Step by Step Guide to Anthem Blue Cross Enrollment Application

For members of the California Association of REALTORS®

Please fill in your CA Real Estate License # and Requested Effective Date at the top of the form

Section A (page 1)

Application Type

- During Open Enrollment you should mark "Open Enrollment" unless you are a new member enrolling within the first 60 days of joining, or have experienced a Qualifying Event.
- Outside of Open Enrollment, applicants will mark either "New Enrollment" or "Qualifying Event"
- If adding or dropping dependents, please check appropriate box.

Section B (page 1)

Employee Information

- Fill in your personal information and provide your email address. We will frequently communicate with you via email so your email address is important.
- Employer name and address is required ONLY if you are a W-2 Employee of a C.A.R. member. If you are a W-2 employee of a C.A.R. member you are required to provide your employer's name, your hire date, your first date of full-time employment and the number of hours you work per week.
- **If you are a C.A.R. Member you should indicate the employer as "C.A.R." and provide your C.A.R. Join Date in the space provided for Hire Date.**

Section C (page 2)

Type of Coverage

C.A.R. has 23 preferred plans and they are indicated in the drop down box if you are completing this application in a PDF document.

- Enter the medical plan name (write in the name of your selected plan or select from the drop down in the fillable pdf.)
- Next to the plan name, write in the "Contract Code" if you know it. (A 4 digit code shown on quotes)
- **Near the bottom of the Medical Coverage section select a box to indicate which dependents you will be enrolling on your selected medical plan Section D (page 3)**

Section D (page 3)

Coverage Information

- **EVERY APPLICANT MUST COMPLETE THE FIRST SECTION WITH THEIR PERSONAL INFORMATION**
- If you are enrolling a Spouse or Domestic Partner and/or your dependent children, you must provide their personal information in the spaces provided.
- **For HMO Plan enrollment ONLY: Complete the "PCP Name" and "PCP ID No." to designate the Primary Care Physician for each family member. Also, check the box to indicate if the person is an existing patient. The PCP ID No. can be found by looking up your doctor on the Anthem website. Visit: www.Anthem.com/ca and click on "Find a Doctor." Search as a "guest" and be sure you select "California Care HMO/Small Grp" as the network for the HMO.**

Section E (page 4)

Prior and Other Coverage

- Provide information for any other coverage you or your dependents will keep in addition to the plan you are applying for. This information is particularly important to ensure smooth claims processing. Claims can be delayed if this information is not completed.
- **Be sure to answer all four questions**

Section F (page 4)

Waiver/Declining Coverage

You must complete this section ONLY if you have a Spouse/Domestic Partner or eligible dependent ***you are NOT enrolling*** on the medical plan at this time.

- Check a box to indicate who you are waiving/declining coverage for and indicate the reason you are declining coverage.
- List the names of the dependents that are not enrolling.
- Sign and date the bottom of this page **ONLY if you are waiving/declining medical coverage for a family member**.

Section G (page 5)

Terms, Conditions and Authorizations

- Read this section and **sign and date the bottom of page 5**. Your application must be signed in order for us to process it.

If you have questions, please contact us at (800) 939-8088

Submit Completed Application WITH Initial Payment

- If enrolling in Automatic Premium Payment Authorization, you must include a voided check or other documentation of your bank routing and account numbers.

Anthem Minimum Initial Payment Requirements	**No payment required**	**Payment for one month required**	**Payment for two months required**
If authorizing **Automatic Premium Payment**	If application is complete by 12/7/2020	If application is complete by 12/15/2020	Applications not complete by 12/15/2020
If not authorizing Automatic Premium payments	Does not apply	If application is complete by 12/7/2020	Applications not complete by 12/7/20

Make your check payable to: RealCare Insurance Trust Account (R.I.T.A.)

Mail To:
430 West Napa Street, Suite F
Sonoma, CA 95476

Fax to:
(707) 939-8450

Email to:
Enrollment@RealCare.biz

California Employee Enrollment Application For Small Groups
Medical, Dental, Vision, Life and Disability

Use this form to:
* **Enroll or Change Coverage**
* **Add/Drop Dependents**

Anthem

Health care plans offered by Anthem Blue Cross (Anthem). Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application. **Note:** Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect Social Security numbers. Submit application to your employer.

Please complete in black ink only.

CA Real Estate License #: _____
Requested Effective Date: _____

Group/Case no. (if known)

Section A: Application Type — select one

☐ New enrollment ☐ Open enrollment (not applicable for Life and Disability) ☐ Qualifying event (not applicable for Life and Disability)
☐ COBRA/Cal-COBRA ☐ Rehire date (MM/DD/YYYY): ____ ____ ____

If you select **Qualifying event** or **COBRA/Cal-COBRA**, please select one event reason.
☐ Marriage ☐ Birth of child ☐ Adoption of child ☐ Divorce or legal separation ☐ Death
☐ COBRA ☐ Cal-COBRA — Cal-COBRA applicants must submit first month's premium.
☐ Involuntary loss of coverage — please explain (required): _____
☐ Other — please explain (required): _____

Qualifying event or COBRA/Cal-COBRA date — Required (MM/DD/YYYY): _____

Section B: Employee Information

Last name	First name	M.I.	Social Security no.[1] (required)

Home address - (P.O. Box not acceptable unless rural address)	City	State	ZIP code

County	Marital status	Employment status	Primary phone no.	Cell phone no.
	☐ Single ☐ Married ☐ Domestic Partner (DP)	☐ Full-time ☐ Part-time		

Employer name	Occupation

Date of hire (MM/DD/YYYY)	Date of full-time employment (MM/DD/YYYY)	Date waiting period begins (MM/DD/YYYY)	No. of hours worked per week

Language choice (optional): ☐ English (ENG) ☐ Spanish (SPA) ☐ Chinese (ZHO) ☐ Korean (KOR) ☐ Vietnamese (VIE) ☐ Tagalog (TGL)
☐ Other (W09) — please specify: _____
Do you read and write English? ☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability/Translator's Statement.

Employee email address:

For **Medical plans** and all **Dental Net DHMO plans** offered by Anthem Blue Cross and regulated by the Department of Managed Health care.

I (primary applicant) agree to receive my plan-related communications for myself and any dependents, either by email or electronically. This may include my certificate, evidence of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my plan. I agree to provide an update Anthem with my current email address. I know that at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Anthem. I (or my enrolled dependents) will update our communication preferences by going to anthem.com/ca or calling Member Services at 1-855-383-7248.

For **Dental PPO**, **Vision**, **Life** and **Disability plans** offered by Anthem Blue Cross Life and Health Insurance Company and regulated by the California Department of Insurance, Anthem will deliver plan materials and related items by mail.

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.

Social Security no.[1]: _____ _____ _____

Section C: Type of Coverage —Your employer will advise you of your plan options and contract codes.

1. Medical Coverage

Please Note: All health plans[2] include the required coverage for the dental and vision pediatric essential health benefits.

Medical plan name: Anthem Silver HMO 55/2250/45% | Contract code, if known: _____

Member medical coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

2. Dental Coverage

Anthem Dental HMO[2] and Dental PPO[3] plans do not include certified pediatric dental essential health benefits.

Member dental coverage - select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

Dental plan name: _____ | Contract code, if known: _____

3. Vision Coverage

These optional vision plans[3] do not include coverage for vision pediatric essential health benefits.

Member vision coverage - select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family

Vision plan name: _____ | Contract code, if known: _____

4. Life[3], Accidental Death & Dismemberment[3] (AD&D), and Disability[3] Coverage

☐ Basic Life & AD&D ☐ Basic Dependent Life
☐ Supplemental/Voluntary Life and AD&D $ _____ (Employee amount)
☐ Supplemental/Voluntary Dependent Life Spouse/DP $ _____ (Spouse/DP amount)
☐ Supplemental/Voluntary Dependent Life Child $ _____ (Child amount)
☐ Short Term Disability
☐ Long Term Disability
☐ Voluntary Short Term Disability
☐ Voluntary Long Term Disability

Current annual income $ _____ Life and Disability class no. _____

Total percentages must add up to 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

Beneficiary designation — Attach a separate sheet if necessary.

	Name of beneficiary	Percentage	Social Security no.	Relationship to applicant	Age
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse's consent for designation.) If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following.

Authorization

I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy. I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.
In CA, NV, and WA, Spouse also includes your registered Domestic Partner.

Spouse signature X | Spouse name | Date (MM/DD/YYYY) / /

If an applicant's age at the time of application is 15, the applicant must submit a written statement, signed by the parent, consenting to the minor's application for coverage.

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 These plans are offered by Anthem Blue Cross and regulated by the Department of Managed Health Care.
3 Dental PPO, Vision, and Life and Disability plans are offered by Anthem Blue Cross Life and Health Insurance Company and regulated by the California Department of Insurance.

Social Security no.[1]: _____ _____ _____

Section D: Family Information —Complete this section for yourself and all dependents. All fields required. Attach a separate sheet if necessary.
Please access *Find a Doctor* at anthem.com/ca to determine if your physician is a participating provider.
For HMO plans: provide 3- or 6- digit Primary Care Physician no.

Dependent information must be completed for all additional dependents (if any) **to be covered under this coverage**. An eligible dependent may be your spouse or domestic partner, your children, children for whom you've assumed a parent-child relationship[2] (not including foster children) or your spouse or domestic partner's children (to the end of the calendar month in which they turn age 26). In the case of your child, the age limit of 26 does not apply when the child is and continues to be (1) incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and (2) chiefly dependent upon the subscriber for support and maintenance. The employee will be required to submit certification by a physician of the child's condition. List all dependents beginning with the eldest.

Employee last name	First name	M.I.
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	
Primary Care Physician (PCP) name (if selecting an HMO)	PCP ID no. (HMO only)	Existing patient ☐ Yes ☐ No
Primary Care Dentist (PCD) name (If selecting Dental net DHMO plan) N/A	PCD ID no. N/A	Existing patient ☐ Yes ☐ No N/A

Add ○ Drop ○

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner	
PCP name (if selecting an HMO plan)	PCP ID no. (HMO only)	Existing patient ☐ Yes ☐ No	
PCD name (If selecting Dental net DHMO plan) N/A	PCD ID no N/A	Existing patient ☐ Yes ☐ No N/A	
Does this dependent have a different address? ☐ Yes ☐ No If yes, full address and ZIP code: _____			

Add ○ Drop ○

Dependent last name	First name	M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other[3] If other, what is relationship?_____	
PCP name (if selecting an HMO plan)	PCP ID no. (HMO only)	Existing patient ☐ Yes ☐ No	
PCD name (If selecting Dental net DHMO plan) N/A	PCD ID no N/A	Existing patient ☐ Yes ☐ No N/A	
Does this dependent have a different address? ☐ Yes ☐ No If yes, full address and ZIP code: _____			

Add ○ Drop ○

Dependent last name	First name	M.I.	Social Security no.[1] (required)
Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other[3] If other, what is relationship?_____	
PCP name (if selecting an HMO plan)	PCP ID no. (HMO only)	Existing patient ☐ Yes ☐ No	
PCD name (If selecting Dental net DHMO plan) N/A	PCD ID no N/A	Existing patient ☐ Yes ☐ No N/A	
Does this dependent have a different address? ☐ Yes ☐ No If yes, full address and ZIP code: _____			

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 As defined in 2 CCR § 599.500(o).
3 Eligibility subject to Evidence of Coverage.

Social Security no.[1]: _____ _____ _____

Section E: Prior and Other Coverage

1. Is anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No If yes, give name:_____

Medicare ID no.	Part A effective date (MM/DD/YYYY)	Part B effective date (MM/DD/YYYY)
Medicare Part D ID no.	**Medicare Part D Carrier**	**Part D effective date (MM/DD/YYYY)**

2. Does anyone on this application intend to continue other coverage if this application is accepted? ☐ Yes ☐ No
3. Is anyone applying for coverage covered by other health, dental, or orthodontia coverage? ☐ Yes ☐ No
4. On the day your coverage begins, will you or a family member be covered by other dental coverage? ☐ Yes ☐ No

If yes to any of these questions, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (select one)	Coverage (select all that apply)	Carrier name	Policy ID no.	Dates (if applicable) (MM/DD/YYYY)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia			Start: End:

Section F: Waiver/Declining Coverage — Proof of coverage may be required. (Proof of coverage not applicable for Life and Disability.)

Type of coverage/Declined for: Select all that apply.

☐ ~~Employee~~	☐ ~~Medical~~ ☐ ~~Dental~~ ☐ ~~Vision~~ ☐ ~~Life/AD&D~~ ☐ ~~Short Term Disability~~ ☐ ~~Long Term Disability~~
☐ Spouse/ Domestic Partner	☐ Medical ☐ ~~Dental~~ ☐ ~~Vision~~ ☐ ~~Dependent Life~~
☐ Dependent(s)	☐ Medical ☐ ~~Dental~~ ☐ ~~Vision~~ ☐ ~~Dependent Life~~ List name of dependents to be waived: _____

Reason for declining/refusing coverage: Select all that apply.

- ☐ No coverage
- ☐ Covered by Spouse's/Domestic Partner's group coverage
- ☐ Spouse/Domestic Partner covered by their employer's group coverage.
- ☐ Enrolled in Individual coverage
- ☐ Medicare/Medi-Cal/VA
- ☐ Enrolled in other Insurance — Please provide company name and plan:_____
- ☐ Other — please explain _____

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, including but not limited to my employer, agent or life carrier, has tried to influence me or put any pressure on me to waive coverage. BY WAIVING THIS GROUP MEDICAL, DENTAL, VISION, DISABILITY OR LIFE COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, VISION, DISABILITY OR LIFE COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT TO BE ENROLLED IN THIS GROUP'S MEDICAL, DENTAL, OR VISION PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT. I also understand that if I wish to apply for Life coverage in the future, I may be required to provide evidence of insurability at my expense. Please note Spouse/Domestic Partner and Dependent coverage will not be available if the Employee has waived/declined.

Special Open Enrollment (Not applicable to Life or Disability.

If you declined enrollment for yourself or your dependent(s) (including a spouse/domestic partner), you may be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of certain triggering events, including: (1) you or your dependent loses minimum essential coverage; (2) you gain or become a dependent; (3) you are mandated to be covered as a dependent pursuant to a valid state or federal court order; (4) you have been released from incarceration; (5) your health coverage issuer substantially violated a material provision of the health coverage contract; (6) you gain access to new health benefit plans as a result of a permanent move; (7) you were receiving services from a contracting provider under another health benefit plan, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan; (8) you are a member of the reserve forces of the United States military or a member of the California National Guard, and returning from active duty service; or (9) you demonstrate to the department that you did not enroll in a health benefit plan during the immediately preceding enrollment period because you were misinformed that you were covered under minimum essential coverage. You must request special enrollment within 60 days from the date of the triggering event to be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of a qualifying triggering event.

Sign here only if you are declining coverage for yourself or dependents.

Signature of applicant	Printed name	Date (MM/DD/YYYY)
X		

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) to collect this information.

Social Security no.[1]: _____/_____/_____

Section G: Terms, Conditions and Authorizations — Please read this section carefully before signing the application.

As an eligible employee, I am requesting coverage for myself and all eligible dependents listed and authorize my employer to deduct any required contributions for this insurance from my earnings. To the best of my knowledge or belief, all statements and answers I have given are true and complete. I understand it is a crime to make or cause to be made a knowingly false or fraudulent material statement or material representation to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I understand all benefits are subject to conditions stated in the Group Contract and coverage document.

In signing this application I represent that:

I have read or have had read to me the completed application, and I realize any acts of fraud or intentional misrepresentation of material fact in the application may result in loss of coverage within 24 months following the issuance of the coverage.

I certify each Social Security number listed on this application is correct.

I understand that I may not assign any payment under my Anthem Blue Cross (Anthem) program. I agree to have money taken from my wages, if necessary, to cover the premium cost for the coverage applied for.

I am asking for the coverage I chose on this form. If I made choices that are not available to me, I agree that my choices may be changed to those on the employer's application or sold case coverage documents.

I understand that, to the extent allowed by law, Anthem reserves the right to accept or decline this application for coverage (and that Anthem Blue Cross Life and Health Insurance Company may accept only certain people or terms for coverage), and that no right is created by my application for coverage.

I also understand that I may not be covered for pre-existing conditions for Long Term Disability and Short Term Disability, if applicable. (See the policy/certificate for important information).

I agree that I will let my employer know right away of any changes that would make me or any dependent(s) ineligible for this coverage.

I understand that coverages will become effective on the date established by the provisions of the group policy, contract and certificates issued thereunder.

By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.

For Health Savings Account enrollees: I authorize the Health Savings Account (HSA) financial custodian (provided I am enrolling in an HSA) to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA and that I may provide Anthem with a written request to revoke my authorization at any time.

If applying for Life and/or Disability insurance, I represent that I have read and agree to the terms in the Life and Disability Coverage in Section 4, above.

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.

Read carefully — Signature required

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage.)

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. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: 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. This agreement does not limit your rights to internal and external review of adverse benefit determinations as required by 45 CFR 147.136. 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.

Sign here	Applicant Signature X	Date (MM/DD/YYYY)

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) to collect this information.

APPLICATION CHECKLIST

- Remember to **answer** all questions and **sign** the application(s) for the plan(s) you are choosing.
- Enclose initial month's premium payment **(even if you are selecting the Automatic Premium Payment option)**. Include premiums/fees for all applicable insurance plans (medical, dental, vision, and life insurance).

  If you are enrolling with Anthem Blue Cross, you may be required to **send two months of premium with your application.** After your initial payment you will pay a single monthly premium. Please check with your agent, or call RealCare to confirm the minimum payment due with your application.
- Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- If you are choosing the Automatic Premium Payment method, enclose check for your first premium payment PLUS **a voided check.** Complete the form below and return to RealCare with your initial premium check**.**
- Include **proof of eligibility** if you are a new C.A.R. member or W-2 employee of a C.A.R. member. If you are enrolling outside of open enrollment, you must have a qualifying event. Please refer to the General Guidelines "Special Enrollment Provision" section to review a list of qualifying events.
- Have questions or need assistance? Call 1-800-939-8088

Submit Completed Application and Initial Payment

Mail To:	Fax to:	Email to:
430 West Napa Street, Suite F Sonoma, CA 95476	(707) 939-8450	Enrollment@RealCare.biz

MONTHLY CHECKING/SAVINGS ACCOUNT AUTOMATIC PREMIUM PAYMENT AUTHORIZATION

As a convenience to me, I request and 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 C.A.R health care dues and/or insurance premiums, adjustments and administration fees due. I agree that your rights in respect to each such debit shall be the same as if it were a check signed by an authorized signer on the bank account. 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 RealCare 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 prior to the month of coverage. 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 first of the month of coverage. 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.

C.A.R. Health & Life Insurance Plans Account Information

C.A.R. Member/Employee Name: _____

Phone: _____ Email Address: _____

Banking Information

Name of Bank or Financial Institution: _____

Name on Bank Account: _____

Bank Routing Number: _____ ☐Checking Account

Account Number: _____ ☐Savings Account

Authorized Signature

_____ Date:_____

Signature of Authorized Signer on Above Bank Account

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

PLEASE ATTACH A COPY OF YOUR VOIDED CHECK AND SUBMIT WITH YOUR ENROLLMENT APPLICATION.

Note: The $5.00 Electronic Check Fee normally charged for payments submitted via fax or email is *waived* for the initial payment.

Rating, Billing, Cancellation & Reinstatement Policies

General Rating Rules

Member Level Rating

In accordance with the Affordable Care Act guidelines, for C.A.R. members, both Kaiser and Anthem rate each covered family member based on the home zip code for the family, and the age of the covered individual. Note: For W2 employees, Anthem rates the employee and each family member based on the employer's zip code.

- Kaiser calculates rates on the age of each covered family member as of the policy renewal date (January 1st)
- Anthem Blue Cross calculates rates on the age of each covered family member as of the coverage effective date.
- Rates are re-calculated for all members on the policy renewal date, January 1st.
- When calculating rates for a family:
    - For children under 21, include a rate for only the three oldest children.
    - For children 21 and older, include a rate for each child separately.

Maximum Eligibility Age for Dependents: Medical, Dental and Vision Plans

The maximum age for a dependent child on the medical, dental and vision plans is age 26. Please read the *Who is Eligible* section in the *General Guidelines* document included on our website for additional details or call RealCare at 1-800-939-8088.

Anthem Blue Cross Rating & Billing

Rates

- For C.A.R. members, Anthem Blue Cross rates are based on the plan selected, the member's home zip code and county, and each covered family member's age *as of the effective date of the coverage.* If a covered family member has a birthday that moves him/her into the next age bracket, the associated rate increase will become effective on the plan renewal date, January 1st.
- For W2 employees, the rates are based on the plan selected, the employer's zip code and county, and each family member's age *as of the effective date of the coverage.* If a covered family member has a birthday that moves him/her into the next age bracket, the associated rate increase will become effective on the plan renewal date, January 1st.
- Rating Changes during the year
    - **If a member is added** during the plan year Anthem will use the member's age as of the coverage effective date to determine the rate for that member.
    - **If a member is dropped** during the plan year, Anthem will reduce the billed amount by the cost for the member whose coverage terminated as of the effective date of the change.
    - **If a member changes addresses** to a new rating region during the plan year, all members will be re-rated based on the new region as of the effective date of the change.
    - **If a member changes plans** as a result of a qualifying event, all members will be re-rated based on the new plan as of the effective date of the change.
- Annual Renewal Date
    - The plan renews each year on January 1st. Rate changes take effect on January 1st regardless of the member's initial effective date.

Initial Payment

All applicants are required to pay a minimum of the first month's premium with their enrollment application unless they have authorized RealCare to draft monthly automatic payments from a bank account and their application is completed in time for the automatic payment to be withdrawn for their first month of coverage. Due to the timing of billing cycles, Anthem applicants may be required to send the first two months of premium with their enrollment application. The initial premium payment may be mailed, faxed, or scanned and emailed.

Monthly Billing Cycle - Anthem Health Coverage (with or without dental/vision)

Bills are generated around the 11th of each month. Premiums are due by the 1st of each month for coverage beginning the next month. (For example, premiums for coverage for the month of June are due on May 1st.) 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.

Payments

Monthly payments may be made by check or Automatic Premium Payment Authorization.

Check Payments

Checks should be made **payable to RealCare Insurance Trust Account (RITA)**

- If Mailed, send to: 430 West Napa Street, Suite F, Sonoma, CA, 95476.
- If Faxed, add the $5.00 processing fee to the total premium and fax your check to: (707) 939-8450
- If Scanned/Emailed, add the $5.00 processing fee to the total premium and scan/email to: enrollment@realcare.biz
    - For initial premium payment only, the $5.00 electronic check processing fee is waived.

Automatic Premium Payment Authorization (APPA)

Plan members electing APPA will have all applicable premiums, dues, fees and adjustments debited on the first business day of the month. 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 of Coverage

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 websites, www.RealCareOnline.com or www.RealCareCAR.com. The effective date of termination will be no earlier than the first of the month following receipt of the completed form.

Involuntary Termination

RealCare may cancel coverage for:

- Failing to pay premium and applicable administrative fees before the end of the grace period
- Failing to maintain active membership in C.A.R.
- Providing false information about membership in C.A.R.
- Providing false information about eligibility
- Providing false information about a qualifying event
- Reaching maximum allowable age for a dependent child
- Failing to continue to meet eligibility requirements as a member, employee or dependent

Reinstatement

- Subject to approval from the insurance carrier, a subscriber may be allowed to reinstate his/her coverage if the subscriber submits 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 subsequent reinstatement, payable to RealCare Insurance Trust Account, (RITA). If a reinstatement request is approved by the insurance carrier, coverage will be reinstated effective as of the cancellation date.
- If your medical coverage is not reinstated, you may be eligible to re-enroll at the next Open Enrollment or within 60 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 or vision 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 60 days of a loss of other coverage. 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.

Eligibility for Re-Enrollment

Re-Enrollment is contingent on meeting all eligibility requirements.

Kaiser: If your coverage terminates due to voluntary request or non-payment of premium, you may be eligible to re-enroll at the next Open Enrollment or during a Special Enrollment Period following a qualifying event. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.

Anthem Blue Cross: If your coverage terminates due to voluntary request or non-payment of premium, you may be eligible to re-enroll at the next Open Enrollment or during a Special Enrollment Period following a qualifying event. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.

MetLife Dental & Vision: If your coverage terminates due to voluntary request or non-payment of premium, you may be eligible to re-enroll at the next applicable Open Enrollment following a 13 month waiting period; or within 31 days of a loss of other coverage. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.

MetLife Life: If your coverage terminates and you are ineligible for reinstatement, you will not be allowed to re-enroll without submitting evidence of medical insurability. If you must re-apply, coverage is not guaranteed.

Plan Administration

Plan Administrator

The C.A.R. Insurance Plan is administered by the California Association of REALTORS® (C.A.R.) On behalf of C.A.R., RealCare Insurance Marketing, Inc., a licensed Third Party Administrator, handles all eligibility, enrollment and billing. The RealCare office is located at 430 West Napa Street, Suite F, Sonoma, CA 95476. Calls and inquires can be directed to this office at 800-939-8088. Information on plans and rates; forms, administrative policies and Explanation of Coverage documents can be found on the RealCare website, www.RealCareCAR.com.

RealCare is licensed as a third party administrator by the California Department of Insurance, license Number 0B23546.

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.

C.A.R. Health Plan Administrative Fees

The following is a list of administrative fees charged by RealCare.

Check By Fax or Scan/Email (waived for initial premium payment)	$ 5.00
Credit Card convenience fee	$25.00
Late Fee (for past due payments)	$15.00
Monthly Administration Fees:	
Accounts that include medical coverage	$22.00
Accounts that include dental coverage and no medical coverage	$ 5.00
Accounts that include vision and/or life insurance without medical or dental coverage	$ 2.00
Reinstatement Fee	$25.00
Reinstatement Fee (Second and subsequent reinstatement in a plan year)	$50.00
Returned Check Fee	$25.00
Returned Item Fee for Automatic Premium Payment Deduction	$25.00

For more information visit: www.RealCareCAR.com