ACCOUNT CHANGE FORM FOR C.A.R.
ANTHEM BLUE CROSS HEALTH PLANS

Submit Completed Form to RealCare:
Via Fax: (707) 939-8450 OR Via Email: rc-Enrollment@nfp.com
Via Mail: 548 Market St., PMB 91266, San Francisco, CA 94104

A. TO BE COMPLETED BY REALCARE Group #:_____

B. SUBSCRIBER INFORMATION
(Please complete all fields)

_____ CA Real Estate License #

_____ Policy ID Number

_____ Last Name _____ First _____ MI _____ Social Security Number

_____ Home Address _____ City _____ State _____ ZIP Code

_____ Home Phone _____ Work Phone _____ Cell Phone _____ Email Address

C. REQUESTED CHANGE(S) **Reason:** ☐ Open Enrollment ☐ Other ☐ Qualifying Event: _____ (Type of event)

REQUESTED EFFECTIVE DATE: _____ Event Date: _____

☐ **Plan Change** (Complete Sections B and D) ☐ **Name Change** (Complete Sections B and E)

D. PLAN CHANGE
Change Plan To:

Bronze Plans:
- ■ Bronze 70/6600/35% (8VB9)
- ■ Bronze 6700/0% HSA (8VE4)
- ■ Bronze 40/6200/40% (8VAN)
- ■ Bronze 6000/45% HSA (8VDP)

Silver Plans:
- ■ Silver 2600/35% HSA (8VCR/8VCS)
- ■ Silver 2300/30% HSA (8VC4/8VC5)
- ■ Silver 55/2500/45% (8V9X)
- ■ Silver 50/2200/40% (8V9F)
- ■ Silver 55/1950/35% (8V91)
- ■ Silver 45/1750/40% (8V87)

Gold Plans:
- ■ Gold 35/1000/20% (8V7B)
- ■ Gold 30/750/20% (8V70)
- ■ Gold 30/500/20% (94JT)
- ■ Gold 25/30% (94JB)

Platinum Plans:
- ■ Platinum 15/250/10% (8V6N)
- ■ Platinum 15/40/10% (94HX)

HMO Plans:
- ■ Silver 55 (94K7)
- ■ Gold 35 (903R)

HMO Members ONLY – List Primary Care Physician for each family member:

Self: _____ (PCP Name) PCP Code: _____

Spouse: _____ (PCP Name) PCP Code: _____

Child: _____ (Child Name) _____ (PCP Name) PCP Code: _____

Child: _____ (Child Name) _____ (PCP Name) PCP Code: _____

Child: _____ (Child Name) _____ (PCP Name) PCP Code: _____

Child: _____ (Child Name) _____ (PCP Name) PCP Code: _____

E. NAME CHANGE:

From:_____ To:_____
Last Name First Name M.I. Last Name First Name M.I.

REVIEW, SIGN AND DATE THE NEXT PAGE

CHANGE CANNOT BE PROCESSED WITHOUT SIGNATURE

As an eligible member, I am requesting coverage for myself and all eligible dependents and (for W2 employees only) authorize my employer to deduct any required contributions for this insurance from my earnings. 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. As a W2 employee, 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.**
- **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 or RealCare know right away of any changes that would make me or any dependent(s) ineligible for this coverage.**
- **By signing this application, I agree to the taping or monitoring of any phone calls between Anthem and myself.**
- **By signing below, I (primary applicant) agree to receive my plan-related communications 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 and RealCare 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 or RealCare.**
- **For Health Savings Account enrollees: Except as otherwise provided in any agreement between me and the financial custodian, the custodian of my Health Savings Account (HSA), I understand that my authorization is required before the financial custodian may provide Anthem with information regarding my HSA. I hereby authorize the financial custodian to provide Anthem with information about my HSA, including account number, account balance and information regarding account activity. I also understand that I may provide Anthem with a written request to revoke my authorization at any time.**
- **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

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 ARTIBTRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER ALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND /OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. 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.

_____	_____	_____
Applicant Signature	**Printed Name**	**Date**