Employee Enrollment Application
For 1–100 Employee Small Groups
California

Anthem BlueCross

Health care plans offered by Anthem Blue Cross. 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 Blue Cross is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect Social Security numbers.

Submit application to: your employer.

Group/Case no. (if known)

Please complete in blue or black ink only.

Section A: Employee Information

Last name	First name	M.I.	Social Security no.* (required)

Home address – Street and PO Box if applicable

City	State	ZIP code

County	Marital status ☐ Single ☐ Married ☐ Domestic Partner	Primary phone no.	Number of dependents

Employee email address

Employer name

Employer street address

City	State	ZIP code

Employment status ☐ Full time ☐ Part time ☐ Disabled	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 (ZHOX) (C/M) ☐ 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.

Section B: Application Type

Select one

☐ New enrollment
☐ Open enrollment (not applicable for Life and Disability)
☐ Family addition Event date:
☐ COBRA
☐ Cal-COBRA
Cal-COBRA applicants must submit first month's premium.

Select qualifying event
☐ Left employment
☐ Loss of dependent child status
☐ Covered employee's Medicare entitlement
☐ Reduction in hours
☐ Divorce or legal separation
☐ Death

Note: For Cal-COBRA/COBRA applicants: Effective date of qualifying event:

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Social Security no.*

Section C: Type of Coverage – Select from only the coverages offered by your employer.

1. Medical Coverage – select one option **Medical plans offered by Anthem Blue Cross.**

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

	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
PPO: Prudent Buyer PPO Network	☐ 200/10%/3000	☐ 20/30%/5500 ☐ 500/20%/4500 ☐ 1000/20%/4000 ☐ 2000/0%/2500 w/HSA -RxC ☐ 2000/0%/3000 w/HSA ☐ 2000/20%/4000 ☐ 2000/20%/4000 w/HRA[1]	☐ 2000/35%/6850 ☐ 2000/20%/4850 w/HSA ☐ 2000/20%/4600 w/HSA -RxC	☐ 4500/30%/6350 w/HSA ☐ 5000/30%/6850 ☐ 6000/0%/6000 w/HSA ☐ 6000/35%/6600
PPO: Select PPO Network	☐ 20/10%/4000 ☐ 200/10%/3000	☐ 20/30%/5500 ☐ 35/20%/6200 ☐ 500/20%/4500 ☐ 1000/20%/4000 ☐ 2000/0%/2500 w/HSA -RxC ☐ 2000/0%/3000 w/HSA ☐ 2000/20%/4000 ☐ 2000/20%/4000 w/HRA[1]	☐ 1500/20%/6500 ☐ 2000/35%/6850 ☐ 2000/20%/4850 w/HSA ☐ 2000/20%/4600 w/HSA -RxC	☐ 4500/30%/6350 w/HSA ☐ 5000/30%/6850 ☐ 6000/0%/6000 w/HSA ☐ 6000/35%/6600 ☐ 6000/100%/6500
HMO: CaliforniaCare HMO Network		☐ 50/30%/6850 ☐ 500/20%/5000	☐ 1750/40%/6850	
HMO: Select HMO Network	☐ 25/20%/5000	☐ 50/30%/6850 ☐ 500/20%/5000	☐ 1750/40%/6850	
HMO: Priority Select HMO Network	☐ 25/20%/5000	☐ 50/30%/6850 ☐ 500/20%/5000	☐ 1750/40%/6850	

☐ Other: _____

Please indicate the contract code for the medical plan selected: Contract code, if known: _____

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

2. Dental Coverage – Select from only the coverages offered by your employer.

Dental Complete PPO Plan[1,2]	Dental Net DHMO Plan[1,3]	Dental Net Voluntary DHMO Plan[1,3]
☐ Classic ☐ Enhanced ☐ Voluntary	☐ Dental Net 2000A ☐ Dental Net 2000B ☐ Dental Net 2000C	☐ Dental Net Voluntary 2000A ☐ Dental Net Voluntary 2000B ☐ Dental Net Voluntary 2000C

For all DHMO plans, you must enter your Dental office no.: _____ ☐ Other: _____

1 These optional dental plans do not include coverage for dental pediatric essential health benefits.
2 Offered by Anthem Blue Cross Life and Health Insurance Company.
3 Offered by Anthem Blue Cross.

Member dental coverage – select one: ☐ Employee only ☐ Employee + Spouse/Domestic Partner ☐ Employee + Child(ren) ☐ Family ☐ No coverage

3. Vision Coverage – Select from only the coverages offered by your employer. **Offered by Anthem Blue Cross Life and Health Insurance Company.**

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

Full Service				Materials Only Plans
☐ Blue View Vision A1 ☐ Blue View Vision A2 ☐ Blue View Vision A3 ☐ Blue View Vision A4 ☐ Blue View Vision A5 ☐ Blue View Vision A6	☐ Blue View Vision B1 ☐ Blue View Vision B2 ☐ Blue View Vision B3 ☐ Blue View Vision B4 ☐ Blue View Vision B5 ☐ Blue View Vision B6	☐ Blue View Vision C1 ☐ Blue View Vision C2 ☐ Blue View Vision C3 ☐ Blue View Vision C4 ☐ Blue View Vision C5	☐ Blue View Vision C6 ☐ Blue View Vision C7 ☐ Blue View Vision C8 ☐ Blue View Vision C9	☐ Blue View Vision M01 ☐ Blue View Vision M02 ☐ Blue View Vision M03 ☐ Blue View Vision M04 ☐ Blue View Vision M05 ☐ Blue View Vision M06

☐ Other: _____ **Please indicate the contract code for the vision plan selected:** Contract code, if known: _____

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

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Social Security no.*

4. Life and Disability Coverage — Select from only the coverages offered by your employer. Offered by Anthem Blue Cross Life and Health Insurance Company.

☐ Life & AD&D ☐ Optional Life ☐ Other: _____
☐ Dependent Life Select one:
☐ $15,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $_____

Current income: $_____ ☐ Hour ☐ Week ☐ Month ☐ Year | Life class

If you select Life and/or Disability coverage over the guarantee issue amount or are a late entrant an *Evidence of Insurability* form will be sent to you to complete.

☐ Life & AD&D ☐ Optional/Voluntary Life & AD&D ☐ Short Term Disability ☐ Voluntary Short Term Disability
☐ Dependent Life ☐ Optional/Voluntary Dependent Life ☐ Long Term Disability ☐ Voluntary Long Term Disability

Primary Beneficiary — Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Contingent Beneficiary — Attach a separate sheet if necessary

Last name	First name	M.I.	Relationship	Social Security no.	Percentage

Total percentages should 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.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse 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. 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.

Spouse signature	Spouse name	Date
X		

NOTICE OF EXCHANGE OF INFORMATION: To proposed Insured and other persons proposed to be Insured, if any — information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of this information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901.

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4. Life and Disability Coverage — Continued

I authorize the release of any medical records or information concerning claims, conditions or treatment of myself and for any dependents listed herein, by any provider of health services, pharmacy related service organization, medical or medically-related facility, or the MIB, Inc., to Anthem Blue Cross Life and Health Insurance Company (Anthem Life), its affiliates, and any administrators, reinsurers, agents, or other entity providing services on behalf of Anthem Life. This information will be used for purposes which include but are not limited to: processing this application for enrollment; group risk classification; detecting or preventing fraud or misrepresentation; internal and external audits; administration of claims; and quality improvement programs. Anthem Life will advise such entities that such information must be kept confidential to the extent necessary or as otherwise provided by law, and should not be used for any unlawful purpose. This information includes any records or knowledge about medical history, including sensitive services such as mental health, psychiatric, substance abuse, reproductive health, information relating to ARC or AIDS (excluding disclosure of HIV testing or HIV status), sexually transmitted or other communicable diseases contained in such records, including but not limited to, all records of office visits, examinations, treatment, evaluation, diagnostic and laboratory testing, reports, consultations, hospital records, prescription history, records for treatment of substance abuse, psychiatric counseling, notes, correspondence, insurance and billing information for treatment or services rendered by any provider. I understand that Anthem Life may collect personal information about me from outside sources, and that both personal and privileged information may be collected and disclosed to third parties without my further authorization, and may no longer be protected by Federal privacy laws. I also understand that I have a right to see and correct personal information that Anthem Life collects about me, and that I may receive a more detailed description of my rights under this law by writing to Anthem Life.

I acknowledge that I have read the foregoing provisions and I expressly accept such provisions as a condition of coverage. I also acknowledge receipt and understanding of the Notice of Exchange of Information explained above. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in accepting this application. I understand that any misstatements or failure to report new medical information prior to my effective date may result in a material change to coverage or premium rates. Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s). This authorization, for purposes of processing this application form, is valid from the date signed for a period of thirty months unless revoked by me in writing, which I may do at any time by contacting Anthem Life. A photocopy is as valid as the original.

I give this authorization for and on behalf of myself and my eligible dependents, including my children and my spouse (if spouse does not sign below), if covered by the Plan. I am acting as their agent and representative.

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

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Social Security no.*

Section D: Coverage Information — All fields required. Attach a separate sheet if necessary.
Please access *Find a Doctor* at anthem.com 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, 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	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant Self
Primary Care Physician (PCP) name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient ☐ Yes ☐ No	

Spouse/Domestic Partner last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Spouse ☐ Domestic Partner
PCP name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient ☐ Yes ☐ No	

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please provide full address and ZIP code: ____________________

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ____________
PCP name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient ☐ Yes ☐ No	

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please provide full address and ZIP code: ____________________

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ____________
PCP name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient ☐ Yes ☐ No	

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please provide full address and ZIP code: ____________________

Dependent last name	First name	M.I.	Social Security no.* (required)
Sex ☐ Male ☐ Female	Disabled ☐ Yes ☐ No	Birthdate (MM/DD/YYYY)	Relationship to applicant ☐ Child ☐ Other If other, what is relationship? ____________
PCP name (if selecting an HMO plan)	PCP ID no. (if selecting an HMO plan)	Existing patient ☐ Yes ☐ No	

Does this dependent have a different address? ☐ **Yes** ☐ **No**
If yes, please provide full address and ZIP code: ____________________

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Social Security no.*

Section E: Other Coverage

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

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply) ☐ Age ☐ Disability ☐ ESRD: Onset date:

Medicare Part D ID no.	Medicare Part D carrier	Part D effective date

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 vision 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 (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision				Start: End:
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision				Start: End:

Section F: Waiver/Declining Coverage – Proof of coverage will be required

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
***Life/AD&D** coverage declined for: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)
Dependent Life coverage declined for: ☐ Spouse/Domestic Partner ☐ Dependents
Short Term Disability coverage declined for: ☐ Myself
Long Term Disability coverage declined for: ☐ Myself

Reason for declining coverage – check all that apply:
☐ Covered by Spouse's/Domestic Partner's group coverage
☐ Enrolled in other Insurance –
Please provide company name and plan: _____
☐ Enrolled in Individual coverage
☐ Spouse/Domestic Partner covered by employer's group medical coverage
☐ Medicare/Medicaid/VA
☐ Other – please explain: _____
☐ No coverage

List names 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 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, DISABILITY OR LIFE PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT.

Special Open Enrollment
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.

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense. Please examine your options carefully before waiving this coverage.

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

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

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

Social Security no.*

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. 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.

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.

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

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.

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 coverage.)

ALL DISPUTES 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 AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND MEDICAL MALPRACTICE CLAIMS.

By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

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

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Social Security no.*

Anthem Blue Cross
Language Assistance Notice

IMPORTANT: An interpreter can be provided for you to communicate with your doctor or health plan at no cost. To get an interpreter or to ask about written information in your language, please contact your group administrator.

IMPORTANTE: Se le puede brindar sin costo los servicios de un intérprete para que pueda comunicarse con su médico o plan de salud. Para obtener un intérprete o para solicitar información escrita en su idioma, comuníquese con el administrador de su grupo. (Spanish)

重要提示： 您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請聯絡您的團體行政人員。(Cantonese or Mandarin)

중요: 의사 또는 건강보험사와의 의사소통을 위하여 통역사를 무료로 이용하실 수 있습니다. 통역이나 한국어로 번역된 정보를 원하시면 그룹 담당자에게 요청하시기 바랍니다. (Korean)

MAHALAGA: Mai-alok ang tagapagsalin sa iyo nang libre upang makipag-usap ka sa iyong doktor o planong pangkalusugan. Upang kumuha ng tagapagsalin o magtanong tungkol sa nakasulat na impurmasyon sa iyong lengguahe, paki-usap ang tagapangasiwa ng iyong pangkat. (Tagalog)

CHÚ Ý QUAN TRỌNG: Quý vị có thể được thông dịch viên giúp đỡ miễn phí khi quý vị cần tiếp xúc với bác sĩ hoặc nhân viên trong chương trình bảo hiểm sức khỏe của quý vị. Để được thông dịch viên giúp đỡ hoặc được cấp thông tin, văn bản chuyển ngữ sang ngôn ngữ của quý vị, xin quý vị vui lòng liên lạc ban quản trị chương trình bảo hiểm. (Vietnamese)

Anthem Blue Cross Life and Health Insurance Company
Notice of Language Assistance

IMPORTANT: An interpreter can be provided for you to communicate with your doctor or health plan at no cost. To get an interpreter or ask about written information in your language, please call the phone number listed on the back of your ID card or contact your group administrator.

IMPORTANTE: Se le puede brindar sin costo los servicios de un intérprete para que pueda comunicarse con su médico o plan de salud. Para obtener un intérprete o para solicitar información en su idioma, llame al número que figura en el reverso de su tarjeta de identificación o póngase en contacto con el administrador de su grupo. (Spanish)

重要提示： 您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請撥打您識別證背面的電話號碼，或聯絡您的團體行政人員。(Chinese)

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Social Security no.*

Anthem Blue Cross Life and Health Insurance Company
Notice of Language Assistance

CHÚ Ý QUAN TRỌNG: Quý vị có thể được thông dịch viên giúp đỡ miễn phí khi quý vị cần tiếp xúc với bác sĩ hoặc nhân viên trong chương trình bảo hiểm sức khỏe của quý vị. Để được thông dịch viên giúp đỡ hoặc được cấp thông tin, văn bản chuyển ngữ sang ngôn ngữ của quý vị, xin quý vị vui lòng gọi số điện thoại ghi phía sau thẻ hội viên của quý vị hoặc liên lạc ban quản trị chương trình bảo hiểm. (Vietnamese)

MAHALAGA: Mai-alok ang tagapagsalin sa iyo nang libre upang makipag-usap ka sa iyong doktor o planong pangkalusugan. Upang kumuha ng tagapagsalin o magtanong tungkol sa nakasulat na impurmasyon sa iyong lengguahe,paki-tawagan ang numero ng telepono na nakalista sa likod ng iyong ID card o paki-usap ang tagapangasiwa ng iyong pangkat. (Tagalog)

중요: 의사 또는 건강보험사와의 의사소통을 위하여 통역사를 무료로 이용하실 수 있습니다. 통역이나 한국어로 번역된 정보를 원하시면 가입자님의 ID 카드 뒷면에 있는 전화번호로 연락하시거나 그룹 담당자에게 요청하시기 바랍니다. (Korean)

ԿԱՐԵՎՈՐ. Ձեր բժշկի կամ առողջապահական ծրագրի հետ հաղորդակցվելու համար՝ Ձեզ անվճար թարգմանիչ կարող է մատակարարվել: Թարգմանիչ ստանալու կամ Ձեր լեզվով գրավոր տեղեկութ յունների մասին հարցնելու համար՝ խնդրվում է զանգահարել Ձեր ինքնութ յան քարտի ետ§ի մասում գրված հեռախոսի համարով կամ կապվեք Ձեր խմբայինի կառավարչի հետ: (Armenian)

ПОМНИТЕ: Для общения с вашим врачом или представителем плана медицинского страхования вам могут предоставить бесплатные услуги переводчика. Для того, чтобы получить услуги переводчика или попросить о предоставлении информации в письменном виде на вашем языке, пожалуйста, позвоните по номеру, который указан на оборотной стороне вашей идентификационной карты (ID card), или свяжитесь с администратором вашей медицинской группы. (Russian)

重要事項： 医師、および、ヘルスプラン担当者との意思疎通には、通訳者による通訳サービスを無料で受けることが出来ます。通訳者サービス、または、あなたが話す言語で書かれた文書による情報を要請するには、あなたのIDカードの裏側に記載された電話番号に電話をするか、または、あなたの属するグループのアドバイザーに連絡をとってください。(Japanese)

ਜ਼ਰੂਰੀ ਸੂਚਨਾ: ਤੁਹਾਡੇ ਡਾਕਟਰ ਨਾਲ ਜਾਂ ਹੈਲਥ ਪਲਾਨ ਬਾਰੇ ਗੱਲਬਾਤ ਕਰਨ ਲਈ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ (ਅਨੁਵਾਦਕ) ਦੀ ਸੇਵਾ ਮੁਫਤ ਦਿੱਤੀ ਜਾ ਸਕਦੀ ਹੈ। ਦੁਭਾਸ਼ੀਆ ਲੈਣ ਲਈ ਜਾਂ ਲਿਖਤ ਜਾਣਕਾਰੀ ਪੰਜਾਬੀ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਆਈ.ਡੀ. ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਆਪਣੇ ਗਰੁੱਪ ਪ੍ਰਬੰਧਕ ਨੂੰ ਸੰਪਰਕ ਕਰੋ। (Punjabi)

សារៈសំខាន់ ៖ យើងអាចផ្តល់អ្នកបកប្រែជូនអ្នកដោយឥតគិតថ្លៃ សំរាប់ប្រាស្រ័យទាក់ទងជាមួយនឹងគ្រូពេទ្យ ឬគំរោងសុខភាពរបស់អ្នក ។ ដើម្បីទទួលអ្នកបកប្រែ ឬសាកសួរអំពីព័ត៌មានដែលសរសេរជាភាសាខ្មែរ សូមទូរស័ព្ទទៅលេខដែលមានកត់នៅលើខ្នងអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ឬទាក់ទងអ្នកគ្រប់គ្រងក្រុមរបស់អ្នក ។ (Khmer)

هام: يمكننا توفير مترجم فوري لك للتواصل مع الطبيب الخاص بك أو بخصوص خطتك الصحية بدون مقابل. للحصول على مترجم فوري أو لطلب معلومات كتابية بلغتك، رجاء الاتصال على رقم الهاتف الموجود على ظهر بطاقة العضوية أو اتصل بمسؤول المجموعة. (Arabic)

TSEEM CEEB: Yeej nrhiav tau ib tug neeg pab txhais lus uas yuav pab koj nrog koj tus kws kho mob los sis pawg kho mob tham pub dawb rau koj. Yog xav tau ib tug neeg txhais lus los sis xav tau cov ntawv hauv koj yam lus, thov hu mus rau tus naj npawb xov tooj nram qab koj daim ID los sis hu mus rau tus neeg saib xyuas koj pawg hauj lwm. (Hmong)

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