# **Enrolling is Simple.** Just Follow These 3 Easy Steps...

# Step 1

@C75H9'H<9'7CFF97H'5DD'fl G=B; 'D5; 9'&L'H<9B'COMPLETE THE 'APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions #########f you have any questions, or you are not sure how to answer a question, fax: at:

# GhYd'&

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:

# 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:

Thank you for choosing...



# 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	on A – Coverage Inf	ormation	
Applic	cation Type (select	one):	
o Nev	v Coverage	Change plan/policy coverage Policy No	<ul> <li>Add dependent(s) to current coverage</li> <li>Policy No.</li> </ul>
Open	Enrollment		
Effecti	ve Date for the annu	al Open Enrollment period is the first	overage, or members can change plans. The earliest day of the following calendar year. The actual Effective plication with the applicable premium payment.
above Follov Minim	, the applicant may ving a qualifying ev um Essential Cove	still apply for a health plan if he/s ent, an applicant has 60 days to so	period. Outside the Open Enrollment period referenced the experiences a qualifying event as defined below. Upon an application. In the case of a future Loss of ear health plan coverage, an application may be date.
No qu	alifying event is requ	ired to apply for new dental coverage	ı <u>.</u>
additio	on of dependents ma		d Dental SelectHMO, dental coverage changes and/or e or if you experience a qualifying event. Following a ion.
Please	e indicate the reaso	n you are submitting this applicat	on:
•	en Enrollment Period ecial Enrollment Peri		
	Special Enrollment overage effective da		ing event date, qualifying event and, if applicable, the
1.	Date of the qualify	ying event (which includes the date	of Loss of Minimum Essential Coverage):
2.	Qualifying Event:	<del></del>	

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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

O Involuntary loss of Minimum Essential Coverage (loss of minimum essential coverage includes loss of eligibility

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);

- O Gain a dependent or become a dependent through marriage, domestic partnership, or appointment of domestic partnership;
- O Gain a dependent or become a dependent through birth, adoption or placement for adoption:
- O Mandated to be covered as a dependent pursuant to a valid state or federal court order;
- O Release from incarceration;
- O Death of a family member enrolled under your current coverage;
- O Renewal of non-calendar year health plan coverage;
- O Health coverage issuer substantially violated material provision of health coverage contract;
- O Access to new health benefit plans due to permanent move:
- O 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;

O Member of the Reserve Forces of the U.S. military returni National Guard returning from active duty under Title 32 of th	,
O Other Qualifying Event:rules established by applicable state or federal law in defining	_ (Any other event or circumstance as set forth in the g 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; O AO B O C O D

In the case of a mandate to be covered as a dependent pursuant to a valid state or O A O C federal court order:

In the case of death of a family member enrolled under your current coverage; OBOC

# Effective date options

- Coverage is effective on the date of birth, or adoption, or placement for adoption, or date of valid state or federal court order.
- First day of the month following receipt of your application.
- 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.

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Section B – Applicant Information	on								
Last Name	First Name		МІ	Social S	Social Security Number*(required)				
Home Address**									
City	State ZIP County		County						
Billing Address (street and P.O. Box if applicable)									
City		State		ZIP					
Marital/Domestic Partner Status	Sex	Date of Birth							
O Single O Married O Don	омоғ	1 1							
Primary Phone Number Sec	E-mail***								

<sup>\*</sup>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.

<sup>\*\*</sup> 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").

<sup>\*\*\*</sup>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 D	omestic Partner to be 0			nation				
Last Name		First Name			MI Relationship			
						o Spouse	<ul> <li>Domestic Partne</li> </ul>	
Social Security Number*	(required)	Sex		Data	of Birth			
Coolar Security Harrison (required)		Sex		Date	OI DII III			
			o F			/ /	,	
Section D - Child Depen	dents to be Covered Inf			fields require	d. Att	ach a separat	e sheet if	
necessary).			· ·	•		•		
Dependent information mu								
An eligible dependent may								
and adopted children and								
relationship under age two 26 may be eligible for cove								
physically or mentally disa								
support and maintenance.								
period he or she would be			,					
Last Name	First Name	MI	Sex	Date of Birt	h Sc	ocial	Relationship to	
				mm/dd/yyyy		curity	Applicant	
						ımber*		
					(re	equired)		
			MF				o Child	
			0 0	/ /			o Other:	
			MF				o Child	
		-	0 0 <b>M</b> F	/ /			o Other:	
			0 0	, ,			o Child o Other:	
			M F	, ,			o Child	
			0 0	/ /			o Other:	
			MF				o Child	
			0 0	/ /			o Other:	
*Anthem is required by the	RS to collect this inforn	nation	. It is use	d for internal p	urpos	es only and wi	Il not be disclosed	
unless you select the heal	th savings account option	in th	is Applica	ation or to fede	ral and	d state agencie	es as required by	
applicable law.								
Do you have a shild ago	26 or over who is incor	abla	of colf o	uotoinina omn	.lo.m	ont by		
Do you have a child age reason of a physically or							O Yes O No	
is being requested unde		ıı <b>y</b> ,	11633 01	condition for	WIIOII	Coverage		
		4.						
If YES, a separate Disal	pied Dependent Certific	ation	torm mu	ist be submiti	ea to	aetermine eii	gibility.	
O Please send n	no a form							
O Flease Sellu II	ile a ioiiii.							
Are any of the applican	te lieted on the annlicat	ion c	urrently	incarcorated	lovcor	nt nendina		
disposition of charges)		.1011 C	urrentily	ilicalcerated	(excel	or penanig	o Yes o	
IT YES, Wno?								
Preferred written language	, , ,							
O Chinese (ZHO) (C/M)	, ,			tnamese (VIE)	0	Spanish (SP	N)	
O English (ENG)	<ul><li>Tagalog (TGL)</li></ul>		O Oth	er (W09)				
Duefermed 1								
Preferred spoken langua			0.15	(	_	0	N IX	
O Chinese (ZHO) (C/M)	, ,			tnamese (VIE)	0	Spanish (SP	N)	
O English (ENG)	O Tagalog (TGL)		o Oth	er (W09)				

O 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".

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#### 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**

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

#### **METAL LEVEL SILVER**

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

#### **METAL LEVEL GOLD**

O Anthem Gold 80 D PPO \$0/20% 1G09

#### **METAL LEVEL PLATINUM**

O Anthem Platinum 90 D PPO \$0/10% 1G0F

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

O Anthem Minimum Coverage D \$6,850/0% 1FZE

## **HSA Plans**

#### **METAL LEVEL BRONZE**

- O Anthem Bronze 60 D HSA PPO \$4,500/40% 1FZQ
- O **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.)
- O **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.

#### Section F - Dental and Vision Coverage

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

o 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.

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<sup>\*\*</sup>These products are issued by Anthem Blue Cross and are regulated by the California Department of Managed.

#### Select ONE Plan:

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

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

O Applicant only

- O Applicant & all dependent children listed
- O Applicant & Spouse or Domestic Partner only
- O 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	Primary Care Dentist Number
	o Yes o No	

<sup>\*</sup>This product is issued by Anthem Blue Cross and is regulated by the California Department of Managed Health Care.

#### 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.

O Blue View Vision Individual\*\*\* (1RYD)

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

O Applicant only

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

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

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

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

Section G – Other Health and Dental Cov	verage								
1) Are you or anyone applying for coverag	ge currently eligible for Medicare?		O Yes O No						
If YES, who?									
Do you or anyone applying for coverage, currently have health care coverage?  O Yes O No									
If YES, please provide the following	g for health coverage:								
Name(s) of covered persons. If the below.	Name(s) of covered persons. If the whole family, simply write ALL in space below.								
Name and phone number of prior	carrier(s)								
Type of coverage O Group O Individual	Effective Date of Coverage								
Will you be terminating this health Blue Cross coverage? O Yes O	If YES,	YES, what is the termination date?							
Do you or anyone applying for coverag     If YES, please provide the following	,		O Yes O No						
Name(s) of covered persons. If th below.	e whole family, simply write ALL in sp	ace	Identification Number(s)						
Name and phone number of prior	carrier(s)								
Type of coverage O Group O Individual	Effective Date of Coverage								
Will you be terminating this dental Dental coverage? O Yes O No	I coverage if approved for Anthem	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

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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 employersponsored 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

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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

<sup>\* (</sup>or Custodial Parent's or Guardian's signature if applicant is under age 18)

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## Section I - Agent/Broker Certification

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

- O 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.
- O 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 (ple	Agent/Bro	Agent/Broker Street Address/Suite No./Personal Mail Box (PMB) No.						
Agent/Broker ID/TIN	Agent/Broker ID/TIN Agency ID/Parent TIN				State ZIP			
Agent/Broker Phone No	Agent/Broker Phone No. Agent/Broke			er Fax No. Agent/Broker E-mail				
GA (if applicable)			GA code	GA code (if applicable)				
Section J – Statement of Primary Applicant's Na To be completed when NOTE: Interpreter must	me:the applican	t cannot cor	mplete appl	lication.	on behalf of the	e applicant		
I,applicant named below b	pecause:		_ , personal	lly read and co	mpleted this Indi	ividual Appl	ication for the	
						O Application	ant is Limited roficient	
O Other (explain):			· · · · · · · · · · · · · · · · · · ·	<del></del>	· · · · · · · · · · · · · · · · · · ·			
I interpreted the contents medical history disclosed		and to the be	st of my kno	owledge obtaine	ed and listed all	the request	ed personal and	
Annlicant Or by:								

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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):						

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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

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# Payment Methods for Individual Applications – California



Applicant / Member Name:			Primary Applicant's SSN:				
Premium Payment Please Note: All Paym							
☐ OPTION 1 – If you choose the following option for FUTURE MONTHLY payments, you are NOT required selection from Option 2 for your initial payment.	INITIAL and to make a	Э	☐ 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				
☐ Monthly Automatic Premium Payment (comple	ete Section		for which you are responsible for payment.  Paper Check* Electronic Check (complete Section B)				
				∐ Credit	t / Debit Card (comple	ete Section C)	
<b>A. Monthly Automatic Premium Payment</b> – By provunderstand this authorization will apply to all products							
☐ Checking Account			A L Webb 133 Wain Street		1175		
<ul> <li>Savings Account         <ul> <li>(You may need to contact your fining institution for routing and account information.)</li> </ul> </li> </ul>	nt number		Anytown, USA 12345  RAY TO THE ORDER OF	AMPLI	BATE \$ DOLLARS		
Requested Debit Day: (1 <sup>st</sup> to 6 <sup>th</sup> of each month If no date is requested, your premiums will be debited on the first of each month.			1234567891	234567890123 <b>•</b> 1175			
Provide your Routing and Account Numbers here:	9-1	-Digit Bank	ank Routing Number Bank Account Number				
my account checks drawn on that account by and made paccount to pay the same upon presentation. I understand subsequent payment amount may vary as a result of char residence, changing coverage and/or changes made by Aeach such debit shall be the same as if it were a check signor my account with the financial institution indicated for providing Anthem a 30-day written notice. I agree that Antidishonored, whether with or without cause and whether ir results in forfeiture of coverage. NOTE: I understand that Monthly Automatic Premium Payment and will be billed by Authorized Signature (as it appears in the financial institution's record X	I that the inition nge(s) I make Anthem of whom the gned person repayment of them shall be be the them shall be should Anthey mail. I will	tial paymen we once enrichich I am no hally by me f my Anther oe fully proto or inadverte hem's without I incur a se	at amount rolled, such trolled, such trolled, such trolled, such trolled, and troll	may vary as a result thas, but not limited rsuant to my plan/po ze Anthem to initiate ns. This authority is onoring any such de nem shall be under ro be honored by my be	of change(s) during eleto, adding and deleting licy. I agree that Anth- e debits (and/or correct to remain in effect unti- bit. I further agree that no liability whatsoever elebank, I will automatical	igibility review, and/or g dependents, moving my em's rights with respect to ons to previous debits) revoked by me by if any such debit be even though such dishonor	
B. Electronic Check – In lieu of sending a Paper Che information below. We require an exact amount to be deb		submit th	is same i	nformation electror	nically. We will need yo	ou to complete the	
Account Holder Name (Please PRINT) Bank Rout	ting 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:							
L Billing address for this Credit / Debit Card:				City:	l Zip	Code:	
Authorized Signature (as it appears on the credit card)		Cardboldor	· Namo (ac	it appears on the cro	dit card Plaasa Print)	Date	
V	[ ]	Carunoidei	ivalle (dS	in appears on the cre	dit card – Please Print)	Date	

<sup>\*</sup> 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	on A – Coverage In	formation	
Appli	cation Type (selec	t one):	
New Coverage     O Change plan/policy coverage     Policy No			<ul> <li>Add dependent(s) to current coverage</li> <li>Policy No</li> </ul>
Open	Enrollment		
Effecti	ive Date for the ann	ual Open Enrollment period is the first day	rage, or members can change plans. The earliest y of the following calendar year. The actual Effective ation with the applicable premium payment.
above Follov Minim	e, the applicant ma wing a qualifying e num Essential Cov	y still apply for a health plan if he/she ovent, an applicant has 60 days to subm	od. Outside the Open Enrollment period referenced experiences a qualifying event as defined below. nit an application. In the case of a future Loss of health plan coverage, an application may be e.
No qu	alifying event is req	uired to apply for new dental coverage.	
additio	on of dependents m		ental SelectHMO, dental coverage changes and/or r if you experience a qualifying event. Following a
Pleas	e indicate the reas	on you are submitting this application:	:
	en Enrollment Peric ecial Enrollment Pe		
	Special Enrollmen overage effective d		event date, qualifying event and, if applicable, the
1.	Date of the quali	fying event (which includes the date of L	oss of Minimum Essential Coverage):
2.	Qualifying Even	<del></del> !:	
	O Involuntary los	s of Minimum Essential Coverage (loss o	f minimum essential coverage includes loss of eligibility

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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

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	(su pla	ch as making a fraudulent claim or an intentional misrepresentation of a material fact in);	n connection with the	
		Gain a dependent or become a dependent through marriage, domestic partnership, on mestic partnership;	appointment of	
	0	Gain a dependent or become a dependent through birth, adoption or placement for ac	loption;	
	0	Mandated to be covered as a dependent pursuant to a valid state or federal court orde	er;	
	0	Release from incarceration;		
	О	Death of a family member enrolled under your current coverage;		
	О	Renewal of non-calendar year health plan coverage;		
	О	Health coverage issuer substantially violated material provision of health coverage co	ntract;	
	О	Access to new health benefit plans due to permanent move;		
	the Co bet	Loss of services from contracting provider under another health benefit plan, as defined insurance Code or 1399.845 of the Health and Safety Code, for a condition described de § 1373.96(c) (an acute condition, serious chronic condition, pregnancy, terminal illar ween birth and 36 months of age, or performance of a surgery or other procedure that documented by the provider) and that provider is no longer participating in the health	d in Health and Safety ness, care of newborn thas been recommende	
		Member of the Reserve Forces of the U.S. military returning from active duty or member tional Guard returning from active duty under Title 32 of the U.S. Code.	er of the California	
		Other Qualifying Event: (Any other event or circumes established by applicable state or federal law in defining qualifying events please in		е
	Co	mments:		
3.	Covera	age Effective Date:		
	the mo	are applying due to a qualifying event and your application is processed, your coverage on when the application is received. If the application is received between the first day on the coverage shall become effective the first day of the following month. If the application eenth day and last day of the month, coverage shall become effective the first day of the mover the following qualifying events allow for different effective dates:	and the fifteenth day of tion is received between	
		In the case of marriage, domestic partnership, appointment of domestic partnership, Essential Coverage, coverage is effective on the first day of the month following rece		
	For the	e following qualifying events, select one of the effective date options as describe	ed in the chart below.	
		In the case of birth, or adoption, or placement for adoption;	o	
		In the case of a mandate to be covered as a dependent pursuant to a valid state or	0 A 0 C	
		federal court order; In the case of death of a family member enrolled under your current coverage;	овос	
	E#	ective date options	- <del>-</del>	
	A		date of valid state or	
	^	federal court order.	date of valid state of	

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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

**B** First day of the month following receipt of your application.

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*(require					
Home Address**									
City	State	ZIP		County					
Billing Address (street and P.O.	Billing Address (street and P.O. Box if applicable)								
City		State		ZIP					
Marital/Domestic Partner Status	s	Sex	Date	Date of Birth					
O Single O Married O Do	o M o F	1 1							
Primary Phone Number Se	E-mail***								
( ) (	)								

<sup>\*</sup>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.

<sup>\*\*</sup> 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").

<sup>\*\*\*</sup>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 D	omestic Partner to be 0			nation				
Last Name		First Name			MI Relationship			
						o Spouse	<ul> <li>Domestic Partne</li> </ul>	
Social Security Number*	(required)	Sex			Data	of Birth		
Social Security Number	(required)	Sex		Date	OI DII III			
		о М	o F			/ /	,	
Section D - Child Depen	dents to be Covered Inf			fields require	d. Att	ach a separat	e sheet if	
necessary).			· ·	•		•		
Dependent information mu								
An eligible dependent may								
and adopted children and								
relationship under age two 26 may be eligible for cove								
physically or mentally disa								
support and maintenance.								
period he or she would be			,					
Last Name	First Name	MI	Sex	Date of Birt	h Sc	ocial	Relationship to	
				mm/dd/yyyy		curity	Applicant	
						ımber*		
					(re	equired)		
			MF				o Child	
			0 0	/ /			o Other:	
			MF				o Child	
		-	0 0 <b>M</b> F	/ /			o Other:	
			0 0	, ,			o Child o Other:	
			M F	, ,			o Child	
			0 0	/ /			o Other:	
			MF				o Child	
			0 0	/ /			o Other:	
*Anthem is required by the	RS to collect this inforn	nation	. It is use	d for internal p	urpos	es only and wi	Il not be disclosed	
unless you select the heal	th savings account option	in th	is Applica	ation or to fede	ral and	d state agencie	es as required by	
applicable law.								
Do you have a shild ago	26 or over who is incor	abla	of colf o	uotoinina omn	.lo.m	ont by		
Do you have a child age reason of a physically or							O Yes O No	
is being requested unde		ıı <b>y</b> ,	11633 01	condition for	WIIOII	Coverage		
		4.						
If YES, a separate Disal	pied Dependent Certific	ation	torm mu	ist be submiti	ea to	aetermine eii	gibility.	
O Please send n	no a form							
O Flease Sellu II	ile a ioiiii.							
Are any of the applican	te lieted on the annlicat	ion c	urrently	incarcorated	lovcor	nt nendina		
disposition of charges)		.1011 C	urrentily	ilicalcelated	(excel	or penanig	o Yes o	
IT YES, Wno?								
Preferred written language	, , ,							
O Chinese (ZHO) (C/M)	, ,			tnamese (VIE)	0	Spanish (SP	N)	
O English (ENG)	<ul><li>Tagalog (TGL)</li></ul>		O Oth	er (W09)				
Duefermed 1								
Preferred spoken langua			0.15	(	_	0	N IX	
O Chinese (ZHO) (C/M)	, ,			tnamese (VIE)	0	Spanish (SP	N)	
O English (ENG)	O Tagalog (TGL)		o Oth	er (W09)				

O 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".

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DMHC\_RR2

#### 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**

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

#### **METAL LEVEL SILVER**

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

#### **METAL LEVEL GOLD**

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

#### METAL LEVEL PLATINUM

O 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**

O Anthem Silver 70 D HMO \$2,250/20% 1G02

#### **METAL LEVEL GOLD**

O Anthem Gold 80 D HMO \$0/20% 1G0B

#### **METAL LEVEL PLATINUM**

O Anthem Platinum 90 D HMO \$0/10% 1G0H

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

O Anthem Minimum Coverage D \$6,850/0% 1X5N

# **HSA Plans**

#### **METAL LEVEL BRONZE**

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

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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			O Yes O No	
Spouse/ Domestic Partner			O Yes O No	
Dependent Name:			O Yes O No	
Dependent Name:			O Yes O No	
Dependent Name:			O Yes O No	

<sup>\*</sup>PMG = Participating Medical Group, IPA = Independent Practice Association

# Section F – Dental and Vision Coverage

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

o 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:

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

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

O Applicant only

- Applicant & all dependent children listed
- O Applicant & Spouse or Domestic Partner only
- O 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	Primary Care Dentist Number
	o Yes o No	

<sup>\*</sup>This product is issued by Anthem Blue Cross and is regulated by the California Department of Managed Health Care.

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O 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.

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

<sup>\*\*\*</sup> 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.

O Blue View Vision Individual\*\*\* (1RYD)

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

O Applicant only

- O Applicant & all dependent children listed
- O Applicant & Spouse or Domestic Partner only
- O 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.

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Sec	ction	G - Other Health and Dental Cov	verage							
		you or anyone applying for coverag			(	Yes	0	No		
•		If <b>YES</b> , who?	, ,							
2)		,	e, currently have health care coverage	e?	C	Yes	 O	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.									
		Name and phone number of prior	carrier(s)							
	Type of coverage O Group O Individual Effective Date of Coverage									
Will you be terminating this health coverage if approved for Anthem Blue Cross coverage? O Yes O No								?		
3)	•	ou or anyone applying for coverag			C	) Yes	0	No		
		If <b>YES</b> , please provide the following	g for dental coverage:							
Name(s) of covered persons. If the whole family, simply write ALL in space below.										
Name and phone number of prior carrier(s)  Type of coverage O Group O Individual										

# 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

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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 employersponsored 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

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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)	Date

<sup>\* (</sup>or Custodial Parent's or Guardian's signature if applicant is under age 18)

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## Section I - Agent/Broker Certification

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

- O 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.
- O 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	Agent/Broker Signature X									
Agent/Broker Name (pl	ease print)		Agent/Bro	Agent/Broker Street Address/Suite No./Personal Mail Box (No.						
Agent/Broker ID/TIN Agency ID/Parent TIN			City		State ZIP					
Agent/Broker Phone No. Agent/Brok			er Fax No.	Fax No. Agent/Broker E-mail						
GA (if applicable)	GA code (if applicable)									
Section J – Statement of Primary Applicant's Na	me:									
NOTE: Interpreter mus	• •				on behalf of the	applicant				
I, applicant named below t	pecause:		_ , personal	lly read and cor	mpleted this Indi	vidual Appl	ication for the			
O Applicant does not read O Applicant does English English			not speak	not speak O Applicant does not write English		O Applica English P	ant is Limited roficient			
O Other (explain):										
I interpreted the contents medical history disclosed		and to the be	st of my kno	owledge obtaine	ed and listed all t	he request	ed personal an			
O Applicant Or by:										

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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.	I confirm that the application was interpreted on my behalf.						
Signature of Applicant (Required)	Today's Date (Required)						
X							
Language interpreted (e.g. Spanish):							

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# Payment Methods for Individual Applications – California



Applicant / Member Name:			Primary Applicant's SSN:					
Premium Payment Please Note: All Paym								
☐ OPTION 1 – If you choose the following option for FUTURE MONTHLY payments, you are NOT required selection from Option 2 for your initial payment.	☐ 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.			☐ 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				
☐ Monthly Automatic Premium Payment (comple	ete Section		for wind	☐ Paper ☐ Electr	sible for payment.  Check* onic Check (complete	e Section B)		
				∐ Credit	t / Debit Card (comple	ete Section C)		
<b>A. Monthly Automatic Premium Payment</b> – By provunderstand this authorization will apply to all products								
☐ Checking Account			A L Webb 133 Wain Street		1175			
<ul> <li>Savings Account         <ul> <li>(You may need to contact your fining institution for routing and account information.)</li> </ul> </li> </ul>	nt number		Anytown, USA 12345  RAY TO THE ORDER OF	AMPLI	BATE \$ DOLLARS			
Requested Debit Day: (1 <sup>st</sup> to 6 <sup>th</sup> of each month If no date is requested, your premiums will be debited on the first of each month.			1234567891	234567890123 <b>•</b> 1175				
Provide your Routing and Account Numbers here:	9-1	-Digit Bank	rank Routing Number Bank Account Number					
my account checks drawn on that account by and made paccount to pay the same upon presentation. I understand subsequent payment amount may vary as a result of char residence, changing coverage and/or changes made by Aeach such debit shall be the same as if it were a check signor my account with the financial institution indicated for providing Anthem a 30-day written notice. I agree that Antidishonored, whether with or without cause and whether ir results in forfeiture of coverage. NOTE: I understand that Monthly Automatic Premium Payment and will be billed by Authorized Signature (as it appears in the financial institution's record X	I that the inition nge(s) I make Anthem of whom the gned person repayment of them shall be be the them shall be should Anthey mail. I will	tial paymen we once enrichich I am no hally by me f my Anther oe fully proto or inadverte hem's without I incur a se	at amount rolled, such trolled, such trolled, such trolled, such trolled, and troll	may vary as a result thas, but not limited rsuant to my plan/po ze Anthem to initiate ns. This authority is onoring any such de nem shall be under ro be honored by my be	of change(s) during eleto, adding and deleting licy. I agree that Anth- e debits (and/or correct to remain in effect unti- bit. I further agree that no liability whatsoever elebank, I will automatical	igibility review, and/or g dependents, moving my em's rights with respect to ons to previous debits) revoked by me by if any such debit be even though such dishonor		
B. Electronic Check – In lieu of sending a Paper Che information below. We require an exact amount to be deb		submit th	is same i	nformation electror	nically. We will need yo	ou to complete the		
Account Holder Name (Please PRINT) Bank Rout	ting Number			Account Number		Amount \$		
C. Credit / Debit Card - As a convenience to me, I required ("Anthem") to charge my card for a one time initial debit uponitial payment amount may vary as a result of change(s) make once enrolled, such as, but not limited to, adding an of which I am notified pursuant to my plan/policy. I agree such card payment be dishonored, whether with or without including any fees imposed by my bank, should my card by and MasterCard  Card Number:	ipon approva during eligib nd deleting d that Anthem ut cause and	al. I unders pility review dependents in shall be f d whether in	tand this a vand/or su s, moving fully protect ntentional th such dis	authorization will appubsequent payment my residence changeted in honoring any by or inadvertently, A	oly to all products select amounts may vary as a ing coverage, and/or co such card payments. I anthem shall be under i	ted. I understand that the a result of change(s) I hanges made by Anthem further agree that if any no liability whatsoever,		
L Billing address for this Credit / Debit Card:				City:	l Zip	Code:		
Authorized Signature (as it appears on the credit card)		Cardboldor	· Namo (ac	it appears on the cro	dit card Plaasa Print)	Date		
V	[ ]	Carunoidei	ivalle (dS	in appears on the cre	dit card – Please Print)	Date		

<sup>\*</sup> 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	<b>HMO not offered in these ZIP codes:</b> 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	<b>HMO</b> not offered in these ZIP codes: 91905, 91906, 91916, 91934, 91948, 91962, 91963, 91980, 91987, 91990, 92004, 92066, 92070, 92086, 92090, 92133, 92194



# 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	on A – Coverage I	nformation	
Appli	cation Type (sele	ct one):	
o <b>Ne</b> v	w Coverage	Change plan/policy coverage Policy No	<ul><li>Add dependent(s) to current coverage Policy No</li></ul>
Open	Enrollment		
Effect	ive Date for the an	nual Open Enrollment period is the first da	erage, or members can change plans. The earliest by of the following calendar year. The actual Effective cation with the applicable premium payment.
above Follov Minim	e, the applicant m wing a qualifying num Essential Co	ay still apply for a health plan if he/she event, an applicant has 60 days to subi	iod. Outside the Open Enrollment period referenced experiences a qualifying event as defined below. mit an application. In the case of a future Loss of health plan coverage, an application may be te.
No qu	alifying event is re	quired to apply for new dental coverage.	
additio	on of dependents r		ental SelectHMO, dental coverage changes and/or or if you experience a qualifying event. Following a
Pleas	e indicate the rea	son you are submitting this applicatior	:
•	en Enrollment Per ecial Enrollment Pe		
	Special Enrollme overage effective		event date, qualifying event and, if applicable, the
1.	Date of the qua	lifying event (which includes the date of	_oss of Minimum Essential Coverage):
2.	Qualifying Ever	nt:	
			of minimum essential coverage includes loss of eligibility tion of dependent status (such as attaining the

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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

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(such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan); O Gain a dependent or become a dependent through marriage, domestic partnership, or appointment of domestic partnership; O Gain a dependent or become a dependent through birth, adoption or placement for adoption; O Mandated to be covered as a dependent pursuant to a valid state or federal court order; O Release from incarceration: O Death of a family member enrolled under your current coverage; O Renewal of non-calendar year health plan coverage; Health coverage issuer substantially violated material provision of health coverage contract; O Access to new health benefit plans due to permanent move; O 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: O 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. O 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; OAOBOCOD In the case of a mandate to be covered as a dependent pursuant to a valid state or O A O C federal court order: In the case of death of a family member enrolled under your current coverage; OBOCEffective date options Coverage is effective on the date of birth, or adoption, or placement for adoption, or date of valid state or federal court order. First day of the month following receipt of your application. Based on when the application is received. If the application is received between the first day and the

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effective the first day of the second following month. **D** First day of the month following the date of the qualifying event.

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

Section B – Applicant Informat	tion					
Last Name	First Name		MI	Social S	Social Security Number*(required)	
Home Address**	1					
City	State	ZIP		County		
Billing Address (street and P.O.	. Box if applicable)					
City	State ZIP					
Marital/Domestic Partner Status	Sex	Date of Birth				
O Single O Married O Domestic Partner		o M o F	<i>I I</i>		1	
Primary Phone Number Secondary Phone Number		E-mail***				
( )	)					

<sup>\*</sup>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.

<sup>\*\*</sup> 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").

<sup>\*\*\*</sup>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 D	omestic Partner to be 0			nation				
Last Name		First	Name		MI Relationship			
						o Spouse	o Domestic Partner	
Social Security Number*	(required)	Sex			Data	of Birth		
Social Security Number* (required)		Sex			Date	OI BII (II		
		о М	o F			/ /	1	
Section D - Child Depen	dents to be Covered In	forma	tion (All	fields require	d. Att	ach a separat	te sheet if	
necessary).								
Dependent information mu								
An eligible dependent may								
and adopted children and relationship under age twe								
26 may be eligible for cove								
physically or mentally disa								
support and maintenance.								
period he or she would be			•	·		,		
Last Name	First Name	MI	Sex	Date of Birt		ocial	Relationship to	
				mm/dd/yyyy		ecurity	Applicant	
						ımber*		
					(re	equired)		
			M F				o Child	
			0 0	/ /			o Other:	
			M F	, ,			o Child	
			0 0 M F	/ /			o Other:	
			0 0	, ,			o Child o Other:	
			M F	, ,			o Child	
			0 0	, ,			o Other:	
			M F				o Child	
			0 0	/ /			o Other:	
*Anthem is required by the	RS to collect this inform	nation	. It is use	d for internal p	urpos	es only and wi	ill not be disclosed	
unless you select the heal	lth savings account option	in th	is Applica	ation or to fede	ral an	d state agenci	es as required by	
applicable law.								
Do you have a shild ago	26 or over who is incor	abla	of colf o	uotoinina omn	alaum	ont by		
Do you have a child age reason of a physically or							O Yes O No	
is being requested unde		11 <b>y</b> , 111	11633 01	condition for	WIIOII	Coverage		
			_					
If YES, a separate Disal	bled Dependent Certific	ation	torm mu	ist be submiti	tea to	aetermine ei	igibility.	
O Please send n	no a form							
O Flease Sellu II	nie a ioiiii.							
Are any of the applican	te lieted on the annlicat	ion c	urrently	incarcorated	lovcoi	ot nendina		
disposition of charges)		ion c	urrenting	incarcerated (	(excel	or pending	O Yes O I	
If <b>YES</b> , wno?								
Preferred written language	, , ,							
O Chinese (ZHO) (C/M)	<ul><li>O Korean (KOR)</li></ul>		o Vie	tnamese (VIE)	0	Spanish (SP	N)	
O English (ENG)	<ul><li>O Tagalog (TGL)</li></ul>	)	o Oth	ner (W09)				
D ( )	0.40 (; "							
Preferred spoken langua							<b>.</b>	
O Chinese (ZHO) (C/M)	, ,			tnamese (VIE)	) 0	Spanish (SP	N)	
O English (ENG)	O Tagalog (TGL)	)	o Oth	ner (W09)				

O 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".

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DMHC\_RR3

#### 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**

- O Anthem Bronze 60 D PPO \$6.000/100% 1FZ4
- O Anthem Bronze Pathway PPO \$5,750/20% 1FZH
- O Anthem Bronze Pathway PPO \$5,000/25% 1FZ5
- O Anthem Bronze Pathway PPO \$6,600/20% 1FZL

#### **METAL LEVEL SILVER**

- O Anthem Silver 70 D PPO \$2.250/20% 1FZX
- O Anthem Silver Pathway PPO \$2,000/25% 1FZ9
- O Anthem Silver Pathway PPO \$1,750/30% 1FZB

#### **METAL LEVEL GOLD**

O Anthem Gold 80 D PPO \$0/20% 1G09

#### **METAL LEVEL PLATINUM**

O 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**

O Anthem Silver 70 D HMO \$2,250/20% 1G02

#### **METAL LEVEL GOLD**

O Anthem Gold 80 D HMO \$0/20% 1G0B

#### **METAL LEVEL PLATINUM**

O Anthem Platinum 90 D HMO \$0/10% 1G0H

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

O Anthem Minimum Coverage D \$6,850/0% 1FZE

## **HSA Plans**

#### **METAL LEVEL BRONZE**

- O Anthem Bronze 60 D HSA PPO \$4,500/40% 1FZQ
- O **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.)
- O **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.

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\*\*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			O Yes O No	
Spouse/ Domestic Partner			O Yes O No	
Dependent Name:			O Yes O No	
Dependent Name:			O Yes O No	
Dependent Name:			O Yes O No	

<sup>\*</sup>PMG = Participating Medical Group, IPA = Independent Practice Association

#### Section F - Dental and Vision Coverage

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

o 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:**

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

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

O Applicant only

- O Applicant & all dependent children listed
- O Applicant & Spouse or Domestic Partner only
- O 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	Primary Care Dentist Number
	o Yes o No	

<sup>\*</sup>This product is issued by Anthem Blue Cross and is regulated by the California Department of Managed Health Care.

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O 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.

<sup>\*\*</sup> 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.

O Blue View Vision Individual\*\*\* (1RYD)

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

O Applicant only

- O Applicant & all dependent children listed
- O Applicant & Spouse or Domestic Partner only
- O 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.

Sec	tion G – Other Health and Dental Co	verage									
	Are you or anyone applying for coverage			O Yes O No							
	If <b>YES</b> , who?										
2)	Do you or anyone applying for coverag	e, currently have health care coverage	∋?	O Yes O 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.										
	Name and phone number of prior carrier(s)										
	Type of coverage O Group O Individual  Effective Date of Coverage										
	Will you be terminating this health coverage if approved for Anthem Blue Cross coverage? O Yes O No										
3)	Do you or anyone applying for coverag			O Yes O No							
	If <b>YES</b> , please provide the following	g for dental coverage:									
	Name(s) of covered persons. If the whole family, simply write ALL in space below.										
	Name and phone number of prior carrier(s)										
	Type of coverage O Group O Individual  Effective Date of Coverage										
	Will you be terminating this dental coverage if approved for Anthem  Dental coverage? O Yes O No										

#### 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

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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 employersponsored 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

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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

<sup>\* (</sup>or Custodial Parent's or Guardian's signature if applicant is under age 18)

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#### Section I - Agent/Broker Certification

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

- O 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.
- O 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	•						Date
Agent/Broker Name (pl	ease print)		Agent/Bro	oker Street Add	ress/Suite No./P	ersonal Ma	ail Box (PMB)
Agent/Broker ID/TIN	Agency ID/	Parent TIN	City		Sta	te	ZIP
Agent/Broker Phone No	).	Agent/Brok	er Fax No.		Agent/Broker E	-mail	
GA (if applicable)  GA code (if applicable)							
Section J – Statement of Primary Applicant's Na	me:						
NOTE: Interpreter mus					on behalf of the	applicant	
I, applicant named below t	pecause:		_ , personal	lly read and cor	mpleted this Indi	vidual Appl	ication for the
O Applicant does not re English	ad O Ap Engli	oplicant does sh	not speak	O Applicant of English	does not write	O Applica English P	ant is Limited roficient
O Other (explain):							
I interpreted the contents medical history disclosed		and to the be	st of my kno	owledge obtaine	ed and listed all t	he request	ed personal an
O Applicant Or by:							

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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):						

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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

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## Payment Methods for Individual Applications – California



Applicant / Member Name:			Primary Applicant's SSN:				
Premium Payment Please Note: All Paym							
☐ 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.			☐ 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				
☐ Monthly Automatic Premium Payment (comple	ete Section		for wind	☐ Paper ☐ Electr	sible for payment.  Check* onic Check (complete	e Section B)	
				∐ Credit	t / Debit Card (comple	ete Section C)	
<b>A. Monthly Automatic Premium Payment</b> – By provunderstand this authorization will apply to all products							
☐ Checking Account			A L Webb 133 Wain Street		1175		
<ul> <li>Savings Account         <ul> <li>(You may need to contact your fining institution for routing and account information.)</li> </ul> </li> </ul>	nt number		Anytown, USA 12345  RAY TO THE ORDER OF	AMPLI	BATE \$ DOLLARS		
Requested Debit Day: (1 <sup>st</sup> to 6 <sup>th</sup> of each month If no date is requested, your premiums will be debited on the first of each month.			1234567891	234567890123			
Provide your Routing and Account Numbers here:	9-1	-Digit Bank	Routing	Number	Bank Acc	ount Number	
my account checks drawn on that account by and made paccount to pay the same upon presentation. I understand subsequent payment amount may vary as a result of char residence, changing coverage and/or changes made by Aeach such debit shall be the same as if it were a check signor my account with the financial institution indicated for providing Anthem a 30-day written notice. I agree that Antidishonored, whether with or without cause and whether ir results in forfeiture of coverage. NOTE: I understand that Monthly Automatic Premium Payment and will be billed by Authorized Signature (as it appears in the financial institution's record X	I that the initiange(s) I make Anthem of whome defended person them shall be the model of them shall be should Anthey mail. I will	tial paymen we once enrichich I am no hally by me f my Anther oe fully proto or inadverte hem's without I incur a se	at amount rolled, such trolled, such trolled, such trolled, such trolled, and troll	may vary as a result thas, but not limited rsuant to my plan/po ze Anthem to initiate ns. This authority is onoring any such de nem shall be under ro be honored by my be	of change(s) during eleto, adding and deleting licy. I agree that Anth- e debits (and/or correct to remain in effect unti- bit. I further agree that no liability whatsoever elebank, I will automatical	igibility review, and/or g dependents, moving my em's rights with respect to ons to previous debits) revoked by me by if any such debit be even though such dishonor	
B. Electronic Check – In lieu of sending a Paper Che information below. We require an exact amount to be deb		submit th	is same i	nformation electror	nically. We will need yo	ou to complete the	
Account Holder Name (Please PRINT) Bank Rout	ting Number			Account Number		Amount \$	
C. Credit / Debit Card - As a convenience to me, I required ("Anthem") to charge my card for a one time initial debit uponitial payment amount may vary as a result of change(s) make once enrolled, such as, but not limited to, adding an of which I am notified pursuant to my plan/policy. I agree such card payment be dishonored, whether with or without including any fees imposed by my bank, should my card be and MasterCard.  Card Number:	ipon approva during eligib nd deleting d that Anthem ut cause and	al. I unders pility review dependents in shall be f d whether in	tand this a vand/or su s, moving fully protect ntentional th such dis	authorization will appubsequent payment my residence changeted in honoring any by or inadvertently, A	oly to all products select amounts may vary as a ing coverage, and/or co such card payments. I anthem shall be under i	ted. I understand that the a result of change(s) I hanges made by Anthem further agree that if any no liability whatsoever,	
L Billing address for this Credit / Debit Card:				City:	l Zip	Code:	
Authorized Signature (as it appears on the credit card)		Cardboldor	· Namo (ac	it appears on the cro	dit card Plaasa Print)	Date	
V	[ ]	Carunoidei	ivalle (dS	in appears on the cre	dit card – Please Print)	Date	

<sup>\*</sup> 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
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	<b>HMO not offered in these ZIP codes:</b> 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



### 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	on A – Coverage I	nformation	
Appli	cation Type (sele	ct one):	
o <b>Ne</b> v	w Coverage	Change plan/policy coverage Policy No	<ul> <li>Add dependent(s) to current coverage</li> <li>Policy No</li> </ul>
Open	Enrollment		
Effect	ive Date for the an	nual Open Enrollment period is the first da	erage, or members can change plans. The earliest by of the following calendar year. The actual Effective cation with the applicable premium payment.
above Follov Minim	e, the applicant m wing a qualifying num Essential Co	ay still apply for a health plan if he/she event, an applicant has 60 days to subi	od. Outside the Open Enrollment period referenced experiences a qualifying event as defined below. nit an application. In the case of a future Loss of health plan coverage, an application may be te.
No qu	alifying event is re	quired to apply for new dental coverage.	
additio	on of dependents n		ental SelectHMO, dental coverage changes and/or or if you experience a qualifying event. Following a
Pleas	e indicate the rea	son you are submitting this application	:
	en Enrollment Per ecial Enrollment Pe		
	Special Enrollme overage effective		event date, qualifying event and, if applicable, the
1.	Date of the qua	lifying event (which includes the date of	oss of Minimum Essential Coverage):
2.	Qualifying Ever	nt:	
			of minimum essential coverage includes loss of eligibility tion of dependent status (such as attaining the

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

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

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plan);

	0 (	Gain a dependent or become a dependent through birth, adoption or placement for ac	tqot	tion;			
	0 1	Mandated to be covered as a dependent pursuant to a valid state or federal court orde	er;				
	o F	Release from incarceration;					
	0 [	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 co	ntro	ot:			
			IIIIa	iCt,			
	O A	Access to new health benefit plans due to permanent move;					
	the Coo bet	Loss of services from contracting provider under another health benefit plan, as define Insurance Code or 1399.845 of the Health and Safety Code, for a condition described le § 1373.96(c) (an acute condition, serious chronic condition, pregnancy, terminal illruseen birth and 36 months of age, or performance of a surgery or other procedure that documented by the provider) and that provider is no longer participating in the health	d in ness t ha	Heas, cans	alth a are o een r	and Safety f newborn ecommend	
		Member of the Reserve Forces of the U.S. military returning from active duty or membional Guard returning from active duty under Title 32 of the U.S. Code.	oer (	of th	ie Ca	alifornia	
	O (	Other Qualifying Event: (Any other event or circums established by applicable state or federal law in defining qualifying events please in	nsta ndica	nce ate l	as s pelov	et forth in t v).	he
	Cor	nments:				_	
3.	Covera	ge Effective Date:					
	based of the more the sixter	re applying due to a qualifying event and your application is processed, your coverage in when the application is received. If the application is received between the first day of the coverage shall become effective the first day of the following month. If the application entry and last day of the month, coverage shall become effective the first day of the the following qualifying events allow for different effective dates:	ation the	d the n is r seco	e fifte ecei ond f	eenth day o ved betwee ollowing	
	•	In the case of marriage, domestic partnership, appointment of domestic partnership, Essential Coverage, coverage is effective on the first day of the month following rece					
	For the	following qualifying events, select one of the effective date options as describe	ed i	n th	e ch	art below.	
	•	In the case of birth, or adoption, or placement for adoption;	0	Α (	В	o C o D	
		In the case of a mandate to be covered as a dependent pursuant to a valid state or	0	A	οС		
	•	federal court order; In the case of death of a family member enrolled under your current coverage;	0	В	οС		
	Fffe	ctive date options					
	A	Coverage is effective on the date of birth, or adoption, or placement for adoption, or	da	te o	f vali	d state or	
		federal court order.					
	B	First day of the month following receipt of your application.  Based on when the application is received. If the application is received between the	o fir	ret d	2)/ 2	nd tho	
		fifteenth day of the month, coverage shall become effective the first day of the follow application is received between the sixteenth day and last day of the month, covera effective the first day of the second following month.	wing	g mc	nth.	If the	
	D	First day of the month following the date of the qualifying event.					
Sec	ction B -	- Applicant Information					

3.

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

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Last Name	First Name		MI	Social S	Security Number*(required)
Home Address**					
City	State	ZIP	County		
Billing Address (street and P.C	O. Box if applicable)				
City	State		ZIP		
Marital/Domestic Partner Statu	us	Sex	Date	of Birth	
O Single O Married O D	Oomestic Partner	0 M 0 F			1
Primary Phone Number ( ) (	Secondary Phone Number	E-mail***			

<sup>\*</sup>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.

<sup>\*\*</sup> 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").

<sup>\*\*\*</sup>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 D	omestic Partner to be (	COVER	ed Inforr	mation			
Last Name	omostic i aitiici to be t		Name	ilation	MI	Relationship	
		T IIST Name			1711		Domestic Partner
Social Security Number*	(required)	Sex			Date	of Birth	
-		0 M	o F			1 1	
Section D - Child Dependent	dents to be Covered In			fields require	d. Atta	ach a separate	e sheet if
necessary).			·			·	
Dependent information mu An eligible dependent may and adopted children and a relationship under age twe 26 may be eligible for cove physically or mentally disa	be your or your spouse' any child for whom you c nty-six 26. (List all deper grage as a dependent if t bling injury, illness, or co	s or your ndents hey ar nditior	our Dome spouse beginning e incapa n, and ch	estic Partner's or domestic pa ng with the elde ble of self-sust iefly dependen	childre irtner h est). C aining it upor	en, including stonas assumed a hildren over the employment be the policyhold	epchildren, newborn parent-child e age of twenty-six y reason of a ler or subscriber for
support and maintenance. period he or she would bed			endent, th	ne Dependent's	s disat	oility must start	before the end of the
Last Name	First Name	MI	Sex	Date of Birtl mm/dd/yyyy	Se Nu	ocial ecurity umber*	Relationship to Applicant
					(re	equired)	
			M F	, ,			o Child
			0 0 M F	/ /			o Other:
			0 0	, ,			o Other:
			M F	, ,			o Child
			0 0	/ /			o Other:
			ΜF				o Child
			0 0	/ /			o Other:
			M F				o Child
*Anthem is required by the		<u> </u>	0 0	/ /			o Other:
unless you select the healt applicable law.  Do you have a child age reason of a physically or is being requested under	th savings account option  26 or over who is incap  mentally disabling inju  this contract?	a in thi pable ( ury, ill	is Applica of self-s ness or	ation or to fede ustaining emp condition for	oloymo whom	ent by  coverage	os as required by
O Please send m	e a form.						
Are any of the applicant disposition of charges)		tion c	urrently	incarcerated (	(excep	ot pending	O Yes O No
If YES, who?						<del> </del>	
Preferred written languag	` '						
O Chinese (ZHO) (C/M) O English (ENG)	<ul><li>O Korean (KOR)</li><li>O Tagalog (TGL)</li></ul>			etnamese (VIE) ner (W09)	0	Spanish (SPN	٧)
Preferred spoken language	ge? (Optional)						
O Chinese (ZHO) (C/M)			o Vie	tnamese (VIF)	Ω	Spanish (SPN	۷)
O English (ENG)	O Tagalog (TGL)			ner (W09)	J	5 p 5 m 1 ( O 1 )	-,

O 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".

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#### 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**

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

#### **METAL LEVEL SILVER**

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

#### **METAL LEVEL GOLD**

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

#### **METAL LEVEL PLATINUM**

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

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

O Anthem Minimum Coverage D \$6,850/0% 1X5N

#### **HSA Plans**

#### **METAL LEVEL BRONZE**

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

#### Section F - Dental and Vision Coverage

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

o 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.

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<sup>\*\*</sup>These products are issued by Anthem Blue Cross and are regulated by the California Department of Managed.

#### Select ONE Plan:

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

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

O Applicant only

- O Applicant & all dependent children listed
- O Applicant & Spouse or Domestic Partner only
- O 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	Primary Care Dentist Number
	o Yes o No	

<sup>\*</sup>This product is issued by Anthem Blue Cross and is regulated by the California Department of Managed Health Care.

#### 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.

O Blue View Vision Individual\*\*\* (1RYD)

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

O Applicant only

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

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

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

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

Sec	tion G – Other Health and Dental Co	verage						
	If YES, who?							
2) Do you or anyone applying for coverage, currently have health care coverage?								
	If <b>YES</b> , please provide the following							
	Name(s) of covered persons. If th below.	Identification Number(s)						
	Name and phone number of prior carrier(s)							
	Type of coverage O Group O Individual	Effective Date of Coverage						
		Will you be terminating this health coverage if approved for Anthem Blue Cross coverage? O Yes O No						
3)	, , , , , , ,	you or anyone applying for coverage, currently have dental coverage?						
If YES, please provide the following for dental coverage:								
	Name(s) of covered persons. If th below.	Name(s) of covered persons. If the whole family, simply write ALL in space below.						
	Name and phone number of prior carrier(s)							
	Type of coverage O Group O Individual	Effective Date of Coverage						
	Will you be terminating this denta Dental coverage? O Yes O No	I coverage if approved for Anthem	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

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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 employersponsored 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

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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)	Date

<sup>\* (</sup>or Custodial Parent's or Guardian's signature if applicant is under age 18)

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#### Section I - Agent/Broker Certification

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

- O 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.
- O 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								
Agent/Broker Name (pl	Agent/Broker Street Address/Suite No./Personal Mail Box No.				l ail Box (PMB)			
Agent/Broker ID/TIN	Agency ID/	Parent TIN	City		Sta	ZIP		
Agent/Broker Phone No	).	Agent/Brok	er Fax No.		Agent/Broker E	-mail		
GA (if applicable)			GA code (if applicable)					
Section J – Statement of Accountability  Primary Applicant's Name:								
To be completed when NOTE: Interpreter mus					on behalf of the	applicant		
I, applicant named below t	pecause:		_ , personal	ly read and cor	mpleted this Indi	vidual App	ication for the	
O Applicant does not re English	ad 0 Ap Engli	oplicant does sh	not speak	O Applicant of English	does not write	O Applic English P	ant is Limited roficient	
O Other (explain):			· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·			
I interpreted the contents medical history disclosed		and to the be	st of my kno	wledge obtaine	ed and listed all t	he request	ed personal an	
O Applicant Or by:								

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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):					

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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

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## 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.			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				
☐ Monthly Automatic Premium Payment (compl	lete Section	1 A)	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 pro understand this authorization will apply to all products							
☐ Checking Account			A L Web 133 Wain Street		1175		
institution for routing and accour information.)	(You may need to contact your financial institution for routing and account number		Anytown USA 12466 BATE  SAN'TO THE CREDER OF \$ DOLLARS  MEMO				
Requested Debit Day: (1 <sup>st</sup> to 6 <sup>th</sup> of each mont If no date is requested, your premiums will be debited on the first of each month.			1234567891	1234567890123 1175			
Provide your Routing and Account Numbers here	ere: 9-Digit Bar		k Routing	Number	Bank Acc	ount Number	
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 mover 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 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 dishor 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							
B. Electronic Check – In lieu of sending a Paper Che information below. We require an exact amount to be debt		n submit th	is same i	nformation electron	ically. We will need yo	u to complete the	
Account Holder Name (Please PRINT) Bank Rou	uting 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:							
					7		
Billing address for this Credit / Debit Card:				City:	_J Zip	Code:	
Authorized Signature (as it appears on the credit card)		Cardbalda	r Nomo (oo	it appears on the are	dit card – Please Print)	Date	
V		Cardiloidei	i Name (as	it appears on the cre	uit card – Flease Fillit)	Date	

<sup>\*</sup> 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.