NEW MEMBERS: Use to Enroll

Email Address:

2-50 Existing Small Group
Employee Addition/Change of Coverage Application
For adding new/existing employees and eligible dependents to existing coverage.

Employee Application

anthem.com/ca

INSTRUCTIONS

1. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
2. All questions must be answered in full; all signatures and dates must be included where noted; otherwise, the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
3. **Type or print clearly using blue or black ink.**

Requested Effective Date (MM/DD/YY):

Note: Social Security Numbers are required under Centers for Medicare & Medicaid (CMS) regulations.

Group No.

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

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

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

If HMO, be sure to provide physician number in section 3.
[1]Offered by Anthem Blue Cross.
[2]Offered by Anthem Blue Cross Life and Health Insurance Company.
[3]Plans 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.

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

☐ 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**
☐ Other________________

☐ Dental Net*

For above Dental Net plan, you must select a Dental Office Number:

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

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

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)
☐ $10,000/$1,000 *($10,000 spouse/child 6 months-26 yrs; $1,000 less than 6 months)*
☐ $5,000/$500 *($5,000 spouse/child 6 months-26 yrs; $500 less than 6 months)*

Supplemental Life Insurance (in addition to Term Life, if it is offered) ☐ Yes ☐ No
Amount: ☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ $100,000
offered by Anthem Blue Cross Life and Health Insurance Company

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

☐ New group enrollment ☐ New hire ☐ Family addition ☐ Change of coverage ☐ Late enrollment ☐ Other: ________________

Cal-COBRA/COBRA Applicants: ☐ Cal-COBRA ☐ COBRA
Cal-COBRA/COBRA Effective date:
(Cal-COBRA applicants must submit first month's premium)

Indicate Qualifying Event:
☐ Termination of employment ☐ Death of employee
☐ Reduction of hours ☐ Child no longer eligible
☐ Divorce/Legal separation ☐ Medicare entitlement
Date of Qualifying Event:

Last Name	First Name	M.I.	Social Security No.
Home Address *(P.O. Box not acceptable unless rural P.O. Box)* Apt No.	Marital Status ☐ Single ☐ Married ☐ Domestic Partner (DP)		Spouse/DP Social Security No.
City	State / ZIP Code	No. of Dependents including Spouse/DP	Home Phone No. ( )
Employer Name	Occupation/Job Title (Required)		Business Phone No. ( )
Hire/Join Date (MMDDYY) (Required) / Employment Status (Required) ☐ Part time ☐ Full time	Salary (Required) $ ☐ Hourly ☐ Weekly ☐ Monthly		**# of Hours Worked per week (W2 Empls Only)**
Life Insurance Beneficiary - *Last Name*	*First*	*M.I.*	Relationship

Language Choice (Optional) ☐ English (ENG) ☐ Spanish (SPA) ☐ Korean (KOR) ☐ Chinese (ZHO)(C/M)
☐ Vietnamese (VIE) ☐ Tagalog (TGL) ☐ Other (W09)

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, M.I.	Social Security No.	Birthdate Mo. Day Year	Disabled	HMO PLANS ONLY: Choose a physician for each family member from the Provider Directory which can be found at www.anthem.com/ca	HMO PLANS ONLY: Current Patient
☐ Male ☐ Female	Employee			☐ Yes ☐ No		☐ Yes ☐ No
☐ Male ☐ Female	Spouse/DP			☐ Yes ☐ No		☐ Yes ☐ No
☐ Male ☐ Female				☐ Yes ☐ No		☐ Yes ☐ No
☐ Male ☐ Female				☐ Yes ☐ No		☐ Yes ☐ No
☐ Male ☐ Female				☐ Yes ☐ No		☐ Yes ☐ No
☐ Male ☐ Female				☐ Yes ☐ No		☐ Yes ☐ No

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

Type of Coverage:	Waived for:	Reason for waiving: *(proof of coverage will be required)*
Medical coverage	☐ Self ☐ Spouse/DP ☐ Child(ren)	☐ Covered by spouse's/domestic partner's sponsored group plan; Carrier name: ______ ID#: ______
Dental coverage (if offered)	☐ Self ☐ Spouse/DP ☐ Child(ren)	☐ Covered by Individual Policy; Carrier name: ______ ID#: ______
Vision coverage (if offered)	☐ Self ☐ Spouse/DP ☐ Child(ren)	☐ Covered by Tricare ☐ Covered by Medicare ☐ MediCal ☐ Enrolled in any other insurance plan; Carrier name: ______ ID#: ______
Life coverage (if offered)	☐ Self ☐ Spouse/DP ☐ Child(ren)	☐ List names of child(ren) to be waived: ______ ☐ 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 waive coverage. BY WAIVING 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 waiving 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 waived 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 waived 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 waiving 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 waiving coverage for self/dependents *Date (Month/Day/Year)*

5. Other Coverage – please be sure to complete this important information:

1. Do any persons on this application intend to continue other Group coverage if this application is accepted? ☐ Yes ☐ No

   If yes:
   Name of person: ______

   Insurance Company: ______

2. Does any person applying for coverage currently have health insurance coverage? ☐ Yes ☐ No

3. Has any person applying for coverage had health insurance coverage at any time in the past six months? ☐ Yes ☐ No

   If yes:
   Applicant/family member name(s): ______

   Type of coverage: ☐ Group ☐ Individual ☐ Other: ______

   Insurance Company: ______

   Date coverage began: ______ Date ended: ______

3. Does any person applying for coverage currently have dental insurance coverage? ☐ Yes ☐ No

   If yes:
   Applicant/family member name(s): ______

   Type of coverage: ☐ Group ☐ Individual ☐ Other: ______

   Insurance Company: ______

   Date coverage began: ______ Date ended: ______

4. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits? ☐ Yes ☐ No

   NOTE: If you are eligible for Medicare, Anthem Blue Cross may not duplicate Medicare benefits.

SUBMIT PROOF OF COVERAGE.
To comply with federal and state laws, proof of this coverage must accompany this application.

Acceptable forms of proof are:

1. Certificate of coverage from prior carrier, or
2. Copy of ID card and copy of payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill

GENERAL NOTICE OF PRE-EXISTING CONDITION EXCLUSION
The pre-existing condition exclusion does not apply to HMOs; pregnancy; dependent children who are enrolled in the plan within 31 days after birth, adoption, or placement for adoption; or persons under 19 years old. If you or a family member have/had a medical condition before coming to our plan for which medical advice, diagnosis, care or treatment was recommended or received within the last six months and you do not advise and provide proof of prior coverage, you may be subject to a six-month pre-existing condition exclusion. That means that you or a family member might have to wait at least six months before the plan will provide coverage for that condition. In some cases, the exclusion may last up to 12 months, or as long as 18 months for late enrollees. However, the length of the waiting period can be reduced by the number of days of prior "creditable coverage," which means not experiencing a break in qualified prior health coverage that lasted more than 63 days for an Individual plan or 180 days for an employer-sponsored or employer-related plan. Proof of creditable coverage is required to reduce a waiting period, including a copy of the certificate or other documentation, which we can help you obtain from a prior plan/issuer if needed. You have the right to obtain proof of creditable coverage from your prior plan/issuer. Please contact our Small Group Enrollment & Billing Services at 1-800-627-8797 if you have any questions regarding pre-existing conditions.

6. *Agreements and Understandings - The following Agreement is to be signed by the EMPLOYEE applying for coverage.*

I AGREE: To the best of my knowledge and belief, all information on this form is correct and true. I understand that this application and any information Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company obtains prior to the effective date of coverage is the basis on which coverage may be issued under the plan. I authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I work/worked at my employer's place of business in permanent employment.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and any application made by my employer have been accepted and approved by ANTHEM BLUE CROSS and/or ANTHEM BLUE CROSS LIFE and HEALTH INSURANCE COMPANY.

I AM APPLYING FOR PPO COVERAGE: I understand that I am responsible for a greater portion of my medical costs when I use a nonparticipating provider. If a PPO Plan is selected and a nonparticipating provider is used, medical payments will be based upon the lesser percentage of the negotiated fee rate and I will be responsible for any amount over that payment.

I AM APPLYING FOR HMO COVERAGE: I understand that I am responsible for paying for services rendered that are not authorized by my primary medical group.

I AM APPLYING FOR A HEALTHCARE SAVINGS ACCOUNT (HSA) COMPATIBLE EPO PLAN: I understand that the High Deductible EPO Plan is designed for Exclusive Provider Organization (EPO) usage, and that using nonparticipating providers could result in significantly higher out-of-pocket costs. I understand that having this coverage does not establish an HSA. To do so, I must contact a qualified financial institution. Also, I understand that I should consult my tax advisor.

I AM APPLYING FOR ELEMENTS HOSPITAL: I understand that the benefits of this plan are limited, with some exceptions, to inpatient hospital expenses. If I am not admitted to the hospital for inpatient treatment, this plan may not cover all my medical expenses, even if my illness is serious.

I AM APPLYING FOR ELEMENTS HOSPITAL PLUS OR ELEMENTS HOSPITAL PREFERRED: I understand that this plan is not designed to be a comprehensive medical or major medical plan. The benefits provided by this plan are limited, and may not cover all my medical expenses. Under this plan, I may have to pay substantial amounts of my own money for medical expenses, even if my illness is serious.

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.

CANCELLATION OR MODIFICATION OF COVERAGE. PLEASE READ CAREFULLY.
I attest by signing below that I have reviewed the information provided on this application and accept its provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief and I understand they will be relied upon by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company in accepting this application. I understand that misstatements or failures to report new medical information prior to the effective date may result in a material change or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being cancelled. I understand that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may cancel any coverage under this application due to any of the following: (a) any material misrepresentation discovered on an application or health statement; and/or (b) an act of fraud that has been committed.

Please Read Carefully - SIGNATURE REQUIRED

REQUIREMENT FOR BINDING ARBITRATION

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

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 Employee (*Required*)	Date *(MM/DD/YY)*
X	

Small Group Services
Anthem Blue Cross
P.O. Box 9062
Oxnard, CA 93031-9062
anthem.com/ca

Health care plans provided by Anthem Blue Cross. Insurance plans provided by Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross. Independent licensees 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.

MONTHLY CHECKING/SAVINGS ACCOUNT AUTOMATIC PREMIUM PAYMENT AUTHORIZATION

As a convenience to me, I request and authorize RealCare Insurance Marketing, Inc. to pay and charge to my account indicated below checks drawn on that account by and payable to the order of RealCare Insurance Trust Account (RITA) provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize RealCare Insurance Marketing, Inc. to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my health care dues and/or insurance premiums, adjustments and administration fees due. This authority is to remain in effect until revoked by me by providing RealCare Insurance Marketing, Inc. a 10-day advance written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, RealCare Insurance Marketing, Inc. shall be under no liability whatsoever even though such dishonor results in forfeiture of health care or insurance coverage.

If I am enrolled in an Anthem Blue Cross plan, payments will be debited from my account on the first of the month following the due date. If I am enrolled in a Kaiser plan or only enrolled in a dental, vision, and/or life insurance plan, payments will be debited from my account on the fifth of the month following the due date. If any such debits are dishonored, I agree to make payment to RealCare Insurance Trust Account (RITA) by cashier's check or money order before the end of the 30-day grace period in order to keep my health care and/or insurance coverage in force. I authorize any changes in premium and administration fees to be debited unless I notify RealCare Insurance Marketing, Inc. to terminate my health care and/or insurance coverage.

Policyholder Information

Policyholder name: ______________________________ Phone: ____________________

Social Security Number: ______________________ Email Address: ______________________

Banking Information

Name of bank or financial institution: ____

Bank Account Name: ____

☐ Checking Account ☐ Savings Account Account Number: ______________________

Bank Routing Number: ______________________________

Authorized Signature

____ Date: __________________

Authorized Signature
(As it appears in the financial institution's records)

MEMBERS CURRENTLY ENROLLED: Fax this completed authorization and a voided check to: (707) 939-8450
IF ENROLLING FOR THE FIRST TIME: Please attach a copy of your check and submit with your enrollment application.

LUD 6-24-11

C.A.R. ENROLLMENT & PAYMENT INSTRUCTIONS

For Assistance, Call RealCare Insurance Marketing at (800) 939-8088

Step 1: Calculate Rates

Medical Plans

Medical rates are based on a Medical Rating Region for each carrier. The region is determined by the county and zip code for the address stated on the subscriber's Anthem Blue Cross application form. This address is used to determine the rating area, and for mailing all correspondence from Anthem Blue Cross including your ID cards, the Explanation of Coverage (EOC), and Explanation of Benefits (EOB) forms generated when claims are submitted.

Follow the steps below to calculate your rate:

1. Look up your county and zip code on the Medical Rating Regions page. *(If your county is included in more than one rating region, check to find your zip code to determine which rating region to use.)*
2. Find the rate table that applies to your rating region.
3. To determine the rate, look up the subscriber's attained age as of the requested effective date, the plan chosen and which dependents (if any) are to be enrolled. Rates are based on the subscriber's attained age as of the requested effective date; and will change effective the first day of the month following the subscriber's birthday when the attained age moves to another age category.
4. **Calculate the first two months of premium.** Because of enrollment and billing dates, Anthem Blue Cross enrollees are required to send the first two month's premium payment with the application.
5. Add $20 monthly administration fee for each month of premium submitted.

Dental/Vision/Life

The dental rates are based on the MetLife dental rating region. The rating region is determined by the county. The vision rates are not based on region but are determined by which (if any) dependents are enrolled. The life rates are based on the C.A.R. member's attained age and the amount of coverage purchased. **Note: You do not have to enroll the same family members in every plan. *Follow the steps below to calculate your rate.***

1. For Dental: Look up your county on the Dental Plans rate page. Find the rate table that applies to your rating region. Look up the rate based on the plan chosen and whether the member wants to enroll any eligible dependents.
2. For Vision: Review the Vision Plan rate page. Find the rate based on who is enrolling on the plan.
3. For Life: Review the Life Plan rate page. Find the rate based on the C.A.R. member's attained age and the level of coverage desired.
4. If enrolling *without* medical coverage, add monthly administration fee (see rate guide for amount).

Step 2: Complete Forms

Please note you may need to complete more than one application, depending upon the coverage you select.

All Applications

- Do not complete any shaded sections of the form.
- **Personal Data:** List yourself and all eligible dependents you wish to enroll. Make sure to include each person's date of birth, social security numbers (if requested), and your C.A.R. join date or hire date.
- **Requested Effective Date:** Write in the day, month and year. If enrolling outside of Open Enrollment, please see "General Guidelines" section "Special Enrollment Provision" for information on qualifying events and effective dates.
- **Adding Dependents after you enroll:** If you initially waive coverage for your dependents, they will not be able to enroll until the next Open Enrollment period unless they experience a qualifying event (See section "Special Enrollment Provision" for more information.) If coverage is desired for newborns, they must be added **within 30 days** of the date of their birth (their effective date of coverage will be their actual date of birth.)
- **Signature/Date:** The C.A.R. member must sign and date the form.

Anthem Blue Cross "Employee Addition" Application Form

- **Anthem Blue Cross HMO:** If you are enrolling in the Saver HMO plan, you must select a Primary Care Physician (PCP) for each enrolling family member. You will find the Anthem Blue Cross PCP listing on the Anthem Blue Cross website at www.anthem.com/ca. Click on "Find a Doctor" and choose "Doctor or other health professional" and enter your city and state. Under "Advanced Search" choose "Insurance Plan Information" and select your state, type of plan (HMO) and plan name (Blue Cross (Ca Care.) The physician's PCP number will be listed under "Affiliations" and "Medical Group Affiliation." You will need to complete a **PCP number** for each doctor selected. If you do not choose a PCP of your own, Anthem Blue Cross will assign one to you.
- **If you choose to waive coverage for your eligible dependents**, you must complete and sign Section 4 to decline coverage.

MetLife Dental/Life Applications

- Use this application to enroll in either of the dental plans, life insurance on a stand alone basis, or dental and life insurance together.
- **Life Insurance Beneficiary:** ONLY complete this section if you are enrolling in the life insurance program. This coverage is only available on ***a guaranteed basis to new C.A.R. members*** **and W2 employees of C.A.R. members or local C.A.R. associations** who enroll between their 60th and 120th day of membership/employment; and who have not been hospitalized in the 90 days prior to making application. Affiliate C.A.R. members are not eligible for guaranteed life coverage but may apply for coverage with evidence of medical insurability. Those who do not qualify for guaranteed coverage must contact RealCare for a statement of health form. They will require medical history underwriting to determine if they qualify for life coverage.

MES Vision Application

- Use this application if you are enrolling in the vision plan in combination with other coverages, or on a stand alone basis.

Step 3: Calculate Initial Payment

Use the worksheet below to calculate your initial payment:

Item	Amount
Medical Premium	$
Dental Premium	$
Vision Premium	$
Life Premium *	$
Monthly Administration Fee **	$ 20.00
Total Due With Applications	**$**

* If you do not qualify for guaranteed issued life insurance (see above), do not submit any life premium at this time.
** Administration fee is lower if subscriber does not enroll in medical insurance.

Step 4: Select A Payment Method

After the initial payment, you can either be billed monthly or pay by Automatic Premium Payment Authorization. Monthly invoices are sent around the 8th of the month and are due by the 25th for the coverage period beginning the first of the second month following the due date. For example, coverage for the month of March is billed in early January. If you elect to pay by Automatic Premium Payment Authorization, you will need to complete the Automatic Premium Payment Authorization form and submit it with a voided check along with your initial payment. The Automatic Premium Payment will be debited for all premiums and fees on the first of the month following the due date.

Step 5: Review & Mail Enrollment Materials & Payment

- ✓ Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- ✓ Check your enrollment forms to be sure they are complete and have been signed.
- ✓ Submit proof of eligibility (see Eligibility Guidelines for more information).
- ✓ Submit completed Automatic Premium Payment Authorization and voided check.

Mail Completed Application and Payment To:

REALCARE INSURANCE MARKETING, INC.
19310 Sonoma Highway, Ste. A
Sonoma, CA 95476

ANTHEM BLUE CROSS – METLIFE – MES
BILLING, CANCELLATION & REINSTATEMENT POLICIES

RealCare Insurance Marketing, Inc. Billing Department: (800) 939-8088, Ext. 201 • Fax: (707) 939-8450

If you are enrolled in an **Anthem Blue Cross** medical plan, (with or without MetLife dental/life or MES vision plan), premiums are billed based on the Anthem Blue Cross-MetLife-MES Billing Cancellation and Reinstatement Policies. If you are not enrolled in an Anthem Blue Cross medical plan, refer to the **Kaiser Permanente-MetLife-MES** Billing, Cancellation and Reinstatement Policies.

Initial Payment

Applicants are required to send the first two months of premium with their **initial enrollment application**.

Monthly Billing

- Bills are sent to plan members around the 8thth of each month. Premiums are due by the 25th of each month for coverage beginning the first of the second month following the due date. (For example, premiums for coverage for the month of June are due on April 25th.) If payment is not received by the 10th day following the premium due date, a late fee of $15 will be applied. If payment is not received within 30 days of the due date, coverage will be terminated effective the last day of the month through which premiums have been paid.
- Anthem Blue Cross rates are based on the subscriber's attained age, zip code and dependent status. If a subscriber has a birthday that moves him/her into the next age bracket, the rate increase will become effective the first of the month following the birthday, and will be reflected on that month's billing statement. Eligible subscribers who turn 65 while enrolled in an Anthem Blue Cross medical plan will be charged the "Medicare Secondary" rate effective the first of the month in which the subscriber reaches age 65. If a subscriber provides written documentation that s/he is eligible for Medicare, whether enrolled in Medicare or not, RealCare will change the Anthem Blue Cross billed rate to the "Medicare Primary" rate retroactive to the first of the month in which the subscriber reaches age 65. However, if a subscriber is ineligible for Medicare, that subscriber will continue to be charged the "Medicare Secondary" rate.
- Checks should be made payable to RealCare Insurance Trust Account (RITA) and remitted to 19310 Sonoma Highway, Suite A, Sonoma, CA 95476.

Automatic Premium Payment Authorization (APPA)

Plan members electing APPA will have all applicable premiums, dues, fees and adjustments debited on the first of the month following the due date. If an automatic debit is dishonored, a $25 fee will be assessed and the premium payment and applicable fees must be remitted to RITA by cashier's check or money order and received before the end of the 30-day grace period to avoid cancellation of your health care and/or insurance coverage.

Cancellation

Coverage may be cancelled for:

- ✓ Failing to pay premium and applicable administrative fees before the end of the grace period.
- ✓ Providing false information about membership in C.A.R.
- ✓ Providing false information about eligibility.
- ✓ Providing false information about a qualifying event.
- ✓ Failing to maintain active membership in C.A.R.

Voluntary Termination

A subscriber may voluntarily cancel coverage for himself or covered dependents. A subscriber who wishes to terminate coverage for any covered person must submit the completed termination form to RealCare Insurance Marketing - available on our member website, www.RealCareOnline.com. The effective date of termination will be the first of the month following receipt of the completed form.

Reinstatement/Re-Enrollment Policy

- Subject to approval from Anthem Blue Cross of California, a subscriber may be allowed to reinstate his/her coverage twice in a plan year (June 1 through May 31) if the subscriber submits an appeal letter to the Plan Administrator and a cashier's check or money order for all premiums, dues and administrative fees due, plus a $25 fee for the first reinstatement and $50 for the second reinstatement payable to RealCare Insurance Trust Account, (RITA). If a reinstatement request is approved by Anthem Blue Cross of California, coverage will be reinstated effective as of the cancellation date.
- If your **medical or vision** coverage is not reinstated, you may be eligible to re-enroll at the next Open Enrollment or within 30 days of a qualifying event. If your **life** coverage is not reinstated, you may be eligible to re-enroll; however medical underwriting will be required and coverage is not guaranteed. If your **dental** coverage is terminated for any reason, you may be eligible to re-enroll at the first Open Enrollment following a thirteen month waiting period or within 30 days of a qualifying event. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.
- No lapses in coverage between the cancellation date and the reinstatement date are allowed.
- If your coverage is not reinstated, please contact RealCare to review your health care coverage options.

Amendment or Termination of the Plan

The California Association of REALTORS® intends to continue the Plan described within this summary, but reserves the right to amend or terminate the Plan at any time and for any reason. In addition, the carrier reserves the right to terminate the Plan at the end of the policy year.