METAL LEVEL SILVER

- ☐ Anthem Silver 70 D PPO (a Tiered PPO Plan) $2,250/20% 1X5S
- ☐ Anthem Silver Pathway PPO (a Tiered PPO Plan) $2,000/25% 1X5X
- ☐ Anthem Silver Pathway PPO (a Tiered PPO Plan) $1,750/30% 1X5Y

METAL LEVEL GOLD

- ☐ Anthem Gold 80 D PPO (a Tiered PPO Plan) $0/20% 1X5L

METAL LEVEL PLATINUM

- ☐ Anthem Platinum 90 D PPO (a Tiered PPO Plan) $0/10% 1X5Q

HMO [For zip code exclusions, please see the attached "Zip code exclusions for HMO plans."]

METAL LEVEL SILVER

- ☐ Anthem Silver 70 D HMO $2,250/20% 1G02

METAL LEVEL GOLD

- ☐ Anthem Gold 80 D HMO $0/20% 1G0B

METAL LEVEL PLATINUM

- ☐ Anthem Platinum 90 D HMO $0/10% 1G0H

Catastrophic Plans (only available for Applicants under age 30 or otherwise qualified)

- ☐ Anthem Minimum Coverage D $6,850/0% 1X5N

HSA Plans

METAL LEVEL BRONZE

- ☐ Anthem Bronze 60 D HSA PPO (a Tiered PPO Plan) $4,500/40% 1X5D

☐ **YES,** I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Anthem Blue Cross's banking partner. (Please fill in your social security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Anthem Blue Cross's banking partner.

****These products are issued by Anthem Blue Cross and are regulated by the California Department of Managed.**

If you select an HMO plan, please choose a Primary Care Physician for each family member from the Provider Directory, which can be found at www.anthem.com, or by calling 1 (866) 297-7647. If you do not choose a PCP, then one will be selected for you.

Applicant	Primary Care Physician (PCP)	PCP ID	Current Patient	PMG/IPA ID*
Primary Applicant			☐ Yes ☐ No	
Spouse/ Domestic Partner			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	

**PMG = Participating Medical Group, IPA = Independent Practice Association*

☐ Please check box if any additional sheets of paper have been completed for this section. If so, please attach and return the additional sheets with this application.

Section F – Dental and Vision Coverage

Dental (Anthem is licensed to sell Dental plans in all California counties)

☐ **Yes, I wish to purchase additional dental coverage to supplement the pediatric Essential Health Benefits available to enrollees to the end of the month they turn age 19 which are included in the medical plans above.**

Select ONE Plan:

- ☐ * **Dental SelectHMO***** (1F3E)
- ☐ ** **Dental Blue Basic***** (1JZ5)
- ☐ ** **Dental Blue Enhanced***** (1JZ6)
- ☐ ** **Dental Prime Plan A***** (1RBD)
- ☐ ** **Dental Prime Plan B***** (1RBE)
- ☐ ** **Dental Prime Plan C***** (1RBF)

Select who you are enrolling (applies to individuals listed on this application only:

- ☐ Applicant only
- ☐ Applicant & Spouse or Domestic Partner only
- ☐ Applicant & all dependent children listed
- ☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

If you choose the Dental SelectHMO plan, you must choose a Primary Care Dentist for the family and enter the number of the Dental Office you have chosen.

Primary Care Dentist	Current Patient ☐ Yes ☐ No	Primary Care Dentist Number

***This product is issued by Anthem Blue Cross and is regulated by the California Department of Managed Health Care.**

**** These products are issued by Anthem Blue Cross Life and Health Insurance Company and are regulated by the California Department of Insurance.**

***** These plans do not include pediatric dental Essential Health Benefits that are required by the Affordable Care Act.**

Vision

Supplemental vision coverage is also available. In order to enroll in this coverage, you must enroll in at least one of the medical or dental coverage options in this application. If you have enrolled in one of the medical or dental plans and would like to add vision coverage, please select your plan option below.

☐ **Blue View Vision Individual*** ** (1RYD)

Select who you are enrolling (applies to individuals listed on this application only:

☐ Applicant only
☐ Applicant & Spouse or Domestic Partner only
☐ Applicant & all dependent children listed
☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

***** These plans do not include pediatric vision Essential Health Benefits that are required by the Affordable Care Act.**

Section G – Other Health and Dental Coverage

1) Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, who? _____

2) Do you or anyone applying for coverage, currently have health care coverage? ☐ Yes ☐ No

If **YES**, please provide the following for health coverage:

Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name and phone number of prior carrier(s)		
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	
Will you be terminating this health coverage if approved for Anthem Blue Cross coverage? ☐ Yes ☐ No		If **YES**, what is the termination date?

3) Do you or anyone applying for coverage, currently have dental coverage? ☐ Yes ☐ No

If **YES**, please provide the following for dental coverage:

Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name and phone number of prior carrier(s)		
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	
Will you be terminating this dental coverage if approved for Anthem Dental coverage? ☐ Yes ☐ No		If **YES**, what is the termination date?

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

All Applicants

I, the undersigned, understand that under the Anthem Blue Cross plan/policy in which I am enrolling, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician. Contact customer service at 1-855-383-7247 with any questions about the use of network providers and the financial impact of using out-of-network providers.

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.

· I understand that although Anthem Blue Cross requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Anthem Blue Cross, does not mean that coverage has been

approved. I may not assign any payment under my Anthem Blue Cross program. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, Anthem Blue Cross reserves the right, based upon eligibility requirements, to accept or decline this application. I understand that if my application is denied, my bank account or credit card will not be charged.

- I will notify Anthem Blue Cross of any changes that affect my eligibility or my dependents eligibility for coverage. This includes changes in address, marriage, divorce, dissolution of domestic partnership, death, or dependent status.
- I understand Anthem Blue Cross may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem Blue Cross automatic debit process and will only occur each time I send a check to Anthem Blue Cross. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem Blue Cross and myself.
- I understand I am applying for individual health and/or dental/vision coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- I understand that my domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem Blue Cross in accepting this application. Any act or practice that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).
- I certify each Social Security Number listed on this application is correct.

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem Blue Cross. I am acting as their agent and representative.

This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

Rescission of Membership

Every applicant age 18 or older acknowledges the following: I have provided true and complete answers to all questions in the application to the best of my knowledge and understand that all answers are important and will be considered in the acceptance or denial of this application. I understand that all information I know, that is responsive to a question on this application, must be provided in my answers consistent with California law.

The primary applicant additionally acknowledges the following: All of my dependents listed on this application who are 18 years of age or older have read this application and have provided complete and accurate information for this application to the best of my knowledge and have signed the application below. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about all applicants, including my children under the age of 18, listed on this application is true and complete.

I understand that if my plan/policy is rescinded, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be considered for benefits. I also understand that, consistent with California law, I will be required to pay for any services Anthem Blue Cross paid on my behalf and that Anthem Blue Cross will refund any premium paid by me, less my medical expenses that Anthem Blue Cross paid.

REQUIREMENT FOR BINDING ARBITRATION

YOU AND ANTHEM BLUE CROSS AGREE TO BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN /POLICY AND CLAIMS OF MEDICAL MALPRACTICE, 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. IT IS UNDERSTOOD THAT ANY DISPUTE INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY, INCLUDING 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, ANTHEM BLUE CROSS AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN YOUR OR ITS INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

SIGN HERE

Signature of Applicant* or Legal Representative X	Date
Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

Please check one of the following and complete the information below:

☐ I have not had any interactions whatsoever with this applicant either by phone, e-mail or in person and did not provide any information, advise or assist the applicant in any manner in providing answers or responses to any questions in the application.

☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code Section 1389.8(c)/Insurance Code Section 10119.3.

I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent/Broker Signature X			Date
Agent/Broker Name (please print) Steve Shorr		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No. 1027 W. 11th Street # 3	
Agent/Broker ID/TIN 550728914	Agency ID/Parent TIN	City San Pedro	State CA ZIP 90731
Agent/Broker Phone No. 310-519-1335	Agent/Broker Fax No.	Agent/Broker E-mail Steveshorr@cox.net	
GA (if applicable)		GA code (if applicable)	

Section J – Statement of Accountability

Primary Applicant's Name: _____

To be completed when the applicant cannot complete application.

NOTE: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I, _____ , personally read and completed this Individual Application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English ☐ Applicant is Limited English Proficient

☐ Other (explain):_____

I interpreted the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

☐ Applicant Or by:_____

I also interpreted and fully explained the "Application Understandings, Conditions and Agreement," the "Authorization for Use of Protected Health Information" and the "Payment Method."	
Signature of Interpreter *(Required)*	Today's Date *(Required)*
X	
I confirm that the application was interpreted on my behalf.	
Signature of Applicant *(Required)*	Today's Date *(Required)*
X	
Language interpreted (e.g. Spanish):	

Payment Methods for Individual Applications – California

Anthem BlueCross

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

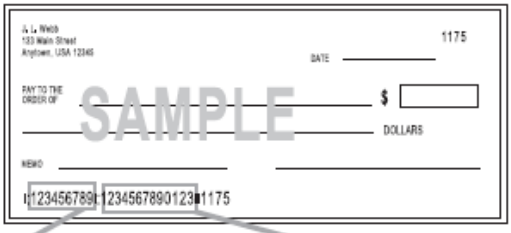
☐ Monthly Automatic Premium Payment (complete Section A)

☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account
☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)



Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") to pay and charge to my account checks drawn on that account by and made payable to the order of Anthem Blue Cross, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing Anthem a 30-day written notice. I agree that Anthem shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Anthem's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **Anthem accepts Visa ☐ and MasterCard☐.**

Card Number:

Expiration Date:

Billing address for this Credit / Debit Card:

City:

Zip Code:

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize Anthem either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Anthem uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.

ZIP code exclusions for HMO plans

Areas served: Pathway X and Pathway networks

County	Exclusions
Los Angeles	**HMO not offered in these ZIP codes:** 90313, 90397, 90398, 90612, 90623, 90630, 90631, 90659, 90704, 90822, 90845, 90888, 91131, 91191, 91310, 91354, 91363, 91383, 91384, 91390, 91399, 91497, 91709, 91797, 91799, 91841, 93243, 93532, 93544
Orange	No excluded ZIP codes in Pricing Region 18 for HMO
San Diego	**HMO not offered in these ZIP codes:** 91905, 91906, 91916, 91934, 91948, 91962, 91963, 91980, 91987, 91990, 92004, 92066, 92070, 92086, 92090, 92133, 92194

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California
Individual Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Anthem Blue Cross, premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 212-1796. If you have questions about a previously submitted application, please call 1 (855) 383-7247.

Applicants must reside in one of these counties to enroll in the medical plans: Fresno, Kings, Madera, Sacramento, Placer, El Dorado, Riverside, San Bernardino, Santa Clara, and Yolo.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage ☐ Change plan/policy coverage Policy No._____ ☐ Add dependent(s) to current coverage Policy No._____

Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. The earliest Effective Date for the annual Open Enrollment period is the first day of the following calendar year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable premium payment.

Applications can be received during the Open Enrollment period. Outside the Open Enrollment period referenced above, the applicant may still apply for a health plan if he/she experiences a qualifying event as defined below. Following a qualifying event, an applicant has 60 days to submit an application. In the case of a future Loss of Minimum Essential Coverage or renewal of non-calendar year health plan coverage, an application may be submitted up to 60 days in advance of the qualifying event date.

No qualifying event is required to apply for new dental coverage.

For existing dental plan members, not including Dental Blue and Dental SelectHMO, dental coverage changes and/or addition of dependents may only occur at your next renewal date or if you experience a qualifying event. Following a qualifying event, an applicant has 60 days to submit an application.

Please indicate the reason you are submitting this application:

☐ Open Enrollment Period
☐ Special Enrollment Period

If Special Enrollment Period, please provide the qualifying event date, qualifying event and, if applicable, the coverage effective date:

1. **Date of the qualifying event** (which includes the date of Loss of Minimum Essential Coverage):

   _____

2. **Qualifying Event:**

   ☐ Involuntary loss of Minimum Essential Coverage (loss of minimum essential coverage includes loss of eligibility of coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment. Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause

(such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan);

☐ Gain a dependent or become a dependent through marriage, domestic partnership, or appointment of domestic partnership;

☐ Gain a dependent or become a dependent through birth, adoption or placement for adoption;

☐ Mandated to be covered as a dependent pursuant to a valid state or federal court order;

☐ Release from incarceration;

☐ Death of a family member enrolled under your current coverage;

☐ Renewal of non-calendar year health plan coverage;

☐ Health coverage issuer substantially violated material provision of health coverage contract;

☐ Access to new health benefit plans due to permanent move;

☐ Loss of services from contracting provider under another health benefit plan, as defined in Sections 10965 of the Insurance Code or 1399.845 of the Health and Safety Code, for a condition described in Health and Safety Code § 1373.96(c) (an acute condition, serious chronic condition, pregnancy, terminal illness, care of newborn between birth and 36 months of age, or performance of a surgery or other procedure that has been recommended and documented by the provider) and that provider is no longer participating in the health benefit plan;

☐ Member of the Reserve Forces of the U.S. military returning from active duty or member of the California National Guard returning from active duty under Title 32 of the U.S. Code.

☐ Other Qualifying Event:_____ (Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events please indicate below).

Comments:_____

3. Coverage Effective Date:

If you are applying due to a qualifying event and your application is processed, your coverage effective date will be based on when the application is received. If the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. If the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month. **However the following qualifying events allow for different effective dates:**

- In the case of marriage, domestic partnership, appointment of domestic partnership, or Loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application.

For the following qualifying events, select one of the effective date options as described in the chart below.

- In the case of birth, or adoption, or placement for adoption; ☐A ☐B ☐C ☐D
- In the case of a mandate to be covered as a dependent pursuant to a valid state or federal court order; ☐A ☐C
- In the case of death of a family member enrolled under your current coverage; ☐B ☐C

Effective date options

A	Coverage is effective on the date of birth, or adoption, or placement for adoption, or date of valid state or federal court order.
B	First day of the month following receipt of your application.
C	Based on when the application is received. If the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. If the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month.
D	First day of the month following the date of the qualifying event.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*(required)

Home Address**			
City	State	ZIP	County

Billing Address (street and P.O. Box if applicable)		
City	State	ZIP

Marital/Domestic Partner Status	Sex	Date of Birth
☐ Single ☐ Married ☐ Domestic Partner	☐ M ☐ F	/ /

Primary Phone Number	Secondary Phone Number	E-mail***
( )	( )	

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

*** All information will be mailed to your home address, including billing, private and confidential communications as defined by California law, unless you designate a different address under the "Billing Address" field above. This will not impact rights you may have to invoke a separate Confidential Communication under the Health Insurance and Portability and Accountability Act ("HIPAA").*

****This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner
Social Security Number* (required)	Sex ☐ M ☐ F	Date of Birth / /	

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your or your spouse's or your Domestic Partner's children, including stepchildren, newborn and adopted children and any child for whom you or your spouse or domestic partner has assumed a parent-child relationship under age twenty-six 26. (List all dependents beginning with the eldest). Children over the age of twenty-six 26 may be eligible for coverage as a dependent if they are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and chiefly dependent upon the policyholder or subscriber for support and maintenance. To qualify as an overage dependent, the Dependent's disability must start before the end of the period he or she would become ineligible for coverage.

Last Name	**First Name**	**MI**	**Sex**	**Date of Birth mm/dd/yyyy**	**Social Security Number* (required)**	**Relationship to Applicant**
			M ☐ F ☐	/ /		☐ Child ☐ Other:_____
			M ☐ F ☐	/ /		☐ Child ☐ Other:_____
			M ☐ F ☐	/ /		☐ Child ☐ Other:_____
			M ☐ F ☐	/ /		☐ Child ☐ Other:_____
			M ☐ F ☐	/ /		☐ Child ☐ Other:_____

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Do you have a child age 26 or over who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition for whom coverage is being requested under this contract? ☐ Yes ☐ No

If YES, a separate Disabled Dependent Certification form must be submitted to determine eligibility.

☐ **Please send me a form.**

Are any of the applicants listed on the application currently incarcerated (except pending disposition of charges)? ☐ Yes ☐ No

If **YES**, who? _____

Preferred written language? (Optional)
☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Vietnamese (VIE) ☐ Spanish (SPN)
☐ English (ENG) ☐ Tagalog (TGL) ☐ Other (W09)

Preferred spoken language? (Optional)
☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Vietnamese (VIE) ☐ Spanish (SPN)
☐ English (ENG) ☐ Tagalog (TGL) ☐ Other (W09)

☐ Applicant **DOES** speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a "Statement of Accountability".

Section E – Medical Coverage

Select ONE Plan...then select ONE Individual Deductible/Coinsurance option.

Total Family Deductible is two (2) times the amount shown.

Applicants must reside in one of these counties to enroll: Fresno, Kings, Madera, Sacramento, Placer, El Dorado, Riverside, San Bernardino, Santa Clara, and Yolo.

Plan/Policy	Offered by Anthem Blue Cross**

PPO and Deductible/Coinsurance Options

METAL LEVEL BRONZE

- ☐ Anthem Bronze 60 D PPO $6,000/100% 1FZ4
- ☐ Anthem Bronze Pathway PPO $5,750/20% 1FZH
- ☐ Anthem Bronze Pathway PPO $5,000/25% 1FZ5
- ☐ Anthem Bronze Pathway PPO $6,600/20% 1FZL

METAL LEVEL SILVER

- ☐ Anthem Silver 70 D PPO $2,250/20% 1FZX
- ☐ Anthem Silver Pathway PPO $2,000/25% 1FZ9
- ☐ Anthem Silver Pathway PPO $1,750/30% 1FZB

METAL LEVEL GOLD

- ☐ Anthem Gold 80 D PPO $0/20% 1G09

METAL LEVEL PLATINUM

- ☐ Anthem Platinum 90 D PPO $0/10% 1G0F

HMO [For zip code exclusions, please see the attached "Zip code exclusions for HMO plans."]

METAL LEVEL SILVER

- ☐ Anthem Silver 70 D HMO $2,250/20% 1G02

METAL LEVEL GOLD

- ☐ Anthem Gold 80 D HMO $0/20% 1G0B

METAL LEVEL PLATINUM

- ☐ Anthem Platinum 90 D HMO $0/10% 1G0H

Catastrophic Plans (only available for Applicants under age 30 or otherwise qualified)

- ☐ Anthem Minimum Coverage D $6,850/0% 1FZE

HSA Plans

METAL LEVEL BRONZE

- ☐ Anthem Bronze 60 D HSA PPO $4,500/40% 1FZQ

☐ **YES,** I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Anthem Blue Cross's banking partner. (Please fill in your social security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Anthem Blue Cross's banking partner.

****These products are issued by Anthem Blue Cross and are regulated by the California Department of Managed.**

If you select an HMO plan, please choose a Primary Care Physician for each family member from the Provider Directory, which can be found at www.anthem.com, or by calling 1 (866) 297-7647. If you do not choose a PCP, then one will be selected for you.

Applicant	Primary Care Physician (PCP)	PCP ID	Current Patient	PMG/IPA ID*
Primary Applicant			☐ Yes ☐ No	
Spouse/ Domestic Partner			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	
Dependent Name:			☐ Yes ☐ No	

**PMG = Participating Medical Group, IPA = Independent Practice Association*

☐ Please check box if any additional sheets of paper have been completed for this section. If so, please attach and return the additional sheets with this application.

Section F – Dental and Vision Coverage

Dental (Anthem is licensed to sell Dental plans in all California counties)

☐ **Yes, I wish to purchase additional dental coverage to supplement the pediatric Essential Health Benefits available to enrollees to the end of the month they turn age 19 which are included in the medical plans above.**

Select ONE Plan:

- ☐ * **Dental SelectHMO***** (1F3E)
- ☐ ** **Dental Blue Basic***** (1JZ5)
- ☐ ** **Dental Blue Enhanced***** (1JZ6)
- ☐ ** **Dental Prime Plan A***** (1RBD)
- ☐ ** **Dental Prime Plan B***** (1RBE)
- ☐ ** **Dental Prime Plan C***** (1RBF)

Select who you are enrolling (applies to individuals listed on this application only:

- ☐ Applicant only
- ☐ Applicant & Spouse or Domestic Partner only
- ☐ Applicant & all dependent children listed
- ☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

If you choose the Dental SelectHMO plan, you must choose a Primary Care Dentist for the family and enter the number of the Dental Office you have chosen.

Primary Care Dentist	Current Patient ☐ Yes ☐ No	Primary Care Dentist Number

***This product is issued by Anthem Blue Cross and is regulated by the California Department of Managed Health Care.**

**** These products are issued by Anthem Blue Cross Life and Health Insurance Company and are regulated by the California Department of Insurance.**

***** These plans do not include pediatric dental Essential Health Benefits that are required by the Affordable Care Act.**

Vision

Supplemental vision coverage is also available. In order to enroll in this coverage, you must enroll in at least one of the medical or dental coverage options in this application. If you have enrolled in one of the medical or dental plans and would like to add vision coverage, please select your plan option below.

☐ **Blue View Vision Individual***** (1RYD)

Select who you are enrolling (applies to individuals listed on this application only:

☐ Applicant only
☐ Applicant & Spouse or Domestic Partner only
☐ Applicant & all dependent children listed
☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

***** These plans do not include pediatric vision Essential Health Benefits that are required by the Affordable Care Act.**

Section G – Other Health and Dental Coverage

1) Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, who? _____

2) Do you or anyone applying for coverage, currently have health care coverage? ☐ Yes ☐ No

If **YES**, please provide the following for health coverage:

Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name and phone number of prior carrier(s)		
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	
Will you be terminating this health coverage if approved for Anthem Blue Cross coverage? ☐ Yes ☐ No		If **YES**, what is the termination date?

3) Do you or anyone applying for coverage, currently have dental coverage? ☐ Yes ☐ No

If **YES**, please provide the following for dental coverage:

Name(s) of covered persons. If the whole family, simply write ALL in space below.		Identification Number(s)
Name and phone number of prior carrier(s)		
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage	
Will you be terminating this dental coverage if approved for Anthem Dental coverage? ☐ Yes ☐ No		If **YES**, what is the termination date?

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

All Applicants

I, the undersigned, understand that under the Anthem Blue Cross plan/policy in which I am enrolling, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician. Contact customer service at 1-855-383-7247 with any questions about the use of network providers and the financial impact of using out-of-network providers.

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.

· I understand that although Anthem Blue Cross requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Anthem Blue Cross, does not mean that coverage has been

approved. I may not assign any payment under my Anthem Blue Cross program. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, Anthem Blue Cross reserves the right, based upon eligibility requirements, to accept or decline this application. I understand that if my application is denied, my bank account or credit card will not be charged.

- I will notify Anthem Blue Cross of any changes that affect my eligibility or my dependents eligibility for coverage. This includes changes in address, marriage, divorce, dissolution of domestic partnership, death, or dependent status.
- I understand Anthem Blue Cross may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem Blue Cross automatic debit process and will only occur each time I send a check to Anthem Blue Cross. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem Blue Cross and myself.
- I understand I am applying for individual health and/or dental/vision coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- I understand that my domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem Blue Cross in accepting this application. Any act or practice that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).
- I certify each Social Security Number listed on this application is correct.

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem Blue Cross. I am acting as their agent and representative.

This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

Rescission of Membership

Every applicant age 18 or older acknowledges the following: I have provided true and complete answers to all questions in the application to the best of my knowledge and understand that all answers are important and will be considered in the acceptance or denial of this application. I understand that all information I know, that is responsive to a question on this application, must be provided in my answers consistent with California law.

The primary applicant additionally acknowledges the following: All of my dependents listed on this application who are 18 years of age or older have read this application and have provided complete and accurate information for this application to the best of my knowledge and have signed the application below. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about all applicants, including my children under the age of 18, listed on this application is true and complete.

I understand that if my plan/policy is rescinded, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be considered for benefits. I also understand that, consistent with California law, I will be required to pay for any services Anthem Blue Cross paid on my behalf and that Anthem Blue Cross will refund any premium paid by me, less my medical expenses that Anthem Blue Cross paid.

REQUIREMENT FOR BINDING ARBITRATION

YOU AND ANTHEM BLUE CROSS AGREE TO BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN /POLICY AND CLAIMS OF MEDICAL MALPRACTICE, 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. IT IS UNDERSTOOD THAT ANY DISPUTE INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY, INCLUDING 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, ANTHEM BLUE CROSS AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN YOUR OR ITS INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

SIGN HERE

Signature of Applicant* or Legal Representative X	Date
Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

Please check one of the following and complete the information below:

☐ I have not had any interactions whatsoever with this applicant either by phone, e-mail or in person and did not provide any information, advise or assist the applicant in any manner in providing answers or responses to any questions in the application.

☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code Section 1389.8(c)/Insurance Code Section 10119.3.

I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent/Broker Signature X			Date
Agent/Broker Name (please print) Steve Shorr		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No. 1027 W. 11th Street # 3	
Agent/Broker ID/TIN 550728914	Agency ID/Parent TIN	City San Pedro	State CA / ZIP 90731
Agent/Broker Phone No. 310-519-1335	Agent/Broker Fax No.	Agent/Broker E-mail Steveshorr@cox.net	
GA (if applicable)		GA code (if applicable)	

Section J – Statement of Accountability

Primary Applicant's Name: _____

To be completed when the applicant cannot complete application.

NOTE: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I, _____ , personally read and completed this Individual Application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English ☐ Applicant is Limited English Proficient

☐ Other (explain):_____

I interpreted the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

☐ Applicant Or by:_____

I also interpreted and fully explained the "Application Understandings, Conditions and Agreement," the "Authorization for Use of Protected Health Information" and the "Payment Method."	
Signature of Interpreter *(Required)*	Today's Date *(Required)*
X	
I confirm that the application was interpreted on my behalf.	
Signature of Applicant *(Required)*	Today's Date *(Required)*
X	
Language interpreted (e.g. Spanish):	

Please mail this application to the following address:

Anthem Blue Cross

P.O. Box 9041

Oxnard, CA 93031-9041

Or

Fax to: 1 (800) 327-9255

Payment Methods for Individual Applications – California

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

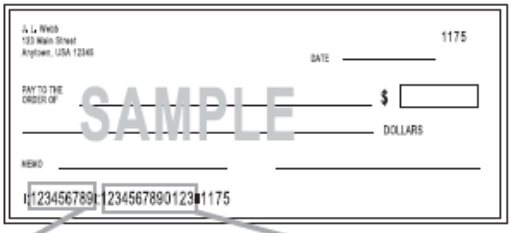
☐ Monthly Automatic Premium Payment (complete Section A)

☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account
☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)



Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") to pay and charge to my account checks drawn on that account by and made payable to the order of Anthem Blue Cross, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing Anthem a 30-day written notice. I agree that Anthem shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Anthem's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **Anthem accepts Visa ☐ and MasterCard ☐.**

Card Number:

Expiration Date:

Billing address for this Credit / Debit Card:

City:

Zip Code:

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize Anthem either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Anthem uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.

Anthem BlueCross

ZIP code exclusions for HMO plans

Areas served: Pathway X and Pathway networks

County	Exclusions
El Dorado, Placer, Sacramento, Yolo	**HMO not offered in these ZIP codes:** **El Dorado:** 95613, 95619, 95623, 95633, 95636, 95656, 95667, 95684, 95709, 95720, 95721, 95726, 95735, 96142, 96150, 96151, 96152, 96154, 96155, 96156, 96157, 96158 **Placer:** 95701, 95714, 95715, 95717, 96140, 96141, 96143, 96145, 96146, 96148 **Sacramento:** 95641 **Yolo:** 95606, 95607, 95627, 95637, 95645, 95679, 95698, 95937
Santa Clara	**HMO not offered in these ZIP codes:** 95020, 95021, 95038, 95046
Fresno, Kings, Madera	No excluded ZIP codes in pricing region 11 for HMO
Riverside, San Bernardino	**HMO not offered in these ZIP codes:** **Riverside:** 91720, 92201, 92202, 92203, 92210, 92211, 92225, 92226, 92234, 92235, 92236, 92239, 92240, 92241, 92247, 92248, 92253, 92254, 92255, 92258, 92260, 92261, 92262, 92263, 92264, 92270, 92274, 92276, 92282, 92292, 92330, 92343, 92561 **San Bernardino:** 91798, 92242, 92252, 92256, 92267, 92268, 92277, 92278, 92280, 92284, 92285, 92286, 92301, 92304, 92309, 92310, 92314, 92315, 92323, 92332, 92333, 92338, 92342, 92347, 92356, 92363, 92364, 92365, 92366, 92386, 92414, 92424, 93555, 93558, 93562, 93592

52373CAMENABC Rev. 9/15

California
Individual Enrollment Application

IMPORTANT: If you are a new applicant, a separate premium payment is required to be submitted with each application. If you are a current Individual policyholder with Anthem Blue Cross, premium payment is required before the requested effective date. Please complete the Payment Method for Individual Applications Form and send it with your completed enrollment application. If premium is not provided as described above we will not process your application. If you have any questions while completing this application, please contact your insurance agent/broker directly. If you have not worked with an insurance agent/broker, please call 1 (877) 212-1796. If you have questions about a previously submitted application, please call 1 (855) 383-7247.

Applicants must reside in San Francisco to enroll in the medical plans.

Please complete in blue or black ink only.

Section A – Coverage Information

Application Type (select one):

☐ New Coverage ☐ Change plan/policy coverage Policy No._____ ☐ Add dependent(s) to current coverage Policy No._____

Open Enrollment

During the annual Open Enrollment period, you may apply for coverage, or members can change plans. The earliest Effective Date for the annual Open Enrollment period is the first day of the following calendar year. The actual Effective Date is determined by the date Anthem receives a complete application with the applicable premium payment.

Applications can be received during the Open Enrollment period. Outside the Open Enrollment period referenced above, the applicant may still apply for a health plan if he/she experiences a qualifying event as defined below. Following a qualifying event, an applicant has 60 days to submit an application. In the case of a future Loss of Minimum Essential Coverage or renewal of non-calendar year health plan coverage, an application may be submitted up to 60 days in advance of the qualifying event date.

No qualifying event is required to apply for new dental coverage.

For existing dental plan members, not including Dental Blue and Dental SelectHMO, dental coverage changes and/or addition of dependents may only occur at your next renewal date or if you experience a qualifying event. Following a qualifying event, an applicant has 60 days to submit an application.

Please indicate the reason you are submitting this application:

☐ Open Enrollment Period
☐ Special Enrollment Period

If Special Enrollment Period, please provide the qualifying event date, qualifying event and, if applicable, the coverage effective date:

1. **Date of the qualifying event** (which includes the date of Loss of Minimum Essential Coverage):

   _____

2. **Qualifying Event:**

   ☐ Involuntary loss of Minimum Essential Coverage (loss of minimum essential coverage includes loss of eligibility of coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment. Loss of eligibility does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan);

☐ Gain a dependent or become a dependent through marriage, domestic partnership, or appointment of domestic partnership;

☐ Gain a dependent or become a dependent through birth, adoption or placement for adoption;

☐ Mandated to be covered as a dependent pursuant to a valid state or federal court order;

☐ Release from incarceration;

☐ Death of a family member enrolled under your current coverage;

☐ Renewal of non-calendar year health plan coverage;

☐ Health coverage issuer substantially violated material provision of health coverage contract;

☐ Access to new health benefit plans due to permanent move;

☐ Loss of services from contracting provider under another health benefit plan, as defined in Sections 10965 of the Insurance Code or 1399.845 of the Health and Safety Code, for a condition described in Health and Safety Code § 1373.96(c) (an acute condition, serious chronic condition, pregnancy, terminal illness, care of newborn between birth and 36 months of age, or performance of a surgery or other procedure that has been recommended and documented by the provider) and that provider is no longer participating in the health benefit plan;

☐ Member of the Reserve Forces of the U.S. military returning from active duty or member of the California National Guard returning from active duty under Title 32 of the U.S. Code.

☐ Other Qualifying Event:_____ (Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events please indicate below).

Comments:_____

3. Coverage Effective Date:

If you are applying due to a qualifying event and your application is processed, your coverage effective date will be based on when the application is received. If the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. If the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month. **However the following qualifying events allow for different effective dates:**

- In the case of marriage, domestic partnership, appointment of domestic partnership, or Loss of Minimum Essential Coverage, coverage is effective on the first day of the month following receipt of your application.

For the following qualifying events, select one of the effective date options as described in the chart below.

- In the case of birth, or adoption, or placement for adoption; ☐ A ☐ B ☐ C ☐ D
- In the case of a mandate to be covered as a dependent pursuant to a valid state or federal court order; ☐ A ☐ C
- In the case of death of a family member enrolled under your current coverage; ☐ B ☐ C

Effective date options

A	Coverage is effective on the date of birth, or adoption, or placement for adoption, or date of valid state or federal court order.
B	First day of the month following receipt of your application.
C	Based on when the application is received. If the application is received between the first day and the fifteenth day of the month, coverage shall become effective the first day of the following month. If the application is received between the sixteenth day and last day of the month, coverage shall become effective the first day of the second following month.
D	First day of the month following the date of the qualifying event.

Section B – Applicant Information

Last Name	First Name	MI	Social Security Number*(required)

Home Address**			
City	State	ZIP	County

Billing Address (street and P.O. Box if applicable)		
City	State	ZIP

Marital/Domestic Partner Status	Sex	Date of Birth
☐ Single ☐ Married ☐ Domestic Partner	☐ M ☐ F	/ /

Primary Phone Number	Secondary Phone Number	E-mail***
( )	( )	

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

*** All information will be mailed to your home address, including billing, private and confidential communications as defined by California law, unless you designate a different address under the "Billing Address" field above. This will not impact rights you may have to invoke a separate Confidential Communication under the Health Insurance and Portability and Accountability Act ("HIPAA").*

****This information is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Section C – Spouse or Domestic Partner to be Covered Information

Last Name	First Name	MI	Relationship ☐ Spouse ☐ Domestic Partner
Social Security Number* (required)	Sex ☐ M ☐ F	Date of Birth / /	

Section D – Child Dependents to be Covered Information (All fields required. Attach a separate sheet if necessary).

Dependent information must be completed for all additional child dependents (if any) to be covered under this coverage. An eligible dependent may be your or your spouse's or your Domestic Partner's children, including stepchildren, newborn and adopted children and any child for whom you or your spouse or domestic partner has assumed a parent-child relationship under age twenty-six 26. (List all dependents beginning with the eldest). Children over the age of twenty-six 26 may be eligible for coverage as a dependent if they are incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and chiefly dependent upon the policyholder or subscriber for support and maintenance. To qualify as an overage dependent, the Dependent's disability must start before the end of the period he or she would become ineligible for coverage.

Last Name	**First Name**	**MI**	**Sex**	**Date of Birth mm/dd/yyyy**	**Social Security Number* (required)**	**Relationship to Applicant**
			M ☐ F ☐	/ /		☐ Child ☐ Other:_____
			M ☐ F ☐	/ /		☐ Child ☐ Other:_____
			M ☐ F ☐	/ /		☐ Child ☐ Other:_____
			M ☐ F ☐	/ /		☐ Child ☐ Other:_____
			M ☐ F ☐	/ /		☐ Child ☐ Other:_____

**Anthem is required by the IRS to collect this information. It is used for internal purposes only and will not be disclosed unless you select the health savings account option in this Application or to federal and state agencies as required by applicable law.*

Do you have a child age 26 or over who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition for whom coverage is being requested under this contract? ☐ Yes ☐ No

If YES, a separate Disabled Dependent Certification form must be submitted to determine eligibility.

☐ **Please send me a form.**

Are any of the applicants listed on the application currently incarcerated (except pending disposition of charges)? ☐ Yes ☐ No

If **YES**, who? _____

Preferred written language? (Optional)
☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Vietnamese (VIE) ☐ Spanish (SPN)
☐ English (ENG) ☐ Tagalog (TGL) ☐ Other (W09)

Preferred spoken language? (Optional)
☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Vietnamese (VIE) ☐ Spanish (SPN)
☐ English (ENG) ☐ Tagalog (TGL) ☐ Other (W09)

☐ Applicant **DOES** speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a "Statement of Accountability".

Section E – Medical Coverage

Select ONE Plan….then select ONE Individual Deductible/Coinsurance Option.

Total Family Deductible is two (2) times the amount shown.

Applicants must reside in San Francisco to enroll.

Plan/Policy	Offered by Anthem Blue Cross**

PPO and Deductible/Coinsurance Options

METAL LEVEL BRONZE

- ☐ Anthem Bronze 60 D PPO (a Tiered PPO Plan) $6,000/100% 1X5E
- ☐ Anthem Bronze Pathway PPO (a Tiered PPO Plan) $5,750/20% 1X5J
- ☐ Anthem Bronze Pathway PPO (a Tiered PPO Plan) $5,000/25% 1X5H
- ☐ Anthem Bronze Pathway PPO (a Tiered PPO Plan) $6,600/20% 1X5K

METAL LEVEL SILVER

- ☐ Anthem Silver 70 D PPO (a Tiered PPO Plan) $2,250/20% 1X5S
- ☐ Anthem Silver Pathway PPO (a Tiered PPO Plan) $2,000/25% 1X5X
- ☐ Anthem Silver Pathway PPO (a Tiered PPO Plan) $1,750/30% 1X5Y

METAL LEVEL GOLD

- ☐ Anthem Gold 80 D PPO (a Tiered PPO Plan) $0/20% 1X5L

METAL LEVEL PLATINUM

- ☐ Anthem Platinum 90 D PPO (a Tiered PPO Plan) $0/10% 1X5Q

Catastrophic Plans (only available for Applicants under age 30 or otherwise qualified)

- ☐ Anthem Minimum Coverage D $6,850/0% 1X5N

HSA Plans

METAL LEVEL BRONZE

- ☐ Anthem Bronze 60 D HSA PPO (a Tiered PPO Plan) $4,500/40% 1X5D

☐ **YES,** I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected. Please forward my information to Anthem Blue Cross's banking partner. (Please fill in your social security number in Section B.)

☐ **NO, I DO NOT** want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above. Please **DO NOT** forward my information to Anthem Blue Cross's banking partner.

****These products are issued by Anthem Blue Cross and are regulated by the California Department of Managed.**

Section F – Dental and Vision Coverage

Dental (Anthem is licensed to sell Dental plans in all California counties)

☐ **Yes, I wish to purchase additional dental coverage to supplement the pediatric Essential Health Benefits available to enrollees to the end of the month they turn age 19 which are included in the medical plans above.**

Select ONE Plan:

- ☐ * **Dental SelectHMO*** ** (1F3E)
- ☐ ** **Dental Blue Basic*** ** (1JZ5)
- ☐ ** **Dental Blue Enhanced*** ** (1JZ6)
- ☐ ** **Dental Prime Plan A*** ** (1RBD)
- ☐ ** **Dental Prime Plan B*** ** (1RBE)
- ☐ ** **Dental Prime Plan C*** ** (1RBF)

Select who you are enrolling (applies to individuals listed on this application only:

- ☐ Applicant only
- ☐ Applicant & Spouse or Domestic Partner only
- ☐ Applicant & all dependent children listed
- ☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

If you choose the Dental SelectHMO plan, you must choose a Primary Care Dentist for the family and enter the number of the Dental Office you have chosen.

Primary Care Dentist	Current Patient ☐ Yes ☐ No	Primary Care Dentist Number

***This product is issued by Anthem Blue Cross and is regulated by the California Department of Managed Health Care.**

**** These products are issued by Anthem Blue Cross Life and Health Insurance Company and are regulated by the California Department of Insurance.**

***** These plans do not include pediatric dental Essential Health Benefits that are required by the Affordable Care Act.**

Vision

Supplemental vision coverage is also available. In order to enroll in this coverage, you must enroll in at least one of the medical or dental coverage options in this application. If you have enrolled in one of the medical or dental plans and would like to add vision coverage, please select your plan option below.

☐ **Blue View Vision Individual*** ** (1RYD)

Select who you are enrolling (applies to individuals listed on this application only:

- ☐ Applicant only
- ☐ Applicant & Spouse or Domestic Partner only
- ☐ Applicant & all dependent children listed
- ☐ Applicant, Spouse or Domestic Partner, and all dependent children listed

***** These plans do not include pediatric vision Essential Health Benefits that are required by the Affordable Care Act.**

Section G – Other Health and Dental Coverage

1) Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If **YES**, who? _____

2) Do you or anyone applying for coverage, currently have health care coverage? ☐ Yes ☐ No

If **YES**, please provide the following for health coverage:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage
Will you be terminating this health coverage if approved for Anthem Blue Cross coverage? ☐ Yes ☐ No	If **YES**, what is the termination date?

3) Do you or anyone applying for coverage, currently have dental coverage? ☐ Yes ☐ No

If **YES**, please provide the following for dental coverage:

Name(s) of covered persons. If the whole family, simply write ALL in space below.	Identification Number(s)
Name and phone number of prior carrier(s)	
Type of coverage ☐ Group ☐ Individual	Effective Date of Coverage
Will you be terminating this dental coverage if approved for Anthem Dental coverage? ☐ Yes ☐ No	If **YES**, what is the termination date?

Section H – Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

All Applicants

I, the undersigned, understand that under the Anthem Blue Cross plan/policy in which I am enrolling, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician. Contact customer service at 1-855-383-7247 with any questions about the use of network providers and the financial impact of using out-of-network providers.

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.

· I understand that although Anthem Blue Cross requires payment with my application, sending my initial premium with this application, and the receipt of my payment by Anthem Blue Cross, does not mean that coverage has been

approved. I may not assign any payment under my Anthem Blue Cross program. I am applying for the coverage selected on this application. I understand that, to the extent permitted by law, Anthem Blue Cross reserves the right, based upon eligibility requirements, to accept or decline this application. I understand that if my application is denied, my bank account or credit card will not be charged.

- I will notify Anthem Blue Cross of any changes that affect my eligibility or my dependents eligibility for coverage. This includes changes in address, marriage, divorce, dissolution of domestic partnership, death, or dependent status.
- I understand Anthem Blue Cross may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction and that my original check will be destroyed. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem Blue Cross automatic debit process and will only occur each time I send a check to Anthem Blue Cross. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.
- By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem Blue Cross and myself.
- I understand I am applying for individual health and/or dental/vision coverage which is not part of any employer-sponsored plan. I certify that neither I nor any dependent is receiving any form of reimbursement or compensation for this coverage from any employer. I understand that I am responsible for 100% of the premium payment and I am also responsible to ensure that premiums are paid.
- I understand that my domestic partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.
- I acknowledge that I have read the Significant Terms, Conditions, and Authorizations, and I accept such provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief, and I understand they are being relied on by Anthem Blue Cross in accepting this application. Any act or practice that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).
- I certify each Social Security Number listed on this application is correct.

I give this authorization for and on behalf of any eligible dependents and myself if covered by Anthem Blue Cross. I am acting as their agent and representative.

This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

Rescission of Membership

Every applicant age 18 or older acknowledges the following: I have provided true and complete answers to all questions in the application to the best of my knowledge and understand that all answers are important and will be considered in the acceptance or denial of this application. I understand that all information I know, that is responsive to a question on this application, must be provided in my answers consistent with California law.

The primary applicant additionally acknowledges the following: All of my dependents listed on this application who are 18 years of age or older have read this application and have provided complete and accurate information for this application to the best of my knowledge and have signed the application below. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about all applicants, including my children under the age of 18, listed on this application is true and complete.

I understand that if my plan/policy is rescinded, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be considered for benefits. I also understand that, consistent with California law, I will be required to pay for any services Anthem Blue Cross paid on my behalf and that Anthem Blue Cross will refund any premium paid by me, less my medical expenses that Anthem Blue Cross paid.

REQUIREMENT FOR BINDING ARBITRATION

YOU AND ANTHEM BLUE CROSS AGREE TO BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN /POLICY AND CLAIMS OF MEDICAL MALPRACTICE, 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. IT IS UNDERSTOOD THAT ANY DISPUTE INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN/POLICY AND/OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY, INCLUDING 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, ANTHEM BLUE CROSS AGREE THAT EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN YOUR OR ITS INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING. THIS MEANS THAT YOU AND ANTHEM BLUE CROSS ARE WAIVING THE RIGHT TO A JURY TRIAL AND/OR TO PARTICIPATE IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

SIGN HERE

Signature of Applicant* or Legal Representative X	Date
Signature of Spouse or Domestic Partner or Dependent Child(ren) age 18 or over (if to be covered) or Legal Representative X	Date
Signature of Dependent Child(ren) age 18 or over (if to be covered) X	Date

** (or Custodial Parent's or Guardian's signature if applicant is under age 18)*

Section I – Agent/Broker Certification

Please check one of the following and complete the information below:

☐ I have not had any interactions whatsoever with this applicant either by phone, e-mail or in person and did not provide any information, advise or assist the applicant in any manner in providing answers or responses to any questions in the application.

☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code Section 1389.8(c)/Insurance Code Section 10119.3.

I certify to the best of my knowledge and belief, the responses herein are accurate.

Agent/Broker Signature X			Date
Agent/Broker Name (please print) Steve Shorr		Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No. 1027 W. 11th Street # 3	
Agent/Broker ID/TIN 550728914	Agency ID/Parent TIN	City San Pedro	State CA	ZIP 90731
Agent/Broker Phone No. 310-519-1335	Agent/Broker Fax No.	Agent/Broker E-mail Steveshorr@cox.net	
GA (if applicable)		GA code (if applicable)	

Section J – Statement of Accountability

Primary Applicant's Name: _____

To be completed when the applicant cannot complete application.

NOTE: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I, _____ , personally read and completed this Individual Application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English ☐ Applicant is Limited English Proficient

☐ Other (explain):_____

I interpreted the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the:

☐ Applicant Or by:_____

I also interpreted and fully explained the "Application Understandings, Conditions and Agreement," the "Authorization for Use of Protected Health Information" and the "Payment Method."	
Signature of Interpreter *(Required)*	Today's Date *(Required)*
X	
I confirm that the application was interpreted on my behalf.	
Signature of Applicant *(Required)*	Today's Date *(Required)*
X	
Language interpreted (e.g. Spanish):	

Please mail this application to the following address:

Anthem Blue Cross

P.O. Box 9041

Oxnard, CA 93031-9041

Or

Fax to: 1 (800) 327-9255

Payment Methods for Individual Applications – California

Anthem BlueCross

Applicant / Member Name:	Primary Applicant's SSN:

Premium Payment is required. Please choose from Option 1 or 2

Please Note: All Payments will be debited as soon as the date of enrollment.

☐ **OPTION 1** – If you choose the following option for **INITIAL and FUTURE MONTHLY** payments, you are **NOT** required to make a selection from Option 2 for your initial payment.

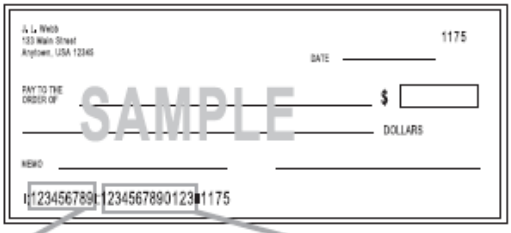
☐ Monthly Automatic Premium Payment (complete Section A)

☐ **OPTION 2 –** If you did not select **OPTION 1**, please choose from the options below for your **INITIAL** premium payment. **If you choose one of these options, you will receive a bill every month thereafter for which you are responsible for payment.**

☐ Paper Check*
☐ Electronic Check (complete Section B)
☐ Credit / Debit Card (complete Section C)

A. Monthly Automatic Premium Payment – By providing your bank information, you authorize us to electronically debit your bank account. I understand this authorization will apply to all products selected. Subsequent premium amounts will be debited on the day you request below:

☐ Checking Account
☐ Savings Account
(You may need to contact your financial institution for routing and account number information.)



Requested Debit Day: _____ (1st to 6th of each month). If no date is requested, your premiums will be debited on the first of each month.

Provide your Routing and Account Numbers here:

9-Digit Bank Routing Number	Bank Account Number

As a convenience to me, I request and authorize Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") to pay and charge to my account checks drawn on that account by and made payable to the order of Anthem Blue Cross, provided there are sufficient collected funds in said account to pay the same upon presentation. I understand that the initial payment amount may vary as a result of change(s) during eligibility review, and/or subsequent payment amount may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem's rights with respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem premiums. This authority is to remain in effect until revoked by me by providing Anthem a 30-day written notice. I agree that Anthem shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever even though such dishonor results in forfeiture of coverage. **NOTE:** I understand that should Anthem's withdrawal not be honored by my bank, I will automatically be removed from Monthly Automatic Premium Payment and will be billed by mail. **I will incur a service charge for any withdrawal not honored.**

Authorized Signature (as it appears in the financial institution's records)	Account Holder Name (Please PRINT)	Date
X		

B. Electronic Check – In lieu of sending a Paper Check, we can submit this same information electronically. We will need you to complete the information below. We require an exact amount to be debited.

Account Holder Name (Please PRINT)	Bank Routing Number	Account Number	Amount
			$

C. Credit / Debit Card - As a convenience to me, I request and authorize Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") to charge my card for a one time initial debit upon approval. I understand this authorization will apply to all products selected. I understand that the initial payment amount may vary as a result of change(s) during eligibility review and/or subsequent payment amounts may vary as a result of change(s) I make once enrolled, such as, but not limited to, adding and deleting dependents, moving my residence changing coverage, and/or changes made by Anthem of which I am notified pursuant to my plan/policy. I agree that Anthem shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, Anthem shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. **Anthem accepts Visa ☐ and MasterCard ☐**

Card Number:

Expiration Date:

Billing address for this Credit / Debit Card:

City:

Zip Code:

Authorized Signature (as it appears on the credit card)	Cardholder Name (as it appears on the credit card – Please Print)	Date
X		

* When you provide a check as payment, you authorize Anthem either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When Anthem uses this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date of coverage approval and you will not receive your check back from your financial institution.