

1. Please tell us about your company...

Company Name		Group No. (For existing groups)	
Street Address	City	State	ZIP Code
Billing Address	City	State	ZIP Code
Employer is: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Other (Explain):	SIC Code	Type of Business (Be specific)	
Date Business Established (Mo/Yr)	Company Contact Person	Phone No. ()	Fax No. ()
Has the company been insured by Anthem Blue Cross in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date prior Anthem Blue Cross coverage terminated: ___/___/___	E-mail Address		Tax ID No.

2. Medical Coverage Preferences...what payment options would you like to select?

2a. My Employer Medical Contribution each month will be:

Traditional Option I will contribute (50% to 100%): _____ % per employee _____ % per dependent

Fixed Dollar Option I will contribute (at least \$100 in \$5 increments): \$ _____

Percentage and Plan Option I will contribute (50-100%) to the following plan (excluding Basic PPO): _____
 _____ % per employee _____ % per dependent

2b. I choose to offer:

ALL PLANS OR **NOTE: Power Select HMO Plan cannot be offered along with any other HMO plan**

DESIGNATED PLANS (designate Single Plan or Mix 'N Match by checking as many as desired)

<input type="checkbox"/> Basic PPO**	<input type="checkbox"/> Lumenos HSA 3000**	<input type="checkbox"/> Power HealthFund 750**	<input type="checkbox"/> Power Select HMO*
<input type="checkbox"/> Saver PPO**	<input type="checkbox"/> Lumenos HIA Plus 3000**	<input type="checkbox"/> PPO 3500 (HSA-Compatible)**	<input type="checkbox"/> Saver HMO*
<input type="checkbox"/> PPO \$35 Copay GenRx**	<input type="checkbox"/> Advantage PPO \$25 Copay**	<input type="checkbox"/> PPO 2400 (HSA-Compatible)**	<input type="checkbox"/> Classic HMO*
<input type="checkbox"/> PPO \$45 Copay GenRx**	<input type="checkbox"/> Premier PPO \$20 Copay*	<input type="checkbox"/> High Deductible EPO*	<input type="checkbox"/> HMO 100%*
<input type="checkbox"/> PPO \$30 Copay*	<input type="checkbox"/> Premier PPO \$10 Copay*	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> PPO \$40 Copay*	<input type="checkbox"/> Power HealthFund 500**		
<input type="checkbox"/> Lumenos HSA 1500**			

Will Employer establish a Mellon Health Savings Account for the Lumenos plan(s) Yes No

* offered by Anthem Blue Cross
 ** offered by Anthem Blue Cross Life and Health

3. Dental Coverage Preferences...what payment options and plan choices would you like to select?

3a. My Employer Dental Contribution each month will be:

Traditional Option I will contribute (at least 50%): _____ % per employee _____ % per dependent

Fixed Dollar Option I will contribute (at least \$15 in \$5 increments): \$ _____

3b. I choose to offer:

ALL PLANS (includes all network levels for Dental Blue plans) **OR**

DESIGNATED PLANS (designate Single Plan or Mix 'N Match by checking as many as desired)

<input type="checkbox"/> Dental Blue Platinum Plus**	_____100_200_300	<input type="checkbox"/> High Option PPO**	<input type="checkbox"/> Dental Net*
<input type="checkbox"/> Dental Blue Platinum**	_____100_200_300	<input type="checkbox"/> Standard Option PPO**	<input type="checkbox"/> Dental SelectHMO*
<input type="checkbox"/> Dental Blue Gold Plus**	_____100_200_300	<input type="checkbox"/> Basic Option PPO**	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Dental Blue Gold**	_____100_200_300		
<input type="checkbox"/> Dental Blue Silver Plus**	_____100_200_300	* offered by Anthem Blue Cross	** offered by Anthem Blue Cross Life and Health
<input type="checkbox"/> Dental Blue Silver**	_____100_200_300	Fee for service coverage will be substituted if member is outside of PPO service area.	

Voluntary Dental Coverage

Please check below to offer one or both voluntary dental plans. (not available in conjunction with any other dental plans):

Dental Saver SelectHMO*

PPO Dental Plan**

4. Vision Coverage Preferences...what plan choice and payment percentage would you like to select?

4a. I choose to offer: Blue View AND/OR Blue View Plus

4b. My employer contribution will be (50-100%): _____ % per employee _____ % per dependent

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5. Life Coverage Selections *Add \$25,000 or more of Life Coverage and your group may qualify for 1% medical premium savings!*

I choose to offer Life coverage, and my Employer Life Contributions will be (25-100%):
 _____ % per employee _____ % per dependent

Please check only one schedule and specify amount of Life coverage
 (from \$15,000 to \$250,000 in \$1,000 increments):

Schedule A Coverage is the same for all job titles \$ _____

Schedule B Coverage differs by job title:
Class I, officers, managers, supervisors _____ \$
Class II, all other group members _____ \$

(Coverage amount for Class I cannot exceed 2.5 times coverage amount for Class II)

Schedule C Coverage is a percentage of salary (maximum coverage \$250,000);
 check one of the following for all employees:

EITHER 1 times annual salary, maximum Life coverage \$ _____

OR 2 times annual salary, maximum Life coverage \$ _____

For Schedule C, please provide list of employees & annual base salaries

I choose to offer Dependent Life coverage:

EITHER \$10,000 spouse, \$10,000 children 6 months to 19 years (age 24 if full-time student), \$1,000 children under 6 months
(only available if employee Life benefit is \$20,000 or more)

OR \$5,000 spouse, \$5,000 children 6 months to 19 years (age 24 if full-time student), \$500 children under 6 months

I choose to make Supplemental Life coverage available;
 Supplemental Life is 100% employee paid *(only available if other Life options are also selected)*

6. Do you want to enroll in P.O.P.?

Yes No Premium Only Plan (P.O.P.) is a payroll administration service offered by Ceridian Benefit Services, Inc. (an independent company not affiliated with Anthem Blue Cross) that helps companies receive IRS Section 125 tax advantages.

The first year may be FREE if your group has 10+ members enrolling in both Medical and Life. Please read the P.O.P. brochure for complete details. If you choose to enroll please complete the enrollment form, provide a separate check (if applicable), and submit along with this application.

7. Please tell us about your group's eligibility...

A. Total number of employees (including owners/officers): _____

B. Number of eligible full-time employees (working a minimum of 30 hours per week): _____

C. Are part-time employees to be covered? Yes No
 If yes, check one option:
 20-29 hours weekly 15-29 hours weekly

D. Number of eligible part-time employees: _____

E. Is this group a class carve-out? Yes No
 If yes, state class of employees to be covered: _____

F. Probationary period/waiting period for new employees:
 1st of month after hire date 3 months 5 months
 1 month 4 months 6 months
 2 months

G. Do you wish to offer coverage for opposite sex domestic partners* under the age of 62 years? Yes No

H. Is your group currently subject to Cal-COBRA? Yes No

(Employed 2-19 eligible employees on at least 50% of its working days in the previous calendar year; or if not in business during any part of the previous calendar year, employed 2-19 eligible employees on at least 50% of its working days during the previous calendar quarter; and not subject to COBRA)

I. Is your group currently subject to COBRA? Yes No

(Employed 20 or more total employees on at least 50% of the working days in the previous calendar year; and not subject to Cal-COBRA)

J. Is your group subject to the Family Medical Leave Act of 1993? (50 or more total employees) Yes No

K. Under TEFRA/DEFRA; which one applies for your group?
 Medicare is primary (less than 20) Anthem Blue Cross is primary (20+)

Medicare is primary coverage for groups with less than 20 employees; Anthem Blue Cross is primary coverage for groups with 20+ employees (based on total number of employees during 50% of the working days in previous calendar year).

* Anthem Blue Cross complies with State law requiring it to cover spouses and qualified registered domestic partners including dependents to the same extent and subject to the same terms and conditions as a spouse. To be an eligible domestic partner one must be a domestic partner registered under a valid Declaration of Domestic Partnership filed with the California Secretary of State, or an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnership.

If yes to questions H, I or J, please complete the Cal-COBRA/COBRA/FMLA questionnaire on page 6.



8. What is your requested effective date?

____/____/____ Actual effective date will be assigned if application is accepted.

9. Please tell us if your group has had coverage within 90 days of this application's signature date ...

Will this plan replace current: If yes, current carrier is: Proposed termination date is:
Medical Coverage? Yes No _____ / _____ / _____
Dental Coverage? Yes No _____ / _____ / _____

10. What about employee Leave of Absence at your firm?

Personal: number of months employees are eligible to continue group coverage while on an employer-approved temporary personal leave of absence (maximum 3 months). None 2 Months
 1 Month 3 Months
Medical: number of months employees are eligible to continue group coverage while on an employer-approved temporary medical leave of absence (maximum 6 months). None 4 Months
 1 Month 5 Months
 2 Months 6 Months
 3 Months

11. To your knowledge, is anyone to be covered unable to work due to injury or illness?

Yes No
If yes:
Name(s) _____ Anticipated return date(s) _____

12. Please tell us about your Workers' Compensation coverage ...

Current carrier: _____ Next renewal date: _____
(mm/dd/yy)

Please list the name and job title for any medically enrolling employee under the Anthem Blue Cross coverage who is not an employee for the purpose of Workers' Compensation law or similar legislation (see the definition provided below):

Name: Job Title: Exempt per definition below?

_____ Yes No
_____ Yes No
_____ Yes No

Definition: Under California Labor Code Section 3351, partners, corporate officers and members of boards of directors are employees for Workers' Compensation purposes except under limited circumstances. In order for individuals holding the above-mentioned positions to fall outside the Workers' Compensation laws, they must be shareholders of the corporation, and all stock of the corporation must be held by persons who are either officers or members of the board of directors of the corporation.



13. This section is important to protect you as a small group employer ...

Please check the box that applies:

- We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employment Retirement Income Security Act of 1974), apply to obtain the coverage indicated. We understand that any dispute involving an adverse benefit decision may be subject to voluntary binding arbitration only after the ERISA appeals procedure has been completed.
- We, the employer, as administrator of an Employee Welfare Benefit Plan which is a church plan or governmental plan as defined under ERISA (Employment Retirement Income Security Act) and therefore not subject to ERISA, apply to obtain the coverage indicated.

Rescission

We have provided a complete history of material information that is considered in the acceptance or denial of the enrollment application. Following approval of coverage, if Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company discovers that we intentionally provided incomplete or false material information or withheld material information from Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company prior to the Effective Date of the Agreement, Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company may revoke coverage. This means Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company may cancel coverage as if it never existed.

If Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company revokes our Group coverage under the Combined Evidence of Coverage and Disclosure Form, Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company will send a written notice explaining the basis for the decision and our appeal rights. We have the option to submit a new application in the future to be underwritten and considered for enrollment. We will be required to pay for any services that were covered for an employee, and Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company will refund any amounts paid by our Group except amounts already paid by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company on behalf of our employees.

We have personally read and attest to the completeness and validity of the information provided on this application for coverage. If we are accepted, this application will become part of the contract between Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and our Group. Initials:

We understand and agree that no coverage will be effective before the date determined by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and only if we have paid our first month's contribution and this application is accepted, that we should keep prior coverage in force until notified of acceptance in writing by Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company and that no agent or broker has the right to accept this application or bind coverage. If this application is accepted, it becomes a part of our contract with Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company.

For Anthem Blue Cross Life and Health insurance coverages, we, the employer, apply to become a participating employer in the Small Group Trust to obtain the coverages indicated. We understand that the Small Group Trust and the underwriting companies may rely on the application, deciding whether to allow us to participate in the Small Group Trust. We hereby acknowledge receipt of Anthem Blue Cross Life and Health Insurance Company's benefit description attached to and made a part hereof. We

understand and agree that: 1) no coverage will be effective before the date determined by the Small Group Trust and the underwriting companies and only if: a) we have paid for the first month's contribution; and b) this application, and any individual applications have been approved by the Small Group Trust and the underwriting companies; 2) this application, if accepted, and any subsequent amendments become our participation agreement with the Small Group Trust, and 3) the trust agreement and contracts under which we elected coverage are incorporated in and are made a part of the participation agreement. The employer agrees to comply with all provisions of the Small Group Trust. I understand and agree to all of the above. I understand that it is required to submit a DECLINATION of coverage any time that an employee and/or dependent is/or becomes eligible for coverage, but does NOT enroll.

For employers offering a Health Savings Account (HSA) compatible EPO Plan: We, the employer, understand that the High Deductible EPO Plan is designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. We understand that having this coverage does not establish an HSA.

The HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institution. Applicant must be an "eligible individual" under IRS regulations to receive the HSA tax benefits. The IRS has not yet issued HSA or high deductible health plan regulations or determined that Anthem Blue Cross high deductible plans are qualifying high deductible health plans. Consultation with a tax advisor is recommended.

ARBITRATION AGREEMENT:

If we are enrolled as an administrator of an Employee Welfare Benefit Plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) we understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, we further understand that any dispute we may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process has been completed.

WE UNDERSTAND THAT ANY AND ALL DISPUTES, BETWEEN US AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THIS MEANS THAT WE AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING OUR RIGHTS TO A JURY TRIAL UNDER THIS COVERAGE, ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AND WE ARE GIVING UP THE RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST EACH OTHER.

WE UNDERSTAND THAT ANY AND ALL DISPUTES, BETWEEN US AND ANTHEM BLUE CROSS AND ITS AFFILIATES, INCLUDING CLAIMS FOR MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THIS MEANS THAT WE AND ANTHEM BLUE CROSS ARE WAIVING OUR RIGHTS TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS AND ANY OTHER DISPUTES. UNDER THIS COVERAGE, ANTHEM BLUE CROSS AND WE ARE GIVING UP THE RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST EACH OTHER.

NOTICE: BY SIGNING THIS APPLICATION YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY TRIAL.

Name of Company Officer (Please print)	Title of Company Officer
Signature of Company Officer	Date (Month/Day/Year)
X	



15. Cal-COBRA/COBRA/FMLA Questionnaire ... please complete this page if any "Yes" answers to H, I or J in Section 7

Cal-COBRA: California law requires employers with 2-19 eligible qualified employees to extend health coverage programs to former employees spouses (widowed/divorced), and their dependents when a qualifying event occurs.

COBRA: The Federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most employers with 20 or more total employees to extend health coverage programs to former employees, spouses (widowed/divorced), and their dependents when a qualifying event occurs, unless the former employee, spouse or dependent was not eligible for continuation of coverage prior to January 1, 2005.

FMLA: The Family and Medical Leave Act of 1993 requires groups with 50 or more employees to provide up to 12 weeks of unpaid, job-protected leave to "eligible" employees for certain family and medical reasons.

A. Cal-COBRA and COBRA:

Complete for each employee or family member currently on Cal-COBRA or COBRA.

Name	Birthdate	Social Security or ID No.	Type	Qualifying Event	
				Description	Date
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		
			<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA		

B. Cal-COBRA: Complete for each employee terminated in the last 60 days who has had a qualifying event.

COBRA: Complete for each employee terminated in the last 90 days who has had a qualifying event.

1.	Name	Social Security or ID No.	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	If terminated, what date?
If qualifying event, please describe:				
To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this employee/dependent presently disabled?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, disabling condition:				
2.	Name	Social Security or ID No.	<input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	If terminated, what date?
If qualifying event, please describe:				
To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option?				<input type="checkbox"/> Yes <input type="checkbox"/> No
Is this employee/dependent presently disabled?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, disabling condition:				

C. FMLA: Complete for each employee on family or medical leave.

1.	Name	Social Security or ID No.	Beginning date of leave
To the best of your knowledge, will this employee return to work?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, is this employee presently disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, disabling condition: _____			
To the best of your knowledge, will this employee/dependent exercise their COBRA option?			<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Name	Social Security or ID No.	Beginning date of leave
To the best of your knowledge, will this employee return to work?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, is this employee presently disabled?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, disabling condition: _____			
To the best of your knowledge, will this employee/dependent exercise their COBRA option?			<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature of Company Official	Title	Company Name	Date
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If additional space is needed to include all applicable employees, please use a photocopy of this page.

