Group Change Form

Please read carefully and provide all applicable information.

Backup documents (copies) are REQUIRED for all dependents you enroll (marriage cert., birth cert. with parent's full names, domestic partnership forms)

Anthem BlueCross

IBEW Local 18

Employee last name (Print)	First name (Print)	Member ID # (on ID card)	Group medical # (on ID card)	DWP employee #

Type of change: ☐ Name ☐ Address ☐ Dependent status ☐ Terminate medical

Name change	Address change			Dependent status change	
☐ Employee name only ☐ Spouse name only	New street address			☐ Add domestic partner – Date of registration: _____	☐ Add spouse – Date of marriage: _____
Last name change	City	State	ZIP code	☐ Add family member(s) – Effective date: _____ Name(s): _____ Reason: _____	☐ Remove family member(s) – Effective date: _____ Name(s): _____ Reason: _____
New first name	New phone #				

Declination information

I understand that if I terminate or decline coverage at this time, if I choose to apply for enrollment at a later date, I may be excluded from coverage until the employer's next open enrollment, or 12 months from date of application, at which time I may reapply for coverage.

In addition, once re-enrolled, I understand that my coverage may be subject to a six-month exclusion for pre-existing conditions. This exclusion also applies to any dependents on this declination. If you are declining coverage for yourself, your spouse, domestic partner or your dependents because of other health insurance coverage, you must tell us. You may enroll yourself or your dependents in this plan provided you request enrollment within 31 days after your coverage ends. You may also enroll following marriage (with your spouse), registration (with your domestic partner), childbirth or adoption (with your spouse and that child only) provided you request enrollment within 31 days after the marriage, registration, birth or adoption.

Family additions

Complete the information below for all family and/or spouse additions or medical office selections and/or changes. Check the disabled box only if the condition prohibits the member from working or performing daily activities. Please indicate if family member is covered by another health insurance plan by checking the Other Health coverage box. For Anthem Blue Cross HMO and POS plans only, each person listed must choose a Medical Group or Independent Practice Association (IPA) within their enrollment area. IF YOU SELECT AN IPA, YOU MUST INDICATE A PRIMARY CARE PHYSICIAN FROM WITHIN THAT IPA. If you need assistance, contact Anthem Blue Cross at the number listed on your Membership ID Card or your health benefit officer.

To be eligible as a Domestic Partner, the Employee and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

Relation	Last name	First name	M.I.	Sex	Date of birth (MM/DD/YYYY)	Age	Social Security number	Coverage	Totally disabled	Has other health coverage	Medical group/IPA office # or Anthem Blue Cross HMO IPA primary care physician code
Self				☐ M ☐ F				Medical	☐ Y ☐ N	☐ Y ☐ N	
☐ Spouse ☐ DP				☐ M ☐ F				Medical	☐ Y ☐ N	☐ Y ☐ N	
Child				☐ M ☐ F				Medical	☐ Y ☐ N	☐ Y ☐ N	
Child				☐ M ☐ F				Medical	☐ Y ☐ N	☐ Y ☐ N	
Child				☐ M ☐ F				Medical	☐ Y ☐ N	☐ Y ☐ N	
Child				☐ M ☐ F				Medical	☐ Y ☐ N	☐ Y ☐ N	

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 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. *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 permitted and as 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.* 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 AND PARTICIPATION IN A CLASS ACTION 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.

Employee signature	Date (MM/DD/YYYY)
X	

Wet Signature Required

Please retain a photocopy for your records and submit this form to: Local 18 Benefit Service Center, 9500 Topanga Canyon Blvd., Chatsworth, CA 91311