Employee Enrollment Application
For 1–100 Employee Small Groups
California

Anthem BlueCross

Health care plans offered by Anthem Blue Cross. Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company.

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Note: Anthem Blue Cross is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect Social Security numbers.

Submit application to: your employer.

Group/Case no. (if known)

Please complete in blue or black ink only.

Section A: Employee Information

Last name	First name	M.I.	Social Security no.* (required)

Home address – Street and PO Box if applicable

City	State	ZIP code

County	Marital status ☐ Single ☐ Married ☐ Domestic Partner	Primary phone no.	Number of dependents

Employee email address

Employer name

Employer street address

City	State	ZIP code

Employment status ☐ Full time ☐ Part time ☐ Disabled	Occupation

Date of hire (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins (MM/DD/YYYY)	No. of hours worked per week

Language choice (optional): ☐ English (ENG) ☐ Spanish (SPA) ☐ Chinese (ZHOX) (C/M) ☐ Korean (KOR) ☐ Vietnamese (VIE) ☐ Tagalog (TGL)
☐ Other (W09) – please specify: _____

Do you read and write English?
☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability/Translator's Statement.

Section B: Application Type

Select one

☐ New enrollment
☐ Open enrollment (not applicable for Life and Disability)
☐ Family addition Event date:
☐ COBRA
☐ Cal-COBRA
Cal-COBRA applicants must submit first month's premium.

Select qualifying event
☐ Left employment
☐ Loss of dependent child status
☐ Covered employee's Medicare entitlement
☐ Reduction in hours
☐ Divorce or legal separation
☐ Death

Note: For Cal-COBRA/COBRA applicants: Effective date of qualifying event:

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Social Security no.*

Section C: Type of Coverage – Select from only the coverages offered by your employer.

1. Medical Coverage – select one option **Medical plans offered by Anthem Blue Cross.**

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

	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
PPO: Prudent Buyer PPO Network	☐ 20/10%/4000 ☐ 200/10%/3000	☐ 20/30%/5500 ☐ 500/20%/4500 ☐ 700/20%/6600 ☐ 1000/20%/4000 ☐ 1000/20%/5900 ☐ 2000/0%/2500 w/HSA -RxC ☐ 2000/0%/3000 w/HSA ☐ 2000/20%/4000 ☐ 2000/20%/4000 w/HRA[1]	☐ 1250/40%/6850 ☐ 1750/35%/6850 ☐ 2000/35%/6850 ☐ 2000/20%/4850 w/HSA ☐ 2000/20%/4600 w/HSA -RxC	☐ 4500/30%/6350 w/HSA ☐ 5000/30%/6850 ☐ 6000/0%/6000 w/HSA ☐ 6000/35%/6600
PPO: Select PPO Network	☐ 20/10%/4000 ☐ 200/10%/3000	☐ 20/30%/5500 ☐ 35/20%/6200 ☐ 500/20%/4500 ☐ 700/20%/6600 ☐ 1000/20%/4000 ☐ 1000/20%/5900 ☐ 2000/0%/2500 w/HSA -RxC ☐ 2000/0%/3000 w/HSA ☐ 2000/20%/4000 ☐ 2000/20%/4000 w/HRA[1]	☐ 1250/40%/6850 ☐ 1500/20%/6500 ☐ 1750/35%/6850 ☐ 2000/35%/6850 ☐ 2000/20%/4850 w/HSA ☐ 2000/20%/4600 w/HSA -RxC	☐ 4500/30%/6350 w/HSA ☐ 5000/30%/6850 ☐ 6000/0%/6000 w/HSA ☐ 6000/35%/6600 ☐ 6000/100%/6500
HMO: CaliforniaCare HMO Network	☐ 25/20%/5000	☐ 50/30%/6850 ☐ 500/20%/5000	☐ 1750/40%/6850	
HMO: Select HMO Network	☐ 25/20%/5000	☐ 50/30%/6850 ☐ 500/20%/5000	☐ 1750/40%/6850	
HMO: Priority Select HMO Network	☐ 25/20%/5000	☐ 50/30%/6850 ☐ 500/20%/5000	☐ 1750/40%/6850	

☐ Other: _____

Please indicate the contract code for the medical plan selected: Contract code, if known: _____

Member medical coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

2. Dental Coverage – Select from only the coverages offered by your employer.

Dental Complete PPO Plan[1,2]	Dental Net DHMO Plan[1,3]	Dental Net Voluntary DHMO Plan[1,3]
☐ Classic ☐ Enhanced ☐ Voluntary	☐ Dental Net 2000A ☐ Dental Net 2000B ☐ Dental Net 2000C	☐ Dental Net Voluntary 2000A ☐ Dental Net Voluntary 2000B ☐ Dental Net Voluntary 2000C

For all DHMO plans, you must enter your Dental office no.: _____ ☐ Other: _____

1 These optional dental plans do not include coverage for dental pediatric essential health benefits. 2 Offered by Anthem Blue Cross Life and Health Insurance Company.
3 Offered by Anthem Blue Cross.

Member dental coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family ☐ No coverage

3. Vision Coverage – Select from only the coverages offered by your employer. **Offered by Anthem Blue Cross Life and Health Insurance Company.**

These optional vision plans do not include coverage for vision pediatric essential health benefits.

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

☐ Other: _____ **Please indicate the contract code for the vision plan selected:** Contract code, if known: _____

Member vision coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

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Social Security no.*

4. Life and Disability Coverage – Select from only the coverages offered by your employer.
Offered by Anthem Blue Cross Life and Health Insurance Company.

☐ Life & AD&D ☐ Optional Life $_____ ☐ Other: _____
☐ Dependent Life

Current income: $_____ ☐ Hour ☐ Week ☐ Month ☐ Year | Life class

If you select Life and/or Disability coverage over the guarantee issue amount or are a late entrant an *Evidence of Insurability* form will be sent to you to complete.

☐ Life & AD&D ☐ Optional/Voluntary Life & AD&D ☐ Short Term Disability ☐ Voluntary Short Term Disability
☐ Dependent Life ☐ Optional/Voluntary Dependent Life ☐ Long Term Disability ☐ Voluntary Long Term Disability

Primary Beneficiary – Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Contingent Beneficiary – Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Total percentages should add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no Primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above.

Spousal Consent for Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse's consent for designation.)
If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following. I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.

Spouse signature	Spouse name	Date
X		

NOTICE OF EXCHANGE OF INFORMATION: To proposed Insured and other persons proposed to be Insured, if any – information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 1-866-692-6901.

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4. Life and Disability Coverage — Continued

I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., to Anthem Blue Cross Life and Health Insurance Company (Anthem Life), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem Life will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to ARC or AIDS (excluding disclosure of HIV testing or HIV status), sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that Anthem Life may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life.

I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage. I also acknowledge receipt and understanding of the Notice of Exchange of Information explained above. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s). This authorization, for purposes of processing this application form, is valid from the date signed for a period of thirty months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. A photocopy is as valid as the original.

I give this authorization for and on behalf of myself and my eligible dependents, including my children and my spouse (if spouse does not sign below), if covered by the Plan. I am acting as their agent and representative.

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

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

Social Security no.*

Section D: Coverage Information — All fields required. Attach a separate sheet if necessary.
Please access *Find a Doctor* at anthem.com to determine if your physician is a participating provider.
For HMO plans: provide 3- or 6-digit Primary Care Physician no.

Dependent information must be completed for all additional dependents (if any) **to be covered under this coverage**. An eligible dependent may be your spouse or domestic partner, your children, or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26). In the case of your child, the age limit of 26 does not apply when the child is and continues to be (1) incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and (2) chiefly dependent upon the subscriber for support and maintenance. The employee will be required to submit certification by a physician of the child's condition. List all dependents beginning with the eldest.

Employee last name	First name	M.I.	
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant Self
Primary Care Physician (PCP) name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient ☐ Yes ☐ No	

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner
PCP name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient ☐ Yes ☐ No	

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please provide full address and ZIP code: ____________________

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ____________
PCP name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient ☐ Yes ☐ No	

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please provide full address and ZIP code: ____________________

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ____________
PCP name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient ☐ Yes ☐ No	

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please provide full address and ZIP code: ____________________

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ____________
PCP name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient ☐ Yes ☐ No	

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please provide full address and ZIP code: ____________________

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Section E: Other Coverage

1. Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name: _____

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date:

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

2. Does anyone on this application intend to continue other coverage if this application is accepted? ☐ Yes ☐ No
3. Is anyone applying for coverage covered by other health, dental, or vision coverage? ☐ Yes ☐ No
4. On the day your coverage begins, will you or a family member be covered by other dental coverage? ☐ Yes ☐ No

If yes to any of these questions, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision				Start: End:

Section F: Waiver/Declining Coverage – Proof of coverage will be required

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
***Life/AD&D** coverage declined for: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Dependent Life coverage declined for: ☐ Spouse/Domestic Partner ☐ Dependents
Short Term Disability coverage declined for: ☐ Myself
Long Term Disability coverage declined for: ☐ Myself

Reason for declining coverage – check all that apply:
☐ Covered by Spouse's/Domestic Partner's group coverage
☐ Enrolled in other Insurance –
Please provide company name and plan: _____
☐ Enrolled in Individual coverage
☐ Spouse/Domestic Partner covered by employer's group medical coverage
☐ Medicare/Medicaid/VA
☐ Other – please explain: _____
☐ No coverage

List names of dependents to be waived: _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to waive coverage. BY WAIVING THIS GROUP MEDICAL, DENTAL, VISION, DISABILITY OR LIFE COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, VISION, DISABILITY OR LIFE COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT TO BE ENROLLED IN THIS GROUP'S MEDICAL, DENTAL, VISION, DISABILITY OR LIFE PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT.

Special Open Enrollment
If you declined enrollment for yourself or your dependent(s) (including a spouse/domestic partner), you may be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of certain triggering events, including: (1) you or your dependent loses minimum essential coverage; (2) you gain or become a dependent; (3) you are mandated to be covered as a dependent pursuant to a valid state or federal court order; (4) you have been released from incarceration; (5) your health coverage issuer substantially violated a material provision of the health coverage contract; (6) you gain access to new health benefit plans as a result of a permanent move; (7) you were receiving services from a contracting provider under another health benefit plan, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan; (8) you are a member of the reserve forces of the United States military or a member of the California National Guard, and returning from active duty service; or (9) you demonstrate to the department that you did not enroll in a health benefit plan during the immediately preceding enrollment period because you were misinformed that you were covered under minimum essential coverage. You must request special enrollment within 60 days from the date of the triggering event to be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of a qualifying triggering event.

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense. Please examine your options carefully before waiving this coverage.

Sign here only if you are declining coverage for yourself or dependents.

Signature of applicant	Printed name	Date (MM/DD/YYYY)
X		

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

Social Security no.*

Section G: Terms, Conditions and Authorizations

Please read this section carefully before signing the application.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. All statements and answers I have given are true and complete. I understand it is a crime to make or cause to be made a knowingly false or fraudulent material statement or material representation to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that:

I have read or have had read to me the completed application, and I realize any acts of fraud or intentional misrepresentation of material fact in the application may result in loss of coverage within 24 months following the issuance of the coverage.

I certify each Social Security number listed on this application is correct.

I understand that I may not assign any payment under my Anthem Blue Cross (Anthem) program. I agree to have money taken from my wages, if necessary, to cover the premium cost for the coverage applied for.

I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application.

I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for coverage (and that Anthem Blue Cross Life and Health Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage.

I also understand that I may not be covered for pre-existing conditions for Long Term Disability and Short Term Disability, if applicable. (See the policy/certificate for important information).

I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.

By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.

If applying for Life and/or Disability insurance, I represent that I have read and agree to the terms in the *Life and Disability Coverage* in Section 4, above.

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.

Read carefully – Signature required

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

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By signing, writing or typing your name below you agree to the terms of this agreement and acknowledge that your signed, written or typed name is a valid and binding signature.

Sign here	Applicant signature X	Date (MM/DD/YYYY)

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Social Security no.*

Anthem Blue Cross
Language Assistance Services

English

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 888-254-2721.

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos ayudarlo a leerla. También es posible que reciba esta carta escrita en su idioma. Para obtener ayuda gratuita, llame ahora mismo a l-888-254-2721.

Chinese (Traditional)

重要事項:您是否能閱讀此信?如果無法閱讀，我們將為您提供專員協助服務。我們也能將此信翻譯成您所使用的語言。欲洽詢免費服務，請立即致電 888-254-2721。

Korean

중요 공지: 이 서신을 읽은 데 어려움은 없으십니까? 만일 어려움이 있다면 이 서신을 잘 읽을 수 있도록 도움을 드릴 수 있습니다. 또한 여러분은 이 서신의 한국어 번역본을 제공받으실 수 있습니다. 이 무료 서비스를 원하시는 분은 지금 바로 888-254-2721 로 전화하십시오.

Vietnamese

QUAN TRỌNG: Quý vị có dọc dược lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị dọc thư. Quý vị cling có thể nhận thư này bằng tiếng Việt. Dể dược giúp dỡ miễn phí, xin gọi ngay số 888-254-2721.

Tagalog

MAHALAGA: Nababasa ba ninyo ang sulat na ito? Kung hindi, makakakuha kami ng taong makakatulong sa inyo na basahin ito. Maaari ninyo ring makuha ang liham na ito sa inyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 888-254-2721.

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

Anthem Blue Cross Life and Health Insurance Company
Notice of Language Assistance

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-888-254-2721. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-888-254-2721. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽有些文件有中文的版本也可以把這些文件寄給您。 欲取得協助請致電您的保險卡所列的電話號碼或撥打 1-888-254-2721 與我們聯絡。欲取得其他協助請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dfch Vy Try. Giúp Ngôn Ngir Mien Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-888-254-2721. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin. Maaari mong ipabasa sa iyo ang mga dokumento at maaari mong hingin na ipadala ang ilang mga dokumento sa iyo sa Tagalog. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-888-254-2721. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357.Tagalog

무료 통역 서비스. 귀하는 통역 서비스를 받으실 수 있습니다. 한국어로 서류를 낭독해주는 서비스 받으실 수 있으며 한국어로 번역된 서류를 받아보실 수도 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-888-254-2721 번으로 문의해 주십시오. 보다 자세한 문의 사항은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357 번으로 연락해 주십시오. Korean

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-888-254-2721 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Becnaarnme ycaynt nepetwita. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-888-254-2721. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または 1-888-254-2721 までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。Japanese

,' 01-4.1-, 2,14 4-(.,-,..1 ,-ه 0 ,-میتوانید از خدمات یک مترجم شفاهی استفاده کنید گوئید مدارک به زبان فارسی برای تان خوانده شود و نسخه هایی دریافت
کمک با ما از طریق شماره تلفنی که روی کارت شناسایی شما درج شده است و یا این شماره 1-888-254-2721 تماس بگیرید برای دریافت کمک بیشتر به
CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تماس بگیرید . Persian

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

Social Security no.*

Anthem Blue Cross Life and Health Insurance Company
Notice of Language Assistance

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸ□ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਿਵੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਿਵੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਿਦੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-888-254-2721 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਿਡਪਾਰਟਮ□ਟ ਆਫ਼ ਇਨਸ਼ੋਰ□ਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នក ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-888-254-2721 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 ។ Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم فوري وقراءة الوثائق باللغة العربية. للحصول على المساعدة، اتصل على الرقم المبين على بطاقة هويتك أو على الرقم 1-888-254-2721. للحصول على مزيد من المساعدة، اتصل بإدارة التأمين في ولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-888-254-2721. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357. Hmong

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