Step by Step Guide to Anthem Blue Cross Enrollment Application

For members of the California Association of REALTORS®

Please complete the 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 many 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)

Coverage Information

- **EVERY APPLICANT MUST COMPLETE THE FIRST BOX 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. 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.**

Sections E (page 4)

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 submitting application via FAX or EMAIL, scan and send your initial check payment with your application.
- If enrolling in Automatic Premium Payment Authorization, you must include a voided check or other documentation of your bank routing and account numbers.

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

Mail To:	Fax to:	Email to:
430 West Napa Street, Suite F Sonoma, CA 95476	(707) 939-8450	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 ☐ Single ☐ Married ☐ Domestic Partner (DP)	Employment status ☐ Full-time ☐ Part-time	Primary phone no.

Employer name	Occupation

Employee's physical work address (required)	City	State	ZIP code

Date of hire [2] (MM/DD/YYYY) / /	Date of full-time employment (MM/DD/YYYY) / /	Date waiting period begins[2] (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 and 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.

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.
2 If your employer imposes an orientation period for new hires, the "date of hire" is the first day after completion of the orientation period.

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[3]: SELECT ONE | 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[4] 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[4] 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.:

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

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100% each named beneficiary's shared will be reduced equally to total 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.

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 Enrollment in the selected plan is dependent upon the employee residing or working within a plan's geographic service area, and the network, provider, and physician availability within the geographical service area. If at the time of enrollment the network, or physician/medical group is not available or an employee does not reside or work in the geographical service area of the plan you may be assigned to or be required to choose a different provider, network, and/or plan.
4 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 and EPO 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[3] or EPO plan)	PCP ID no. (HMO or EPO only)	Existing patient ☐ Yes ☐ No
Primary Care Dentist (PCD) name (If selecting Dental net DHMO plan)	**PCD ID no.**	**Existing patient**
N/A	N/A	☐ 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[3] or EPO plan)	PCP ID no. (HMO or EPO only)	Existing patient ☐ Yes ☐ No
PCD name (If selecting Dental net DHMO plan)	**PCD ID no**	**Existing patient**
N/A	N/A	☐ Yes ☐ No N/A

Does this dependent have a different address? ☐Yes ☐No
If yes, full address and ZIP code: _____

Add ☐ Drop ☐

Dependent Child last name	First name	M.I.	Social Security no.[1] (required) / /

Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY) / /	Relationship to applicant ☐ Child ☐ Other[4] If other, what is relationship? _____

PCP name (if selecting an HMO[3] or EPO plan)	PCP ID no. (HMO or EPO only)	Existing patient ☐ Yes ☐ No
PCD name (If selecting Dental net DHMO plan)	**PCD ID no**	**Existing patient**
N/A	N/A	☐ Yes ☐ No N/A

Does this dependent have a different address? ☐Yes ☐No
If yes, full address and ZIP code: _____

Add ☐ Drop ☐

Dependent Child last name	First name	M.I.	Social Security no.[1] (required) / /

Sex ☐ Male ☐ Female	Birthdate (MM/DD/YYYY) / /	Relationship to applicant ☐ Child ☐ Other[4] If other, what is relationship? _____

PCP name (if selecting an HMO[3] or EPO plan)	PCP ID no. (HMO or EPO only)	Existing patient ☐ Yes ☐ No
PCD name (If selecting Dental net DHMO plan)	**PCD ID no**	**Existing patient**
N/A	N/A	☐ 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 Enrollment in the selected plan is dependent upon the employee residing or working within a plan's geographic service area, and the network, provider, and physician availability within the geographical service area. If at the time of enrollment the network, or physician/medical group is not available or an employee does not reside or work in the geographical service area of the plan you may be assigned to or be required to choose a different provider, network, and/or plan.
4 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.		**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 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 _____
☐ 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 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, 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.

By providing a phone number, I agree and consent that Anthem and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.

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. 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.

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 the initial month's premium payment**. Your payment must include premiums and fees for all applicable insurance plans (medical, dental, vision, and life insurance).
- If paying monthly by Automatic Premium Payment, complete the form below and include your initial premium payment and a **voided check** with your submission.
- 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.).
- RealCare is required to verify your eligibility. If we cannot verify your membership online, you will be required to submit **proof of eligibility.** If you are a W-2 employee of a C.A.R. member or Board, you are required to submit payroll records or other documentation to verify eligibility.
- 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. **Documentation of your qualifying event is required to enroll.**

Submit Completed Application and Initial Payment

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

Fax to:
(707) 939-8450

Email to:
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 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. If a C.A.R. member lives out of state but maintains membership in C.A.R., Anthem will base the member's rates on the location of the C.A.R. office in Los Angeles, Rating Region 16.
- 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.
- For those who are Members and W2 employees:
    - Anthem will rate based on the C.A.R. member's home address when the C.A.R. member is both an employee of a C.A.R. member and a C.A.R. member themselves unless the Employer is being billed for the premiums.
- 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.

Voluntary AD&D coverage is billed annually based on when coverage was effective.

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

As a licensed Third Party Administrator, RealCare handles all administrative functions of the plan on behalf of C.A.R. This includes managing eligibility (including periodic audits), processing applications, conducting Open Enrollments, generating monthly billing, collection and remittance of premium, terminations, etc. All of these functions would normally be handled by an employer in a traditional group insurance plan. 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

Annual Administration Fee for Voluntary AD&D: ..... $ 5.00

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

Get help in your language

Language Assistance Services

Anthem.

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721. (TTY/TDD: 711)

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese
重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。 1-888-254-2721 (TTY/TDD: 711)

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Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។
អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ
សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는
언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오.
(TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ।
(TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы
также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по
номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa
pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa
libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้
เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย
หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc
thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi
ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.