Anthem Blue Cross Enrollment Form Effective Date Group No. APPLICANT'S PERSONAL INFORMATION: Last Name (Print) First Name (Print) M.I. Male Female Street Address City State ZIP Code Telephone No. Employer Job Title Date of Hire Part-time to Full-time Effective Class Dept. No. E-mail Address Date APPLICANT'S LANGUAGE PREFERENCE When information is sent to you, we may be able to send it to you in a language other than English. What language would you prefer? (Optional) ☐ English Spanish 🗌 ☐ Chinese ☐ Japanese □ Tagalog ☐ Vietnamese ☐ Khmer Hmong ☐ Farsi ☐ Arabic □ Armenian Russian 0ther EMPLOYEE & FAMILY INFORMATION - Please list yourself and all eligible family members to be enrolled. (A Birthdate Last Name First Name M.i. Sex Mo/Day/Yr Age Social Security No. Self Same as above Same as above □ Spouse □ Domestic □M Partner □M □f Child \square M Child \square M Child □F \square M Child \Box F To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of Sta DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? If yes, please complete this section **Effective Date** Name Name and Address of Other Insurance Carrier Mo/Day/Yr **Group Number** Self □ Spouse 🗖 Domestic Partner Dependent No. 1 Above Dependent No. 2

DISTRIBUTION: WHITE - Anthem Blue Cross Membership;

Above
Dependent
No. 3
Above
Dependent
No. 4
Above

CANARY - Anthem Blue Cross Sales Office:

Mercifical Authorn Blus Cross plans:		TRYPE (D) F (RO)	VERVOES		Neveanolment		Redine 🖈		aime le 6	ull-time		oen-enrollment						
Intitle Celebrate Programme Programme Programme Programme Programme Programme Programme Programme Programme Programme Pr	Medical				Cross Life and Health Insurance Company plans: An					Dent	al				THE REAL PROPERTY.			
Preferred HW Controlacian PLUST Prover Setator P20 Develope Pental celector and of the Tolorology Develope Pental Celector Revision Select PA07	· ·																	
Select HW or		Preferred HM0 (CaliforniaCare PLUS)* Power S Power Advantage HM0* BBC PP0 Select HM0* BBC Excl PP0 (Prudent Buyer) BC Pow EP0 (Prudent Buyer Exclusive) Lumeno																
Select MAD Select MAD Select MAD Select Provided Buyer Select Provided Buyer Select Provided Buyer Select Provided Buyer Consideration Select Provided Buyer Consideration																		
PPG (Prudent Reyer) Control Research						lusive (non-California resident)						☐ Dental Net* ☐ PPO Dental Anthem Blue Cross Life and Health Insurance Company plans:						
Umenage Fiscales from a first following Dots											Anth							
PFD Benfal Pro										L								
Other		POS (Blue Cros	ss Plus)*	1467						Phie	_							
* Indicate Medical Group PPA No. In the Employee & Family Information section below. * Indicate Medical Broup PPA No. In the Employee & Family Information section below. * Indicate Medical Broup PPA No. In the Employee & Family Information section below. * Indicate Medical Broup PPA No. In the Employee & Family Information section below. * Indicate Medical Broup PPA No. In the Employee & Family Information section below. * Indicate Medical Broup PPA No. In the Employee & Family Information section below. * Indicate Medical Group PPA No. In the Employee & Family Information section below. * Indicate Medical Group PPA No. In the Employee & Family Information section below. * Indicate Medical Group PPA No. In the Employee & Family Information Section Indicate PPA * Indicate Medical Group PPA No. In the Employee & Family Information Section Indicate PPA * Indicate Medical Group PPA No. In the Employee & Family Information Section Indicate PPA * Indicate Medical Group PPA No. In the Employee & Family Information Section Indicate PPA * Indicate Medical Group PPA No. In the Employee & Family Information Section Indicate PPA * Indicate Medical Group PPA No. Interest												☐ Voluntary PPO ☐ Mational Voluntary PPO						
*Indicate Medical GroupPP No. in the Employee & Family Indicate Draw Union Crist Detail Disorder No. in the Employee & Family Section by your employer. *Indicate Medical Solidate the opening of a Health Savings Account in your mone, if directed by Your employer. *Indicate Profetible Spending account!* *Indicate Profetible Spending S					[]							:¥¢	HUHA	voium	ary PP	'U		
*Anthem Blue Crass will salitiate the opening of a bealth Savings Account in your name, if directed by your name, if directed by Yosin Blue View Yosin Indirect and y Anthem Blue Crass PD, Drug and Dental plan enrolless, will have not openenses, automatically deductions of the Class Psyroll Deductions on the following: Health Care PSA account. Automatic PSA processing is not pressible for IMB enrolless and those with coverage through another Health Pian. Reminder Automatic PSA processing is not pressible for IMB enrolless and those with coverage through another Health Pian. Reminder Automatic PSA processing is not pressible for IFSA remindurement and that you will not claim PSA reminder various text you are eligible for PSA remindurement and that you will not claim PSA reminder various text you. **Anthem Blue Crass PNO, Drug and Dental plan enrolless, will have not opposences, automatically deducted from their Health Care PSA account. Automatic PSA processing is not pressing and support the pression of the enrolless and those with coverage through another health PSA account. Automatic PSA processing is not pressing and support pressing and support pression processing is not pressing and pressing and support pression. Automatic PSA processing is not pressing and pressing and support pressing and pression pression pressing and pression pression pressing and pression pressio		* Indicate Medical	Group/IPA No	o. in the i	Employee & Fami	nily Information section below.												
Substance (Flechble Spending account)* Authern Blue Crass PPO, Drug and Dental plan enrolless, will have out-of-pooket greenees, automatically deducted from their Hoalth Care PSA account. Automatic PSA processing is not possible for HIND enrolless and those with coverage performance programs on the following:		** Anthem Blue Cros	ss will facilita	ite the or	ening of a Healt	h Savin	igs Account ir	ı your nan	ne, if dired	cted by								
Maker, own (Fleezible Spending account)* (Indicate Spending account)* (I		your employer.								VISIU								
Indicate Payroll Deductions on the following: Health Care Account S Health Car		HuAccount (Flevih	le Spending	account)	* .		ni				<u> </u>							
authorize payroll deductions on the following: Health Care Account				account								A processing is not possible for HMO enrollees and those with						
Health Care Account				the folio														
Dependent Care S				e circ rone	•													
It children are age 19 or ever you must check the appropriate baxes below wishing the pendent show the student length of the stude			лин ф <u> </u>									enginie ini rav reillini	n sement a	iu ma	. you w	HE HOLE	Uldilli	
Coverage	701	1 '	Ψ	221717E			•		•					W.T.	22.50			
Coverage Group/IPA No. Primary Care Physician Code Current MO? Dental Office No.	r:[n additional si	ieesiiii	E HES	sary.)				19. E. A	4.7.4865.000 200			Salego Fil		100	Part in all	# V	
If children are age 18 or over you must check the appropriate boxes below Vision					0									N 4 - I	occ			
Children are age 19 or over you must						Gro	up/IPA No.	Prin	lary Care	Physician	C006	Current Min?		neursi	итисе	NO.		
check the appropriate boxes below Usision No No No Usision Usision Usision Usision Usision Usision No No Ves No No No Ves No No No Ves No No No No No No No N		If children are age	19 or over vo	u must								☐ Yes						
Qualifies as IRS												□No						
Dependent Student Dental Student Destal					·		Ll											
Ves							1 1	,	1				1	4.	ı			
No		nebeugeut 21		ent								□No			İ			
No		□ Voc		~~	Medical		1				······	["] v	,					
Yes Medical Medical Medical Yes Me		Nn ·		35 n				1	1	1 1	ı	Yes	ı	1	ı	l	ſ	
Yes				·						<u> </u>		L INU						
No		Yes	[☐ Ye	35								Yes						
Yes			□ Ne	0							1	No					1	
Yes Mental Health: Yes No Dental: Yes								L_		<u> </u>	l		L					
Yes						1	,				,	☐ Yes	,	0				
Yes		□No	∟ No	0								□No					1	
No		DVaa								<u></u>		punne, ,						
pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships MEDICARE SECTION		No				[l	1	1 1	l	Yes	ŧ	l	ı	ı	(
Is this yours or your dependent's primary coverage? Sthis yours or your dependent's primary coverage? Does it cover?																		
Is this yours or your dependent's primary coverage? Yes	e pur	suant to the California F	Family Code, o	or have pi	roperly filed an ed	quivale	nt document i	n accorda	nce with t	the laws of	another	jurisdiction recognizin	g the creati	on of d	omestic	a partno	erships	
Is this yours or your dependent's primary coverage? Yes		aludine Medica	ire (ili an		lle)			10.00			MED	on to example of	N					
primary coverage? Does it cover?	HATH (SASSES)							- Andread - Control - Cont	NAME OF TAXABLE PARTY.	Management of the Party of the		AMERICAN PROPERTY OF THE PROPE	de la companie de la		***************************************			
Yes					Does it cover?		ALE YOU ICL	aicur			L. NU							
Yes Mental Health: Yes No Dental: Yes No Dental: Yes No Dental: Yes No Dental: Yes No Medical: Yes No Dental: Yes						Mo	If yes		Part A	□Yes	□No	the entitlement reas	on and Med	ficare	eligibili	tv date	e for	
Dental:									Part B	🗆 Yes	□No	yourself and/or your	Dependent	(s).		-,		
Yes		LJ NO			Yes	No	n						•					
No		Voe		Mental	Health: 🗌 Yes	uu you or your bep			pendents			HIB No.				***		
				1			Have Medic	/GI G f . , . ,	• • • • • • • • • • • • • • • • • • • •		١٧٠ لست	Entitlement Reason:						
Medical: Yes No Name(s) of Medicare Dependents: Effective Date of Medicare: / /							If yes fo	r your	Part A	Yes				1	ESR	D		
No		☐ Yes						nt	Part B			reconting posts of the	dianus.					
Yes					l: Yes	No				_		Effective Date of Me	olcare:	_ '	/_			
Yes							Name(s) of	Medicare	licare Dependents: Name		Name							
Dental:		No Medic Dental		Mental														
Yes Mental Health: Yes No Medical: Yes No Dental: Yes No Medical: Yes No Mental Health: Yes No Medical: Yes Yes No Medical: Yes Ye						□ No					HIR No.							
Medical:	İ														·			
Dental:															. يسے			
Yes Mental Health: Yes No Effective Date of Medicare: / /		LJ NO										∟ Over 65	∟ Disabled		∟JESR!	D		
Medical: Lyes Lino		□ V ₂ ,		Mental]					Effective Date of Me	dicare:	1	1			
Dental: Lyes No Name				Medical	: 🔲 Yes 🛚	No												
		tami ITU		Dental:	☐ Yes [_l No_				····		Name			-			

PRIORISOVARAGA	OR PPO RLANGTON BY								
Please fill out the following in	formation to receive proper cred c or private health care coverage	lit for PREVIOUS COVERAGE. If in							
must provide you with a certif	icate that shows evidence of yo	e uncluding wedical of individual or prior coverage. We reserve th	e right to request a c	; to rederal law your employ opy of this certificate.	ARI DI LOWMEN CHRISK				
	Name	Coverage Covera Begin Date End Da		Carrier Name	Reason for Ending Coverage				
Self									
☐ Spouse ☐ Domestic Partner									
Child									
Child									
Child									
PLEASE READ CARE	FULLY=SIGNATURE F	REQUIRED							
I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no									
omissions or misstatements.									
DEDUCTION AUTHORIZATION: I	f applicable, I authorize my empl	loyer to deduct from my wages	he required dues.						
NON-PARTICIPATING PROVIDER	t: I understand that I am respons	sible for a greater portion of my	medical costs when I	use a non-participating pro	vider.				
HIV TESTING PROHIBITED: Calif	ornia law prohibits an HIV test f	rom being required or used by h	ealth insurance comp	anies as a condition of obta	ining health insurance.				
EFFECTIVE DATE: The effective	date of coverage is subject to A	nthem Blue Cross approval.							
REQUIREMENT FOR BINDING AF	BITRATION								
The following provision doe	es not apply to class actions								
BINDING ARBITRATION TO SETT ISSUES RELATED TO THE PLAN IS California Health and Safety Countries understood that any disjunauthorized or were impropedly a lawsuit or resort to countries it, are giving up their contries MEANS THAT YOU AND AND BOTH MEDICAL MALPRACTICE CORLANDED TO THE PLAN.	ERAGE, PLEASE NOTE THAT ANTH ITLE ALL DISPUTES INCLUDING BUAND CLAIMS OF MEDICAL MALPF ode Section 1363.1 and Insurance oute as to medical malpractice erly, negligently or incompeten t process except as California stitutional right to have any surther STHEM BLUE CROSS AND/OR ANT CLAIMS, AND ANY OTHER DISPUT	IT NOT LIMITED TO DISPUTES RE RACTICE, IF THE AMOUNT IN DIS SE Code Section 10123.19 requi SE, that is as to whether any me tly rendered, will be determine law provides for judicial review ICH dispute decided in a court THEM BLUE CROSS LIFE AND HE	LATING TO THE DELIVING TO THE JU- PUTE EXCEEDS THE JU- PUTE EXCEEDS THE JU- PUTE SERVICES THE JU- PUTE SERVICES THE JU- PUTE SERVICES THE JU- PUTE SERVICES THE JUILING THE JU	ERY OF SERVICE UNDER THE RISDICTIONAL LIMIT OF SM. es in this regard, including the red under this contract we incitration as provided by limited redings. Both parties to the and instead are accepting IPANY ARE WAIVING THE RIGERS.	PLAN OR ANY OTHER ALL CLAIMS COURT. The following notice: Fore unnecessary or California law, and not This contract, by entering The use of arbitration." GHT TO A JURY TRIAL FOR				
Signature (Required)				·					
pplicant				***************************************	Date				