



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

Employee Application

anthem.com/ca

Please complete using black ink/type, seal the inside pages for privacy and return to your Group Administrator. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, please answer all questions and be sure to sign and date your application.

Group No.

1a. Medical Coverage - please ask your employer which Medical options are available before checking your selection:

<input type="checkbox"/> Premier PPO \$10 Copay*	<input type="checkbox"/> Solution 2500 PPO**	<input type="checkbox"/> Lumenos HSA 2000 (100/70)**	<input type="checkbox"/> HMO \$10 100%*	<input type="checkbox"/> Lumenos HSA 1500 (100/70)**	<p>If HMO, be sure to provide physician number in section 3</p> <p>*offered by Anthem Blue Cross</p> <p>**offered by Anthem Blue Cross Life and Health Insurance Company</p>
<input type="checkbox"/> Premier PPO \$20 Copay*	<input type="checkbox"/> Solution 3500 PPO**	<input type="checkbox"/> Lumenos HSA 3000 (100/70)**	<input type="checkbox"/> HMO \$25 100%*	<input type="checkbox"/> Advantage PPO \$25 Copay**	
<input type="checkbox"/> Premier PPO \$30 Copay*	<input type="checkbox"/> Solution 5000 PPO**	<input type="checkbox"/> Lumenos HSA 5000 (100/70)**	<input type="checkbox"/> Classic \$20 HMO*	<input type="checkbox"/> Saver PPO **	
<input type="checkbox"/> PPO \$20 Copay**	<input type="checkbox"/> Elements Hospital Preferred**	<input type="checkbox"/> Lumenos HSA 1500 (80/50)**	<input type="checkbox"/> Classic \$30 HMO*	<input type="checkbox"/> Basic PPO **	
<input type="checkbox"/> PPO \$30 Copay*	<input type="checkbox"/> Elements Hospital Plus**	<input type="checkbox"/> Lumenos HSA 2500 (80/50)**	<input type="checkbox"/> Classic \$40 HMO*	<input type="checkbox"/> PPO 2400 (HSA-Compatible)**	
<input type="checkbox"/> PPO \$40 Copay*	<input type="checkbox"/> Elements Hospital**	<input type="checkbox"/> Lumenos HSA 3500 (80/50)**	<input type="checkbox"/> Saver \$20 HMO*	<input type="checkbox"/> PPO 3500 (HSA-Compatible)**	
<input type="checkbox"/> PPO \$25 Copay GenRx**	<input type="checkbox"/> Lumenos HIA Plus 750**	<input type="checkbox"/> High Deductible EPO*	<input type="checkbox"/> Saver \$30 HMO*	<input type="checkbox"/> Lumenos HIA Plus 3000**	
<input type="checkbox"/> PPO \$35 Copay GenRx**	<input type="checkbox"/> Lumenos HIA Plus 500**		<input type="checkbox"/> Saver \$40 HMO*	<input type="checkbox"/> Power HealthFund 750**	
<input type="checkbox"/> PPO \$45 Copay GenRx**			<input type="checkbox"/> Select \$25 HMO*	<input type="checkbox"/> Power HealthFund 500**	
			<input type="checkbox"/> Select \$35 HMO*	<input type="checkbox"/> Other: _____	

If directed by your employer, Anthem Blue Cross Life and Health will facilitate the opening of a Health Savings Account in your name.

* Plans may not be available at renewal or for new groups beginning in 2010.

1b. Dental Coverage - please ask your employer which Dental options are available before checking your selection:

<input type="checkbox"/> Dental Blue Silver 100-80**	<input type="checkbox"/> High Option PPO**	<input type="checkbox"/> Dental Net*	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental Blue Silver Plus 100-80**	<input type="checkbox"/> Standard Option PPO**	<p>For above Dental Net plan, you must select a Dental Office Number:</p> <input type="text"/>	
<input type="checkbox"/> Dental Blue Gold 100-80**	<input type="checkbox"/> Basic Option PPO**		
<input type="checkbox"/> Dental Blue Gold Plus 100-80**			
<input type="checkbox"/> Dental Blue Platinum 100-80**			
<input type="checkbox"/> Dental Blue Platinum Plus 100-80**			
<input type="checkbox"/> Dental Blue Platinum Plus 100-80**			

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

Voluntary Dental Coverage

Dental PPO**

Dental Saver SelectHMO* - You must select a Dental Office Number (to the left)

1c. Vision Coverage - please check with your employer to make sure these options are available before selecting:

Blue View OR Blue View Plus offered by Anthem Blue Cross Life and Health Insurance Company

1d. Life Coverage - please check with your employer to make sure these options are available before selecting:

Optional Dependent Life Insurance (only if offered by your employer)	Supplemental Life Insurance (in addition to Term Life, if it is offered): <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> \$10,000/\$1,000 (\$10,000 spouse/child 6 months-26 yrs; \$1,000 less than 6 months)	Amount: <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000
<input type="checkbox"/> \$5,000/\$500 (\$5,000 spouse/child 6 months-26 yrs; \$500 less than 6 months)	offered by Anthem Blue Cross Life and Health Insurance Company

2. Please provide the following enrollment information (must be completed by the employee):

<input type="checkbox"/> New group enrollment	<input type="checkbox"/> New hire	<input type="checkbox"/> COBRA	COBRA/Cal-COBRA Effective Date: <input type="text"/>
<input type="checkbox"/> Family addition	<input type="checkbox"/> Change of coverage	<input type="checkbox"/> Cal-COBRA	
<input type="checkbox"/> Late enrollment	<input type="checkbox"/> Other: _____		

(Cal-COBRA applicants must submit first month's premium)

Last Name		First Name		M.I.	Social Security or ID No.	
Home Address (P.O. Box not acceptable unless rural P.O. Box)				Apt. No.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner (DP)	
City		State	ZIP Code		Spouse/DP Social Security or ID No.	
Employer Name		Occupation/Job Title			Home Phone No. ()	
Hire Date		<input type="checkbox"/> Part time <input type="checkbox"/> Full time		Salary (Required) \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	
Business Phone No. ()		# of Hours Worked per Week		Relationship		



Social Security or ID No. _____

Spouse/DP Social Security or ID No. _____

3. Please tell us about yourself and your eligible enrolling dependents:

Eligible dependents include an employee's lawful spouse, or domestic partner, and the enrolled employee's, spouse's or domestic partner's natural child, stepchild, legally adopted child, or child for whom the employee, spouse or domestic partner has been appointed permanent legal guardian by a final court decree or order, up to the child's 26th birthday. Unmarried children age 26 and over may be covered, as specified by the plan certificate or evidence of coverage. Written proof of relationship may be required for certain enrollments. For example, an existing subscriber who is initially enrolling a dependent spouse or domestic partner must provide a copy of a Marriage Certificate, Declaration of Domestic Partnership or equivalent document. For enrollment of an adopted child, legal evidence of adoption (or intent to adopt) is required.

If spouse's last name is different than yours, is he/she a domestic partner? Yes No

FAMILY ADDITION: Date of marriage or domestic partnership declaration: _____

Date of adoption: _____

Sex	Last Name	First Name	MI	Height	Weight	Mo.	Birthdate Day	Year	Disabled	HMO PLANS ONLY:	
										Primary Care Physician No. or 3-digit Medical Group/IPA No.	Current Patient
<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee								<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse/DP								<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: Any enrolling dependent(s) who do not live at the address listed in Section 2 on previous page, please provide their address(es) on a separate piece of paper.

4. Please complete if you want to decline coverage for yourself and/or any eligible dependents:

Type of Coverage:	Declined for:	Reason for declining: (proof of coverage may be required)
Medical coverage	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Covered by spouse's/domestic partner's sponsored group plan; Carrier name: _____ ID#: _____
Dental coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Covered by Individual Policy; Carrier name: _____ ID#: _____
Vision coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Covered by Tricare <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> MediCal <input type="checkbox"/> Enrolled in any other insurance plan; Carrier name: _____ ID#: _____
Life coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Other: _____

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 decline coverage. BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP'S MEDICAL AND/OR GROUP LIFE INSURANCE PLAN, as well as a six-month pre-existing condition exclusion UNLESS ENTITLED TO A SPECIAL ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT). The twelve (12) month wait will not apply if: (1) I certify at the time of initial enrollment that the coverage under another employer health benefit plan, a state child health insurance program, or a state Medicaid plan was the reason for declining enrollment and I lose coverage under that employer health benefit plan, a state child health insurance program, or a state Medicaid plan; (2) my employer offers multiple health benefit plans and I elected a different plan during an open enrollment period; (3) a court orders that I provide coverage under this plan for a spouse or minor child or (4) if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, they may be able to be enrolled if enrollment is requested within 31 days after the marriage, birth, adoption or placement for adoption.

If I declined enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other health insurance or group health plan coverage except coverage under a state child health insurance program, or a state Medicaid plan, I must request enrollment within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

If I declined enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of coverage under a state child health insurance program, or a state Medicaid plan, I must request enrollment for this group coverage within 60 days: (a) after the date my coverage under any of these plans ends; or (b) after the date I become eligible for state premium assistance for group coverage.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

X _____
Signature if declining coverage for self/dependents

Date (Month/Day/Year)



MCAFR1167CEN 10/10 02

5. Health Questionnaire for Groups Enrolling 1-10 Employees - this confidential information will not be seen or given to your employer

Groups with 11-50 Enrolling Employees: Do not complete this section. Please skip to Section 5A.

All questions must be answered "Yes" or "No".

INCOMPLETE APPLICATIONS WILL BE RETURNED TO YOU FOR COMPLETION WHICH MAY DELAY THE EFFECTIVE DATE OF YOUR COVERAGE.

Has any person listed on this application ever had, consulted for, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions?

- 1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins, or any other disorder of the heart, blood, blood vessels, hyperlipidemia or arteriosclerosis?..... Yes No
- 2. Ulcer, colitis, gall stone, hernia or any other disorder of the stomach, intestines, rectum, gall bladder, or liver?..... Yes No
- 3. Cancer, cyst, or tumor?..... Yes No
- 4. Disorder of the kidneys, blood or albumin, thyroid glands, diabetes, venereal disease or any related eye disorders, urinary systems, male or female organs, or menstrual dysfunction?..... Yes No
- 5. Tuberculosis, asthma, hay fever, adenoids, pleurisy or any other disorder of the lungs or respiratory system?..... Yes No
- 6. Epilepsy, fainting spells, mental or nervous condition, paralysis or any disorder of the brain or nervous system?..... Yes No
If epileptic, date of last seizure: ____ / ____ / ____
- 7. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same?..... Yes No
- 8. Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles, or bones?..... Yes No
- 9. Any physical deformity or defect? Any serious bodily injury, fracture, concussion, burn, and/or congenital problems?..... Yes No
- 10. Has any person to be covered had or been told that they had an immune deficiency disorder, AIDS, or AIDS-related complex, not including the results of HIV testing?..... Yes No
- 11. Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner?..... Yes No
- 12. a. Is any female to be covered currently pregnant?..... Yes No
If yes, Due Date: ____ / ____ / ____
b. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application?..... Yes No
- 13. Does anyone listed on this application use tobacco products?..... Yes No

If you answer "Yes" to all or part of above questions 1-12b, please complete the following (Insert additional sheets if necessary):

<p>Question # ____ Name of patient _____</p> <p>Condition treated _____</p> <p>Dates of treatment: Start _____ End _____ check here if still under treatment <input type="checkbox"/></p> <p>Treatment rendered _____</p> <p>Medication and dosage taken _____</p> <p>Dates taken: Start _____ End _____ check here if still taking <input type="checkbox"/></p>	<p>Question # ____ Name of patient _____</p> <p>Condition treated _____</p> <p>Dates of treatment: Start _____ End _____ check here if still under treatment <input type="checkbox"/></p> <p>Treatment rendered _____</p> <p>Medication and dosage taken _____</p> <p>Dates taken: Start _____ End _____ check here if still taking <input type="checkbox"/></p>
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