

Anthem Blue Cross– CaliforniaCare (HMO)

Group Employee Application

For Adding New Employees and Their Eligible Dependents to Existing Coverage

INSTRUCTIONS

Group No. _____

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

Note: Spouse includes domestic partner (ONLY if your employer has selected that coverage). If coverage is available, domestic partner enrollment requires submission of a signed and notarized Domestic Partner Affidavit, or if applicable, a copy of a valid declaration of Domestic Partnership filed with and stamped by the Secretary of State of California.

SECTION 1 - MEDICAL COVERAGE SELECTION - *Please verify with your employer which plans are available*

HMO (CaliforniaCare) 100%

HMO (CaliforniaCare) 80%

You must select a Primary Medical Group (PMG) or an Independent Practice Association (IPA). If you are selecting an IPA, please select a Primary Care Physician (PCP) for each enrolling family member and list them by number below in SECTION 3A.

To locate a PMG or IPA, go to Anthem Blue Cross website: www.anthem.com/ca and then click on "Find a Doctor." When the web page appears, click on "Local California Provider" then click on "Visitor." For Plan Type select "Large Group," Select Plan is "Blue Cross HMO (CaliforniaCare)," Provider Type is "Medical Group/IPAs," then click on "Next." Follow the instruction on the next page to find a provider in your area.

HMO plan PMG or IPA Medical Office Number: _____

Are you currently a patient of this facility? Yes No

SECTION 2 - EMPLOYEE INFORMATION - *Must be completed by employee*

Family Addition

New Hire

COBRA

COBRA/CalCOBRA Effective Date _____

Late Enrollment

Other

CalCOBRA* _____

* CalCOBRA applicants must submit first month's premium.

Last Name	First Name	M.I.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Social Security or ID No.
Home Address (P.O. Box not acceptable unless rural P.O. Box)		Apt. No.	Number of Dependents <i>including spouse</i>	Spouse's Social Security or ID No.
City		State	Zip Code	Home Phone Number
Employer Name		Occupation/Job Title		Business Phone Number
Employer Address		Hire Date (MM/DD/YY)	Work Status <input type="checkbox"/> Part-Time <input type="checkbox"/> Full Time	# of Hours Worked Per Week

SECTION 3 - EMPLOYEE/DEPENDENT INFORMATION - List yourself and only those eligible dependents who are enrolling.

An eligible dependent is an employee's lawful spouse or domestic partner (if employer has elected to cover domestic partners); a child (except a newborn) of an employee who is the permanent legal guardian of that child and for which a valid court order establishing guardianship has been submitted; the unmarried child(ren) of the employee or the employee's spouse who are under age 19, or the unmarried child(ren) of the employee or enrolled spouse of the nineteenth (19th) to the twenty-fourth (24th) birthday who qualify as dependents for federal income tax purposes and are full-time students. Anthem Blue Cross requires written proof of student status annually.

Is spouse's last name different from yours, is he/she a domestic partner? Yes No

FAMILY ADDITION: Date of Marriage: _____ Date of Adoption: _____

3A. HMO Only - IPA (if you select an IPA, you must chose a primary care physician for each member of your family.)

Sex	Last Name	First Name	M.I.	Height	Weight	Disabled?	Date of Birth (MM/DD/YY)	Primary Care Physician No.
<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee					<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse/Domestic Partner					<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Male <input type="checkbox"/> Female						<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Male <input type="checkbox"/> Female						<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Male <input type="checkbox"/> Female						<input type="checkbox"/> Yes <input type="checkbox"/> No		

SECTION 4 - COVERAGE DECLINATION - To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependents.

Health Plan Coverage Declined For: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Child(ren)		
Reason for declining coverage: <i>(Check One)</i>		
<input type="checkbox"/> Covered by spouse's group coverage: Carrier name and I.D. # _____ <input type="checkbox"/> Covered by Anthem Blue Cross Individual Policy <input type="checkbox"/> Spouse covered by employer's group medical coverage: Carrier Name: _____	<input type="checkbox"/> Covered by Tricare <input type="checkbox"/> Enrolled in any other insurance carrier plan: Carrier Name: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Other <i>(Explain)</i> : _____	

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 declined not to enroll myself and/or my dependent(s), if any, I have made this decision voluntarily and no one has tried to influence me or put any pressure on me to decline coverage. BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT TWELVE (12) MONTHS FROM THE DATE OF ANY FUTURE APPLICATION TO BE ENROLLED IN THIS GROUP MEDICAL PLAN. PRE-EXISTING CONDITIONS WHEN ENROLLED IN THIS GROUP MEDICAL PLAN, MAY NOT BE COVERED FOR SIX (6) MONTHS.

X _____
Signature if declining coverage for employee/dependent(s)

Date (MM/DDD/YY)

SECTION 5 - OTHER COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS - All questions must be answered

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

If Yes, name of person: _____

Insurance Company: _____

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

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

If Yes, applicant/family member name(s): _____

Type of continuous coverage: Group Individual Other: _____

Insurance Company: _____

Date coverage began: _____ Date Ended: _____

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

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

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

Acceptable forms of proof are:

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

Failure to advise and provide proof of prior coverage may subject you or a family member to a six-month pre-existing conditions clause.

SECTION 6 - AUTHORIZATION - The following Authorization is to be signed by ALL EMPLOYEES applying for coverage

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

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

Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded.

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

