



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:

Form with fields for Company Name, Group No., Street Address, City, State, ZIP Code, Billing Address, Employer type, SIC Code, Type of Business, Date Business Established, Company Contact Person, Phone No., Fax No., Has the company been insured by Anthem Blue Cross, E-mail Address, Federal Tax ID No.

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 (excluding Basic PPO): \_\_\_\_\_ % per employee \_\_\_\_\_ % per dependent

2b. I choose to offer:

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

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

- List of plan options including Premier PPO \$10 Copay, Solution 2500 PPO, Lumenos HSA 2000 (100/70), HMO \$10 100%, Lumenos HSA 1500 (100/70), etc.

For Lumenos plans: Will Employer establish a Health Savings Account with Anthem banking partner? Yes No

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

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):

- List of dental plan options including Dental Blue Silver 100-80, Dental Blue Platinum 100-80, Basic Option PPO, Dental Net, etc.

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 plan choice and payment percentage would you like to select?

4a. I choose to offer: Blue View AND/OR Blue View Plus
4b. My employer contribution will be (50-100%): \_\_\_\_\_ % per employee \_\_\_\_\_ % per dependent

offered by Anthem Blue Cross Life and Health Insurance Company

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### 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

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

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### 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. Please read the P.O.P. brochure for complete details.  
If you choose to enroll please complete the enrollment form, provide a separate check (if applicable), and submit along with this application.

### 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:

1<sup>st</sup> 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. 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)

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

K. 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).

\* Anthem Blue Cross complies with State law requiring it to cover spouses and qualified registered domestic partners including dependents to the same extent and subject to the same terms and conditions as a spouse. To be an eligible domestic partner one must be a domestic partner registered under a valid Declaration of Domestic Partnership filed with the California Secretary of State, or an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnership.

If yes to questions H, I or J, 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.

**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? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____

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

<b>A. Medical:</b> number of months employees are eligible to continue group coverage while on an employer-approved temporary medical leave of absence (maximum 6 months).	<input type="checkbox"/> None	<input type="checkbox"/> 4 Months
	<input type="checkbox"/> 1 Month	<input type="checkbox"/> 5 Months
	<input type="checkbox"/> 2 Months	<input type="checkbox"/> 6 Months
	<input type="checkbox"/> 3 Months	
<b>B. Personal:</b> number of months employees are eligible to continue group coverage while on an employer-approved temporary personal leave of absence (maximum 3 months).	<input type="checkbox"/> None	<input type="checkbox"/> 2 Months
	<input type="checkbox"/> 1 Month	<input type="checkbox"/> 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?
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> 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, I or J 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 or ID No.	Type <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	Qualifying Event	
				Description	Date
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> 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 or ID No.	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is this employee/dependent presently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, disabling condition:				
2.	Name	Social Security or ID No.	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is this employee/dependent presently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If yes, disabling condition:				

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

1.	Name	Social Security or ID No.	Beginning date of leave
To the best of your knowledge, will this employee return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, is this employee presently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, disabling condition: _____			
To the best of your knowledge, will this employee/dependent exercise their COBRA option? <input type="checkbox"/> Yes <input type="checkbox"/> No			
2.	Name	Social Security or ID No.	Beginning date of leave
To the best of your knowledge, will this employee return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If no, is this employee presently disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, disabling condition: _____			
To the best of your knowledge, will this employee/dependent exercise their COBRA option? <input type="checkbox"/> Yes <input type="checkbox"/> No			

Signature of Company Official	Title	Company Name	Date
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If additional space is needed to include all applicable employees, please use a photocopy of this page.



