Step by Step Guide to Anthem Blue Cross Enrollment Application **FOR Cancelling Anthem Medical**

For members of the California Association of REALTORS®

Complete Termination Request Form

- Complete personal information
- Select the box to indicate each type of coverage to terminate
- Select a box to indicate the reason for your request
- Sign and date the bottom of the form

Complete Anthem Employee Waiver Form Sections 1 and 2

Employee Information

- Fill in your personal information and the requested effective date of cancellation.
    - Retroactive cancellations are not allowed.
- **If you are a C.A.R. Member indicate the employer as "C.A.R." and provide your C.A.R. Join date in the space provided for Hire date.**
- If you are a W-2 employee of a C.A.R. member, enter the C.A.R. member's name or firm name.
- Check a box in the first column to indicate who you are waiving/cancelling/declining coverage for.
- Complete the section identifying the reason you're declining coverage.
- Sign and date the bottom of the page.

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

C.A.R. HEALTH & LIFE PLANS TERMINATION REQUEST FORM

This termination form is for use ONLY with C.A.R. health and life plans.
RealCare is not responsible for termination of coverage outside of the C.A.R. group plans.

Date: _____ Member ID or Policy #:_____

Subscriber Name: _____
Last First M.I.

Address: _____
Street Address

_____
City State Zip

Phone Number: _____ Email: _____

Please terminate the following coverage effective: _____ ***(Terminations must be effective as of the first of the month. Monthly premium payments are not prorated for terminations and retroactive terminations are usually not allowed.)***

☐ C.A.R. Group Kaiser Medical Plan

☐ C.A.R. Group Anthem Blue Cross Medical Plan *(Include completed/signed Anthem "Employee Waiver Form")*

☐ C.A.R. Group Dental Plan - If dental coverage is terminated, you will not be eligible to re-enroll until the next Open Enrollment following a thirteen-month waiting period.

☐ C.A.R. Group Vision Plan - If vision coverage is terminated, you will not be eligible to re-enroll until the next Open Enrollment following a thirteen-month waiting period.

☐ C.A.R. Group Life Insurance

I am terminating coverage because:

☐ I have obtained replacement coverage from another group

☐ I have obtained replacement coverage from an individual/family plan

☐ I have obtained replacement coverage from Covered California

☐ I don't want the coverage

☐ Other – Please Describe: _____

Subscriber Signature: _____ Date: _____

Fax your completed termination request form to RealCare Billing Department (707) 939-8450
or e-mail to enrollment@realcare.biz

RealCare Insurance Marketing, Inc. • 430 West Napa Street, Suite F • Sonoma, CA 95476
Phone: 800-939-8088 or 707-939-8088 • Fax 707-935-7142 • Website: www.RealCareCAR.com
California Insurance License #OB23546

Use this form to TERMINATE Coverage or DROP Dependents

California Employee Waiver Form For Small Groups

Anthem

Health care plans offered by Anthem Blue Cross. Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company.

Instructions: Please complete and return to your Group Administrator. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, please answer all questions and be sure to sign and date your application. **Note:** Anthem Blue Cross (Anthem) is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) to collect Social Security numbers.

Group/Case no. (if known)

Section 1: Employee Information

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

Employment status (required) ☐ Full-time ☐ Part-time	Hire date (required) (MM/DD/YYYY)	Requested effective date

Employer name	Occupation/job title (required)

Do you read and write English? ☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability/Translator's Statement.

Section 2: Waiver/Declining coverage — Complete only if any coverage is declined or refused by you and/or your eligible dependents.
Proof of coverage may be required. (Proof of coverage not applicable for Life and Disability.)

Type of coverage/Declined for: Select all that apply		**Reason for declining/refusing coverage:** Select all that apply
☐ Employee	☐ Medical ☐ ~~Dental~~ ☐ ~~Vision~~ ☐ ~~Life/AD&D~~ ☐ ~~Short Term Disability~~ ☐ ~~Long Term Disability~~	☐ No coverage ☐ Covered by Spouse's/Domestic Partner's group coverage ☐ Spouse/Domestic Partner covered by thier 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: _____
☐ Spouse/ Domestic Partner	☐ Medical ☐ ~~Dental~~ ☐ ~~Vision~~ ☐ ~~Dependent Life~~	
☐ Dependent(s)	☐ Medical ☐ ~~Dental~~ ☐ ~~Vision~~ ☐ ~~Dependent Life~~ List name of dependents to be waived: _____	

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 AND/OR LIFE COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, VISION, DISABILITY AND/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, VISION, INSURANCE 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.

Signature of applicant if declining coverage for yourself or dependents	Date (MM/DD/YYYY)
X	

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