



Effective date	Group no.
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I. PERSONAL INFORMATION

Last name (print)		First name (print)		M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced
Mailing address			City	State	ZIP code (5+4)	
Phone no.	Employer	Hire date/Date rehired	Employee no.	Email address		

II. PLAN OPTIONS — Indicate with a check mark.

TYPE OF COVERAGE:	<input type="checkbox"/> New enrollment <input type="checkbox"/> Open enrollment	<input type="checkbox"/> Plan change	Backup documents (copies) are REQUIRED for all dependents you enroll (marriage cert., birth cert. with parent's full names, domestic partnership forms)
MEDICAL PLAN:	<input type="checkbox"/> HMO <input type="checkbox"/> PPO	<input type="checkbox"/> Blue Card PPO <input type="checkbox"/> Owens Valley PPO	

III. EMPLOYEE AND FAMILY INFORMATION — Please list yourself and all eligible family members to be enrolled (attach additional sheets, if necessary).

	Sex	Last name	First name	M.I.	Date of birth	Social Security no. (required)	Age	HMO IPA Primary care physician code
Self								
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	<input type="checkbox"/> M <input type="checkbox"/> F							
Child	<input type="checkbox"/> M <input type="checkbox"/> F							
Child	<input type="checkbox"/> M <input type="checkbox"/> F							
Child	<input type="checkbox"/> M <input type="checkbox"/> F							
Child	<input type="checkbox"/> M <input type="checkbox"/> F							
Child	<input type="checkbox"/> M <input type="checkbox"/> F							

IV. MEDICARE

Are you retired? Yes No If "Yes," for Medicare for you? **Part A** Yes No **Part B** Yes No

Do you or your Dependents have Medicare? Yes No If "Yes," for your Dependent? **Part A** Yes No **Part B** Yes No

Name(s) of Medicare Dependent(s): _____

Name(s) of Medicare Dependent(s): _____

Name(s) of Medicare Dependent(s): _____

If "Yes," for Medicare for you and/or your Dependent(s) please provide your and/or their HIB number and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).

HIB #: _____ Entitlement reason: Over 65 Disabled ESRD Effective date of Medicare: ___/___/___

Name: _____

HIB #: _____ Entitlement reason: Over 65 Disabled ESRD Effective date of Medicare: ___/___/___

Name: _____

V. PLEASE READ CAREFULLY

Effective date requested: _____ Actual date will be assigned by Anthem Blue Cross if application is accepted.

Upon acceptance of the application, the Group will inform all persons who are eligible for coverage that they may apply for Anthem Blue Cross coverage under the Agreement/Policy.

Application is hereby made to Anthem Blue Cross, or the appropriate affiliated company, for a Group Benefit Agreement/Group Policy providing health service benefits. If this application is accepted, an Agreement/Policy will be issued which will set forth the terms, benefits and conditions of the relationship between the Group and Anthem Blue Cross. This application will become part of that Agreement/Policy.

It is understood that no agent or representative except the President, a Vice President, or the Secretary has power on behalf of Anthem Blue Cross to bind Anthem Blue Cross to accept risk, issue an Agreement/ Policy, or commit to particular provisions of an Agreement/ Policy. No coverage will come into effect unless and until this application is accepted. If accepted, the terms of the relationship will be defined entirely within an Agreement/Policy.

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.

Important information regarding fraudulent information:

The following notice applies to all coverage presented on this form:

For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

ARBITRATION AGREEMENT

IF THE GROUP IS NOT SUBJECT TO ERISA, ANY DISPUTE BETWEEN A PERSON COVERED UNDER THE AGREEMENT/POLICY AND ANTHEM BLUE CROSS, INCLUDING CLAIMS FOR 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, NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. UNDER THIS COVERAGE, BOTH THE PERSON COVERED AND ANTHEM BLUE CROSS ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. IF THE GROUP IS SUBJECT TO ERISA, DISPUTES INVOLVING AN ADVERSE BENEFIT DETERMINATION FOR A HEALTH CLAIM ARE NOT SUBJECT TO BINDING ARBITRATION, BUT, MUST FOLLOW THE ERISA CLAIMS APPEAL PROCESS.

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. For claims that exceed the jurisdiction of the small claims court that are subject to binding arbitration under this Agreement, California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard: 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. If your plan/policy is subject to 45 CFR 147.136, this agreement does not limit your rights to internal and external review of adverse benefit determinations as required by that law. 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.

VI. SIGNATURE OF UNDERSTANDING

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.

Employee signature

Date (MM/DD/YY)

X

PLEASE RETAIN A PHOTOCOPY FOR YOUR RECORDS AND SUBMIT THIS FORM TO LOCAL 18 BENEFIT SERVICE CENTER, 9500 Topanga Canyon Blvd., Chatsworth, CA 91311.

Wet Signature Required

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association.
ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

EMPLOYEE NUMBER _____