Anthem Blue Cross

EmployeeElect for 2-50 Member Small Groups
Health care plans offered by Anthem Blue Cross
Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company

Employer Application

anthem.com/ca

1. Please tell us about your company:

Legal Company Name		Group No. *(For existing groups)*	
Street Address	City	State **CA**	ZIP Code
Billing Address	City	State	ZIP Code
Employer is: ☐ Corporation ☐ Partnership ☐ Sole proprietorship ☐ LLC ☐ Other *(Explain)*:	SIC Code	Type of Business *(Be specific)*	
Date Business Established *(Mo/Yr)* / Company Contact Person		Phone No. ( )	Fax No. ( )
Has the company been insured by Anthem Blue Cross in the last 12 months? ☐ Yes ☐ No If yes, date prior Anthem Blue Cross coverage terminated: ___/___/___		Federal Tax ID No. *(Do not list SSN)*	E-mail Address

2. Medical Coverage Preferences - what payment options and plan choices would you like to select?

2a. My Employer Medical Contribution each month will be:

☐ **Traditional Option** I will contribute *(50% to 100%):* _____% per employee _____% per dependent

☐ **Fixed Dollar Option** I will contribute *(at least $100 in $5 increments):* $_____

☐ **Percentage and Plan Option** I will contribute *(50-100%)* to the following plan _____
_____% per employee _____% per dependent

2b. I choose to offer:

NOTE: *SelectHMO plans cannot be offered along with any other non-SelectHMO plans.*

☐ **All plans** with HRA plans ☐ **All plans** without HRA plans ☐ **Designate specific plans** (check as many as apply)

- ☐ Premier PPO $10 Copay[1]
- ☐ Premier PPO $20 Copay[1]
- ☐ Premier PPO $30 Copay[1]
- ☐ PPO $20 Copay[1]
- ☐ PPO $30 Copay[1]
- ☐ PPO $40 Copay[1]
- ☐ PPO 1000/$25[1]
- ☐ PPO 1500/$35[1]
- ☐ PPO 2000/$45[1]
- ☐ PPO $25 Copay GenRx[2]
- ☐ PPO $35 Copay GenRx[2]
- ☐ PPO $45 Copay GenRx[2]
- ☐ Solution 2500 PPO[2]
- ☐ Solution 3500 PPO[2]
- ☐ Solution 5000 PPO[2]
- ☐ High Deductible EPO[1]
- ☐ Lumenos HRA 3000C[2,5]
- ☐ Lumenos HRA 3000D[2,5]
- ☐ Lumenos HRA 5000C[2,5]
- ☐ Lumenos HRA 5000D[2,5]
- ☐ Lumenos HSA 1500 (80/50)[1]
- ☐ Lumenos HSA 2500 (80/50)[1]
- ☐ Lumenos HSA 3500 (80/50)[1]
- ☐ Lumenos HIA Plus 500[2]
- ☐ Lumenos HIA Plus 750[2]
- ☐ Elements Hospital Preferred[2]
- ☐ Elements Hospital Plus[2]
- ☐ Elements Hospital[2]
- ☐ HMO $10 100%[1]
- ☐ HMO $25 100%[1]
- ☐ Classic $20 HMO[1]
- ☐ Classic $30 HMO[1]
- ☐ Classic $40 HMO[1]
- ☐ Saver $20 HMO[1]
- ☐ Saver $30 HMO[1]
- ☐ Saver $40 HMO[1]
- ☐ HMO $10 100% (Select Network)[1]
- ☐ HMO $25 100% (Select Network)[1]
- ☐ Classic $20 HMO (Select Network)[1]
- ☐ Classic $30 HMO (Select Network)[1]
- ☐ Classic $40 HMO (Select Network)[1]
- ☐ Saver $20 HMO (Select Network)[1]
- ☐ Saver $30 HMO (Select Network)[1]
- ☐ Saver $40 HMO (Select Network)[1]
- ☐ Select $25 HMO[1,4]
- ☐ Select $35 HMO[1,4]
- ☐ Lumenos HSA 2000 (100/70)[2,3]
- ☐ Lumenos HSA 3000 (100/70)[2,3]
- ☐ Lumenos HSA 5000 (100/70)[2,3]
- ☐ Other _____

[1]Offered by Anthem Blue Cross.
[2]Offered by Anthem Blue Cross Life and Health Insurance Company.
[3]Plan will not be available for new group sales or renewals beginning July 2011.
[4] Plans will not be available for new group sales or renewals beginning October 2011.
[5] Plans and rates are subject to regulatory review or approval.

For Lumenos HRA plans:
The selection of any HRA-compatible plan requires enrollment in the Agreement for Health Reimbursement Accounts (HRA Agreement), and submission of the Demand Debit Authorization form. Please complete the Demand Debit Authorization form found after the end of this application.

For Lumenos HSA plans:
☐ Group wants to establish a Health Savings Account (HSA) with Anthem Blue Cross facilitating with a banking services provider.
☐ Group will establish the Health Savings Account (HSA) but does not want Anthem Blue Cross to facilitate in the creation of the account.

3. Dental Coverage Preferences - what payment options and plan choices would you like to select?

3a. My Employer Dental Contribution each month will be:

☐ **Traditional Option** I will contribute *(at least 50%):* _____% per employee _____% per dependent

☐ **Fixed Dollar Option** I will contribute *(at least $15 in $5 increments):* $ _____

3b. I choose to offer:

☐ **All plans OR** ☐ **Designate specific plans** (check as many as apply):

- ☐ Dental Blue Silver 100-80**
- ☐ Dental Blue Silver Plus 100-80**
- ☐ Dental Blue Gold 100-80**
- ☐ Dental Blue Gold Plus 100-80**
- ☐ Dental Blue Platinum 100-80**
- ☐ Dental Blue Platinum Plus 100-80**
- ☐ High Option PPO**
- ☐ Standard Option PPO**
- ☐ Basic Option PPO**
- ☐ Dental Net*
- ☐ Other:_____

Voluntary Dental Coverage

Please check below to offer one or both voluntary dental plans. *(not available in conjunction with any other dental plans):*

- ☐ Dental PPO**
- ☐ Dental Saver SelectHMO*

**offered by Anthem Blue Cross*

***offered by Anthem Blue Cross Life and Health Insurance Company*

4. Vision Coverage Preferences - what payment options and plan choices would you like to select?

4a. My employer contribution will be *(50-100%):*

_____% per employee _____% per dependent

offered by Anthem Blue Cross Life and Health Insurance Company

4b. I choose to offer:

☐ Blue View AND/OR ☐ Blue View Plus

5. Life Coverage Selections

Add $25,000 or more of Life Coverage and your group may qualify for 1% medical premium savings!

☐ I choose to offer Life coverage, and my Employer Life Contributions will be *(25-100%):*

_____% per employee _____% per dependent

Please check only one schedule and specify amount of Life coverage *(from $15,000 to $250,000 in $1,000 increments):*

☐ **Schedule A** Coverage is the same for all job titles $_____

☐ **Schedule B** Coverage differs by job title:

Class I, officers, managers, supervisors $_____

Class II, all other group members $_____

(Coverage amount for Class I cannot exceed 2.5 times coverage amount for Class II)

☐ **Schedule C** Coverage is a percentage of salary (maximum coverage $250,000); check one of the following for **all** employees:

EITHER ☐ 1 times annual salary, maximum Life coverage $_____

OR ☐ 2 times annual salary, maximum Life coverage $_____

For Schedule C, please provide list of employees & annual base salaries

☐ I choose to offer Dependent Life coverage:

EITHER ☐ $10,000 spouse; $10,000 children 6 months to age 26; $1,000 children under 6 months ***(only available if employee Life benefit is $20,000 or more)***

OR ☐ $5,000 spouse; $5,000 children 6 months to age 26; $500 children under 6 months ***(only available if employee life benefit is purchased)***

☐ I choose to make Supplemental Life coverage available; *Supplemental Life is 100% employee paid* ***(only available if other Life options are also selected)***

Offered by Anthem Blue Cross Life and Health Insurance Company

6. Do you want to enroll in P.O.P.?

☐ Yes ☐ No *Premium Only Plan (P.O.P.) is a payroll administration service [offered by Ceridian Benefit Services, Inc. (an independent company not affiliated with Anthem Blue Cross)] that helps companies receive IRS Section 125 tax advantages.*

The first year may be FREE if your group has 10+ members enrolling in both Medical and Life; otherwise the cost per year is $125. Please read the P.O.P. brochure for complete details. If you choose to enroll please complete the P.O.P. application and, provide a separate check (if applicable), along with this application. Please make checks payable to Anthem Blue Cross.

7. Please tell us about your group's eligibility:

A. Total number of employees (including owners/officers): _____

B. Number of eligible full-time employees (working a minimum of 30 hours per week): _____

C. Are part-time employees to be covered? ☐ Yes ☐ No
If yes, check one option: ☐ 20-29 hours weekly ☐ 15-29 hours weekly

D. Number of eligible part-time employees: _____

E. Is this group a class carve-out? ☐ Yes ☐ No

If yes, state class of employees to be covered: _____

F. Probationary period/waiting period for new employees:
☐ 1st of month after hire date ☐ 3 months ☐ 5 months
☐ 1 month ☐ 4 months ☐ 6 months
☐ 2 months

G. Do you wish to offer coverage for opposite sex domestic partners* under the age of 62 years? ☐ Yes ☐ No

H. Is your group currently subject to Cal-COBRA? ☐ Yes ☐ No

(Employed 2-19 eligible employees on at least 50% of its working days in the previous calendar year; or if not in business during any part of the previous calendar year, employed 2-19 eligible employees on at least 50% of its working days during the previous calendar quarter; and not subject to COBRA)

I. Total number of Cal-COBRA enrollees: _____

J. Is your group currently subject to COBRA and Cal-COBRA? ☐ Yes ☐ No

(Employed 20 or more total employees on at least 50% of the working days in the previous calendar year)

K. Total number of COBRA enrollees: _____

L. Is your group subject to the Family Medical Leave Act of 1993? *(50 or more total employees)* ☐ Yes ☐ No

M. Under TEFRA/DEFRA; which one applies for your group?

☐ Medicare is primary (less than 20) ☐ Anthem Blue Cross is primary (20+)

Medicare is primary coverage for groups with less than 20 employees; Anthem Blue Cross is primary coverage for groups with 20+ employees (based on total number of employees during 50% of the working days in previous calendar year).

If yes to questions H, J or L, please complete the Cal-COBRA/COBRA/FMLA questionnaire on page 4.

8. What is your requested effective date?

_____/_____/_____ Actual effective date will be assigned if application is accepted.

8a. Certificates/EOCs - The Employer has the option to receive employee Certificates or Combined Evidence of Coverage and Disclosures Forms (EOCs) in the form electronic or printed copy.

Would you like to receive the employee Certificates and/or Combined Evidence of Coverage and Disclosure Forms (EOCs) in electronic format? ☐ Yes ☐ No

By marking "Yes," employer agrees to comply with all applicable provisions of the Employee Retirement Income Security Act (ERISA) in connection with the delivery of the Certificates/EOCs to its employees in electronic format (e-mail address required).

9. Please tell us if your group has had coverage within 90 days of this application's signature date:

Will this plan replace current:		If yes, current carrier is:	Proposed termination date is:
Medical Coverage?	☐ Yes ☐ No	_____	_____/_____/_____
Dental Coverage?	☐ Yes ☐ No	_____	_____/_____/_____

10. What about employee Leave of Absence at your firm?

A. Medical: number of months employees are eligible to continue group coverage while on an employer-approved temporary medical leave of absence (maximum 6 months).

☐ None
☐ 1 Month ☐ 4 Months
☐ 2 Months ☐ 5 Months
☐ 3 Months ☐ 6 Months

B. Personal: number of months employees are eligible to continue group coverage while on an employer-approved temporary personal leave of absence (maximum 3 months).

☐ None ☐ 2 Months
☐ 1 Month ☐ 3 Months

11. To your knowledge, is anyone to be covered unable to work due to injury or illness?

☐ Yes ☐ No

If yes:
Name(s)_____ Anticipated return date(s) _____

12. Please tell us about your Workers' Compensation coverage:

Current carrier: _____ Next renewal date:_____
(mm/dd/yy)

Please list the name and job title for any medically enrolling employee under the Anthem Blue Cross coverage who is not an employee for the purpose of Workers' Compensation law or similar legislation (see the definition provided below):

Name:	Job Title:	Exempt per definition below?
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

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

13. Cal-COBRA/COBRA/FMLA Questionnaire - please complete this page if any "Yes" answers to H, J or L in Section 7

Cal-COBRA: California law requires employers with 2-19 eligible qualified employees to extend health coverage programs to former employees spouses (widowed/divorced), and their dependents when a qualifying event occurs.

COBRA: The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers with 20 or more total employees to extend health coverage programs to former employees, spouses (widowed/divorced), and their dependents when a qualifying event occurs, unless the former employee, spouse or dependent was not eligible for continuation of coverage prior to January 1, 2005.

FMLA: The Family and Medical Leave Act of 1993 requires groups with 50 or more employees to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

A. Cal-COBRA and COBRA:
Complete for each employee or family member currently on Cal-COBRA or COBRA.

Name	Birthdate	Social Security No.	Type	Qualifying Event	
				Description	Date
	/ /		☐ Cal-COBRA ☐ COBRA		
	/ /		☐ Cal-COBRA ☐ COBRA		
	/ /		☐ Cal-COBRA ☐ COBRA		

B. Cal-COBRA: Complete for each employee terminated in the last 60 days who has had a qualifying event.
COBRA: Complete for each employee terminated in the last 90 days who has had a qualifying event.

1.

Name	Social Security No.	☐ Cal-COBRA ☐ COBRA	If terminated, what date?
If qualifying event, please describe:			
To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? ☐ Yes ☐ No Is this employee/dependent presently disabled? ☐ Yes ☐ No If yes, disabling condition:			

2.

Name	Social Security No.	☐ Cal-COBRA ☐ COBRA	If terminated, what date?
If qualifying event, please describe:			
To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? ☐ Yes ☐ No Is this employee/dependent presently disabled? ☐ Yes ☐ No If yes, disabling condition:			

C. FMLA: Complete for each employee on family or medical leave.

1.

Name	Social Security No.	Beginning date of leave
To the best of your knowledge, will this employee return to work? ☐ Yes ☐ No If no, is this employee presently disabled? ☐ Yes ☐ No If yes, disabling condition: _____ To the best of your knowledge, will this employee/dependent exercise their COBRA/Cal-COBRA option? ☐ Yes ☐ No		

2.

Name	Social Security No.	Beginning date of leave
To the best of your knowledge, will this employee return to work? ☐ Yes ☐ No If no, is this employee presently disabled? ☐ Yes ☐ No If yes, disabling condition: _____ To the best of your knowledge, will this employee/dependent exercise their COBRA/Cal-COBRA option? ☐ Yes ☐ No		

Signature of Company Officer	Title	Company Name	Date

If additional space is needed to include all applicable employees, please use a photocopy of this page.

14. This section is important to protect you as a small group employer:

Please check the box that applies:

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employee Retirement Income Security Act of 1974), apply to obtain the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employee Retirement Income Security Act of 1974) and therefore not subject to ERISA, apply to obtain the coverage indicated.

To the best of our knowledge and belief, all information on this application is true and complete, and Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may rely on this application in deciding whether to provide coverage. If the application is not complete, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company reserve(s) the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted. We understand that the premium rates calculated for the employer are contingent on the accuracy of eligibility data submitted on employees and covered dependents to Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company. Any misstatements on the employees' applications or failure to report new medical information prior to the employee's effective dates may result in a material change to the group's coverage or premium rates as of the effective date of the group coverage. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and that no agent has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Anthem Blue Cross and /or Anthem Blue Cross Life and Health Insurance Company.

If a subscriber or covered dependent of a subscriber fails to elect coverage during the initial enrollment period, and then later decides to elect coverage, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may impose an exclusion from coverage for a twelve (12) month period as well as a six (6) month pre-existing condition exclusion.

For employers offering a Health Savings Account (HSA) compatible EPO Plan: We, the employer, understand that the High Deductible EPO Plan is designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. We understand that having this coverage does not establish an HSA.

The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits. The IRS has not yet issued HSA or high deductible health plan regulations or determined that Anthem Blue Cross high deductible plans are qualifying high deductible health plans. Consultation with a tax advisor is recommended.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

Please Read Carefully - Signature Required

REQUIREMENT FOR BINDING ARBITRATION

We understand that if our coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from Employee Retirement Income Security Act of 1974 (ERISA) or if we have a dispute that is not governed by ERISA that we will be subject to the following binding arbitration proceeding.

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. ***It is understood that any dispute including disputes relating to the delivery of services under the plan/policy 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 provided by California law, 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.*** **THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL 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.**

Signature of Company Officer *(Required)*	Name of Company Officer *(Please print)*
X	
Title of Company Officer	Date *(MM/DD/YY)*

15. Please ask your agent to complete the following:

I hereby certify:

- that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk;
- that I have advised the client not to terminate any existing coverage until receiving written notification from Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, that the coverage being applied for by this application is accepted.

WRITING AGENT	%
Name *(please print)*	
Agent/Agency ID No.	
Sub-Agent ID No. *(if different)*	
Address	
City, State, ZIP	
Phone	
Fax	
E-mail address *(please print)*	
Signature	
Date	

SECOND WRITING AGENT	%
Name *(please print)*	
Agent/Agency ID No.	
Sub-Agent ID No. *(if different)*	
Address	
City, State, ZIP	
Phone	
Fax	
E-mail address *(please print)*	
Signature	
Date	

FOR GENERAL AGENT USE ONLY	
General Agent Name	Agent ID No.
Address	City, State, ZIP

Send Administration Kit to: ☐ Agent ☐ Group

Submit application to:
Small Group Services
Anthem Blue Cross
P.O. Box 9042
Oxnard, CA 93031-9042
anthem.com/ca