

# NORBAR Medical Plan ENROLLMENT INSTRUCTIONS

**Please Type or Print Clearly using only Black Ink, DO NOT USE Felt Tip Pens.**

**MEMBER /  
APPLICANT  
INFORMATION:**

Member/Applicant: \_\_\_\_\_  
Local REALTOR® Assoc. Name: \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_  
Requested effective date of coverage: 1<sup>st</sup> of \_\_\_\_\_

New Enrollee [ ]      Current Benefits Store Member Changing Plans [ ]

Remember to attach your business card and this form to your application

**SELECTING  
YOUR PLAN:  
CHOOSE ONLY  
ONE**

**“SMART & AFFORDABLE” PLAN OPTIONS - BRONZE**

[ ] 6000/35%/6600 - 1K58      [ ] 5,000/30%/6250 - 1K4G      [ ] 6350/0%/6350 w/HSA - 1K64  
[ ] 5500/30%/6450 w/HSA - 1KAX

**“BEST BALANCE & VALUE” PLAN OPTIONS - SILVER**

[ ] 1500/30%/6550 - 1K6K      [ ] 1500/20%/6250 - 1K8W      [ ] 2000/30%/6350 w/HSA - 1KAV  
[ ] 2000/35%/6600 - 1KA8

**“BEST BENEFITS” PLAN OPTIONS - GOLD**

[ ] 35/20%/6600 - 1K7U      [ ] 35/25%/6600 - 1K44      [ ] 500/20%/4500 - 1K46  
[ ] 1000/20%/4000 - 1K33      [ ] 2000/20%/4000 w/HRA - 1KAY

**Medical Plans Provided by Anthem Blue Cross®**

**COMPLETING THE  
APPLICATION:**

**USE BLACK INK AND REFER TO THE APPLICATION INSTRUCTION.**

**EFFECTIVE  
DATE OF**

Applications are accepted (must be received in our office) through the 25th of the current month for coverage to be effective the 1<sup>st</sup> of the following month.

**COVERAGE:**

**To avoid confusion about the effective date of coverage, make sure to clearly show the requested effective date of coverage you are applying for on the application, your premium check and this form.**

**TO ENROLL:**

Review the application for accuracy, sign, date, and return to us with your premium.

**Make Checks Payable to "The Benefits Store"**

**U.S. MAIL (1<sup>st</sup> Class or Priority)**

ATTN: ENROLLMENT

Benefits Store, Inc.

PO Box 238, Alamo, CA 94507

# NORBAR Medical Plan

## ENROLLMENT INSTRUCTIONS

---

### PROCESSING REQUIREMENT:

**NOTE: Incomplete applications or applications without the correct premium included cannot be processed.**

**Applications Postmarked  
by the 15th**

One (1) months premium is required with your application if enrolling for coverage beginning the 1<sup>st</sup> of the following month and postmarked by the 15<sup>th</sup> of the current month.

**Applications Postmarked  
after the 15th**

Two (2) months premium is required with your application if enrolling for coverage beginning the 1<sup>st</sup> of the following month and postmarked after the 15<sup>th</sup> of the current month.

### PREMIUM PAYMENTS:

*You have four (4) ways to pay your monthly premium:*

- Electronic Funds Transfer (EFT)
- Monthly Invoice/Check
- On-Line Bill Payment (through your Financial Institution)
- Credit Card Payment/Visa or MasterCard

**For your convenience we have included an EFT/CCA/ACH Authorization form with the Enrollment Form.**

### APPLICATION PROCESSING:

Allow 12 business days for the processing of your application and for you to appear in Anthem Blue Cross's database. **DON'T DELAY – ENROLL TODAY!** ID Card(s) (from Anthem Blue Cross) are normally generated within 20 working days from the time we receive your application. If we do not receive your application until the 25<sup>th</sup> of the month, you may not receive your ID card(s) until the 15<sup>th</sup> of the following month. *To avoid this delay, we urge you to submit your application to us as soon as possible.*

### THOSE APPLYING WITH CURRENT COVERAGE:

**Remember, everyone applying during the Open Enrollment will be accepted! Coverage is guaranteed.** Those of you that have paid your current coverage premiums in advance will need to request an effective date for your new coverage that will match the date when your current coverage ends. Those of you that are within the “grace period” for premium payment of your current coverage will need to verify the length of time allowed for your coverage before cancellation with your current insurer

### IMPORTANT!

**You should not cancel your current coverage until you are notified of your new coverage. For verification of your new coverage, E-mail: [Customerservice@BenefitsStore.com](mailto:Customerservice@BenefitsStore.com)**

### ADDITIONAL INFORMATION – PLEASE READ

To cancel your coverage or to revoke your application, we require a written notice of your intent including your signature and your requested date of cancellation. We ask this statement be written on a copy of your billing statement and faxed to 925-855-2051 or mailed to our Membership Accounting department. Please visit our website for additional contact information. This notice must be received no later than 12 noon 1 business day (M-F) BEFORE the last business day of the month in which you wish to cancel. For example, April 29, 2014 for an effective cancellation date of April 1, 2014.

By signing your enrollment application you represent that all of the information you have included is complete and accurate, and that you accept all terms of this application and supporting documentation.

# NORBAR Medical Plan

## ENROLLMENT INSTRUCTIONS

---

### DISCLOSURES AND ACKNOWLEDGEMENTS

- 1) Anthem Blue Cross is a registered trademark of the Anthem Blue Cross insurance companies
- 2) This program is a special benefit for members of Local Associations of REALTORS® within California. Refer to the Enrollment Materials and Benefit Booklet for a complete description of the plans. Be advised that your Association, Benefits Store, Inc. and their agents do not control premiums or coverage provided by these plans. Association members participating in these plans do so voluntarily.
- 3) Please Do Not Complete the Employer Section shown below on the application. This section is for internal office use only.

Employer name		Group no. (if known)	
Employer street address	City	State	ZIP code
Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Disabled	Hire date (MM/DD/YYYY)	First date of full-time employment (MM/DD/YYYY)	No. of hours worked per week

### ADDITIONAL INFORMATION – PLEASE READ

To cancel your coverage or to revoke your application, we require a written notice of your intent including your signature and your requested date of cancellation. We ask this statement be written on a copy of your billing statement and faxed to 925-855-2051 or mailed to our Membership Accounting department. Please visit our website for additional contact information. This notice must be received no later than 12 noon 1 business day (M-F) BEFORE the last business day of the month in which you wish to cancel. For example, April 29, 2014 for an effective cancellation date of April 1, 2014.

By signing your enrollment application you represent that all of the information you have included is complete and accurate, and that you accept all terms of this application and supporting documentation.

### DISCLOSURES AND ACKNOWLEDGEMENTS

- 1) Anthem Blue Cross is a registered trademark of the Anthem Blue Cross insurance companies
- 2) This program is a special benefit for members of Local Associations of REALTORS® within California. Refer to the Enrollment Materials and Benefit Booklet for a complete description of the plans. Be advised that your Association, Benefits Store, Inc. and their agents do not control premiums or coverage provided by these plans. Association members participating in these plans do so voluntarily.



## **EXCLUSIVELY FOR THE MEMBERS OF THE LOCAL CALIFORNIA ASSOCIATIONS OF REALTORS®**

### **POWERFUL SAVINGS FROM ANTHEM BLUE CROSS**

With Anthem Blue Cross health coverage, you save in two significant ways:

1. *Our in-network doctors and hospitals charge you lower, Anthem Blue Cross negotiated fees*
2. *Our BlueCard program gives you access to in-network providers at discounted rates all across the country*

### **SPECIAL PROGRAMS INCLUDED IN YOUR CREBP-NORBAR ANTHEM BLUE CROSS**

#### Special Discount Dental Plan

The CREBP-NORBAR Special Discount Dental Plan gives you immediate, predictable and significant discounts for dental services. Because the Special Discount Dental plan is not insurance, plan members decide when to use a participating dentist, how often, and without any limit on their savings. For additional plan information and a list of providers go to [www.NewDentalChoice.com](http://www.NewDentalChoice.com).

#### Included Life Insurance Plan

As a CREBP-NORBAR member, you automatically have a \$10,000 Life Insurance policy through Mutual of Omaha Life Insurance Company included with your Anthem Blue Cross Medical plan. This special life insurance benefit covers the primary insured member only, is guaranteed-issue without any exclusion for medical conditions and includes AD&D benefits.

# Employee Enrollment Application

## EmployeeElect for 1-50 Employee Small Groups California



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: Social Security Numbers are required under Centers for Medicare & Medicaid (CMS) regulations.

Submit application to: Small Group Services  
 Anthem Blue Cross  
 PO Box 9062  
 Oxnard, CA 93031-9062  
 anthem.com/ca

Group 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
Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		Primary phone no.	Number of dependents
Employee email address			
Employer name			
Employer street address			
City			State ZIP code
Employment status <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Disabled	Occupation Association Member	Hire date (MM/DD/YYYY)	No. of hours worked per week
Language choice (optional): <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Vietnamese <input type="checkbox"/> Tagalog <input type="checkbox"/> Other – please specify: _____			
Do you read and write English? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, the translator must sign and submit a Statement of Accountability			
Section B: Application Type			
<b>Select one</b>			
<input type="checkbox"/> New enrollment <input type="checkbox"/> Open enrollment <input type="checkbox"/> Family addition Event date: _____ <input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA Cal-COBRA applicants must submit first month's premium.		Select qualifying event <input type="checkbox"/> Left employment <input type="checkbox"/> Loss of dependent child status <input type="checkbox"/> Covered employee's Medicare entitlement <input type="checkbox"/> Reduction in hours <input type="checkbox"/> Divorce or legal separation <input type="checkbox"/> Death	
<b>Note: For Cal-COBRA/COBRA applicants:</b> Effective date of qualifying event: _____			

\*Anthem Blue Cross is required by the Internal Revenue Service to collect this information.

**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 pediatric essential health benefits.

PPO Plans	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
Prudent Buyer PPO Network		<input type="checkbox"/> 500/20%/4500 <input type="checkbox"/> 1000/20%/4000 <input type="checkbox"/> 2000/20%/4000 w/HRA	<input type="checkbox"/> 1500/20%/6250 <input type="checkbox"/> 2000/35%/6600 <input type="checkbox"/> 2000/30%/6350 w/HSA	<input type="checkbox"/> 5000/30%/6250 <input type="checkbox"/> 6000/35%/6600 <input type="checkbox"/> 5500/30%/6450 w/HSA <input type="checkbox"/> 6350/0%/6350 w/HSA
Select PPO Network	<input type="checkbox"/> <del>20/10%/4000 Plus</del>	<input type="checkbox"/> <del>30/20%/6250 Plus</del> <input type="checkbox"/> <del>500/20%/4500</del> <input type="checkbox"/> <del>1000/20%/4000</del> <input type="checkbox"/> <del>1000/20%/4000 Plus</del> <input type="checkbox"/> <del>2000/20%/4000 w/HRA</del>	<input type="checkbox"/> <del>1500/20%/6250</del> <input type="checkbox"/> <del>1500/20%/6250 Plus</del> <input type="checkbox"/> <del>2000/35%/6600</del> <input type="checkbox"/> <del>2000/35%/6600 Plus</del> <input type="checkbox"/> <del>2000/30%/6350 w/HSA</del>	<input type="checkbox"/> <del>5000/30%/6250</del> <input type="checkbox"/> <del>5000/30%/6250 Plus</del> <input type="checkbox"/> <del>5750/35%/6450 Plus</del> <input type="checkbox"/> <del>6000/35%/6600</del> <input type="checkbox"/> <del>5500/30%/6450 w/HSA</del> <input type="checkbox"/> <del>6350/0%/6350 w/HSA</del>

Other: \_\_\_\_\_

HMO Plans	Anthem Platinum	Anthem Gold	Anthem Silver	Anthem Bronze
CaliforniaCare HMO Network		<input type="checkbox"/> 35/20%/6600 <input type="checkbox"/> 35/25%/6600	<input type="checkbox"/> 1500/30%/6550	
Select HMO Network	<input type="checkbox"/> <del>10/10%/2500 Plus</del> <input type="checkbox"/> <del>20/0%/4000 Plus</del>	<input type="checkbox"/> <del>30/0%/6250 Plus</del> <input type="checkbox"/> <del>35/20%/6600</del> <input type="checkbox"/> <del>35/25%/6600</del> <input type="checkbox"/> <del>500/20%/4500 Plus</del>	<input type="checkbox"/> <del>1500/20%/6250 Plus</del> <input type="checkbox"/> <del>1500/30%/6550</del> <input type="checkbox"/> <del>1500/30%/6550 Plus</del>	
Priority Select HMO Network	<input type="checkbox"/> <del>10/10%/2500 Plus</del> <input type="checkbox"/> <del>20/0%/4000 Plus</del>	<input type="checkbox"/> <del>30/0%/6250 Plus</del> <input type="checkbox"/> <del>35/20%/6600</del> <input type="checkbox"/> <del>35/25%/6600</del> <input type="checkbox"/> <del>500/20%/4500 Plus</del>	<input type="checkbox"/> <del>1500/20%/6250 Plus</del> <input type="checkbox"/> <del>1500/30%/6550</del> <input type="checkbox"/> <del>1500/30%/6550 Plus</del>	

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 one option**

Employer Sponsored		Voluntary
<input type="checkbox"/> Dental Blue Silver 100-80 <sup>1,3</sup> <input type="checkbox"/> Dental Blue Gold 100-80 <sup>1,3</sup> <input type="checkbox"/> Dental Blue Platinum 100-80 <sup>1,3</sup> <input type="checkbox"/> Basic Option PPO <sup>1,3</sup> <input type="checkbox"/> Standard Option PPO <sup>1,3</sup> <input type="checkbox"/> High Option PPO <sup>1,3</sup>	<input type="checkbox"/> Dental Blue Silver Plus 100-80 <sup>1,3</sup> <input type="checkbox"/> Dental Blue Gold Plus 100-80 <sup>1,3</sup> <input type="checkbox"/> Dental Blue Platinum Plus 100-80 <sup>1,3</sup> <input type="checkbox"/> Dental Net 2000A <sup>2,3</sup> <input type="checkbox"/> Dental Net 2000B <sup>2,3</sup> <input type="checkbox"/> Dental Net 2000C <sup>2,3</sup>	<p><b>Voluntary PPO Dental Coverage</b></p> <input type="checkbox"/> Voluntary Dental PPO <sup>1,3</sup>
		<p><b>Dental Net Voluntary DHMO Coverage</b></p> <input type="checkbox"/> Dental Net Voluntary 2000A <sup>2,3</sup> <input type="checkbox"/> Dental Net Voluntary 2000B <sup>2,3</sup> <input type="checkbox"/> Dental Net Voluntary 2000C <sup>2,3</sup>

For all Dental HMO plans, you must enter your Dental office no.: \_\_\_\_\_

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

Other: \_\_\_\_\_

Member dental coverage – select one:  Employee only  Employee + Spouse/Domestic Partner  Employee + child(ren)  Family

**3. Vision Coverage – select one option** Offered by Anthem Blue Cross Life and Health Insurance Company

<input type="checkbox"/> Blue-View Vision <input type="checkbox"/> Blue-View Vision Plus	<b>Voluntary Vision Coverage:</b> <input type="checkbox"/> Voluntary Blue-View Vision <input type="checkbox"/> Voluntary Blue-View Vision Plus
<input type="checkbox"/> Other: _____	<b>Please indicate the contract code for the vision plan selected:</b> Contract code, if known: _____

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

Social Security no. \_\_\_\_\_

**4. Life Coverage — Life benefits are available for 2-50 Employee Small Groups Offered by Anthem Blue Cross Life and Health Insurance Company**

<input type="checkbox"/> Life & AD&D	<input type="checkbox"/> Optional Supplemental Life (if offered by your employer)
<input type="checkbox"/> Dependent Life	Select one:
Salary amount: \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	<input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000
Employee class: <input type="checkbox"/> 1 <input type="checkbox"/> 2	

**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.

**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.

**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 <b>X</b>	Spouse name	Date
------------------------------	-------------	------

Social Security no. 
-------------------------

**Section D: Coverage Information – All fields required. Attach a separate sheet if necessary.**  
 Please access the Provider Directory at [anthem.com](http://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 <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY) 	Relationship to applicant Self	
PCP name (if selecting an HMO plan)		PCP ID no. (if selecting an HMO plan)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No	

Spouse/Domestic Partner last name		First name		M.I.	Social Security no.* (required) 
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY) 	Relationship to applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner		
PCP name (if selecting an HMO plan)		PCP ID no. (if selecting an HMO plan)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please provide full address and ZIP code: _____					

Dependent last name		First name		M.I.	Social Security no.* (required) 
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY) 	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____		
PCP name (if selecting an HMO plan)		PCP ID no. (if selecting an HMO plan)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please provide full address and ZIP code: _____					

Dependent last name		First name		M.I.	Social Security no.* (required) 
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY) 	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____		
PCP name (if selecting an HMO plan)		PCP ID no. (if selecting an HMO plan)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please provide full address and ZIP code: _____					

Dependent last name		First name		M.I.	Social Security no.* (required) 
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	Birthdate (MM/DD/YYYY) 	Relationship to applicant <input type="checkbox"/> Child <input type="checkbox"/> Other If other, what is relationship? _____		
PCP name (if selecting an HMO plan)		PCP ID no. (if selecting an HMO plan)	Existing patient <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does this dependent have a different address? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please provide full address and ZIP code: _____					

\*Anthem Blue Cross is required by the Internal Revenue Service to collect this information.



Social Security no. \_\_\_\_\_

**Section E: Other Group Coverage**

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) <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD: Onset date _____
-----------------	-----------------------	-----------------------	--

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date
------------------------	-------------------------	-----------------------

Is anyone applying for coverage covered by other health, dental, or vision 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)
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Vision				Start: _____ End: _____
	<input type="checkbox"/> Individual <input type="checkbox"/> Group <input type="checkbox"/> Medicare	<input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> 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 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 COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP'S MEDICAL AND/OR GROUP LIFE INSURANCE 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.

Signature of applicant <b>X</b>	Printed name	Date (MM/DD/YYYY)
------------------------------------	--------------	-------------------

Social Security no. <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>																

**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 knowingly provide false, incomplete or misleading information 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.

**W-9 Certification Language**

As part of the W-9 Certification required by the Internal Revenue Service (IRS), I certify that the Social Security number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) and I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding and I am a U.S. citizen or other U.S. person.

**In signing this application I represent that:**

I have read or have had read to me the completed application, and I realize any false statement or misrepresentation in the application may result in loss of coverage.

**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 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.

<b>Sign here</b>	Applicant signature	Date (MM/DD/YYYY)														
	<b>X</b>	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>														

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 impormasyon 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 chuyên 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)

# 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 chuyên 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 impormasyon sa iyong lengguage, 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 տեղեկությունների մասին հարցնելու համար՝ խնդրվում է զանգահարել Ձեր ինքնուրույն քարտի ետևի մասում գրված հեռախոսի համարով կամ կապվել Ձեր խմբային 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)

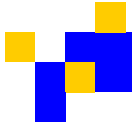
**重要事項:** 医師、および、ヘルスプラン担当者との意思疎通には、通訳者による通訳サービスを無料で受けることが出来ます。通訳者サービス、または、あなたが話す言語で書かれた文書による情報を要請するには、あなたのIDカードの裏側に記載された電話番号に電話をするか、または、あなたの属するグループのアドバイザーに連絡をとってください。 (Japanese)

**ਜ਼ਰੂਰੀ ਸੂਚਨਾ:** ਤੁਹਾਡੇ ਡਾਕਟਰ ਨਾਲ ਜਾਂ ਹੈਲਥ ਪਲਾਨ ਬਾਰੇ ਗੱਲਬਾਤ ਕਰਨ ਲਈ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ (ਅਨੁਵਾਦਕ) ਦੀ ਸੇਵਾ ਮੁਫਤ ਦਿੱਤੀ ਜਾ ਸਕਦੀ ਹੈ। ਦੁਭਾਸ਼ੀਏ 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 ។ ដើម្បីទទួលបានអ្នកបកប្រែ ឬសាកសួរអំពីព័ត៌មានដែលសរសេរជាភាសាខ្មែរ សូមមេត្តាសម្រេចលេខដែលមានកត់នៅលើខ្នងអត្តសញ្ញាណប័ណ្ណរបស់អ្នក 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)



Credit Card Authorization / Automated Clearing House (ACH) Electronic Funds Transfer (EFT) Authorization

Insured Information: Name, Email; Payment Selection: CCA [ ], EFT / ACH [ ]

Credit Card Transaction

Credit Card Information: Visa [ ], Mastercard [ ], Discover [ ], American Express [ ]; Card Number, Exp: (MM / YY); Name, Address, City, State, Zip; Monthly Recurring Charges authorization

Credit Card payments will be assessed the full premium rate which includes a 2.5% administration charge.

Automated Clearing House (ACH) / Electronic Funds Transfer (EFT) Transaction

Name on Account, Name of Financial Institution, Routing Number (9 digits), Account Number, Account Holder Type, Account Type

Determining your routing number: To determine your routing number, refer to your check. The routing number is ALWAYS 9 digits long and it is enclosed by colons.

Three diagrams showing check layouts for Bank 1, Bank 2, and Bank 3, with routing numbers, account numbers, and check numbers circled and labeled.

I authorize the Benefits Store to deduct the monthly premium from this bank account. Yes [ ], No [ ], Initials: \_\_\_\_\_ 5th of the Month [ ], 15th of the Month [ ]

Monthly Recurring Charges (EFT)

Payment Authorization: Authorization is given to The Benefits Store, Inc. to charge my credit card or debit the banking account listed above.

Monthly Transactions Authorization: Authorization is given to The Benefits Store, Inc. to charge my credit card or initiate debits (payments) to the financial institution indicated above.

Note: I understand and authorize a \$25 service charge may be applied against my account for all denied transactions for any reason.

Authorized Signature, Date, Payment Amount: \$ \_\_\_\_\_



**IMPORTANT NOTICE****NEW CUSTOMER SERVICE ACCESS FOR MEMBERSHIP ACCOUNTING AND BILLING QUESTIONS**

PHONE NUMBER: (888) 226-8373

FAX: (925) 855-2051

EMAIL: [BILLING@BENEFITSSTORE.COM](mailto:BILLING@BENEFITSSTORE.COM)

MAILING ADDRESS: BENEFITS STORE/ MEMBERSHIP ACCOUNTING

PO Box 238

Alamo, CA 94507

**Electronic Funds Transfer (EFT)/Automated Clearing House (ACH)**

You may do a one time transaction or monthly deduction.

**RELIABLE!**

EFT/ACH is a method of automatically withdrawing or depositing funds to an individual's bank account.

**SAFE!**

All EFT/ACH transactions are tracked and governed by the Federal Reserve. Only preauthorized transactions are allowed to be processed.

**EFT MONTHLY PAYMENTS!**

You will never again need to worry about late payments due to mail delays, misplaced payments or forgotten payments! Your payment will always be made on time.

**SIMPLE!**

Once you have completed and signed the EFT authorization form, all you need to do is record the payment transaction in your checkbook or savings register on the designated payment date.

**Monthly Invoice / Check**

Premiums are payable in advance of the month of coverage. You will receive your monthly Premium billing on or about the first of each month

Example: Premiums for July coverage are billed on June 1<sup>st</sup> and payable (received) on or before June 20<sup>th</sup>.Late fees are charged for payments received after the 20<sup>th</sup>.Your full payment must be received by the 20<sup>th</sup> to avoid a late charge. We suggest that you mail your payment on or before the 12<sup>th</sup> of each monthPayments **MUST** be mailed to:**The Benefits Store, Inc.****P.O. Box 743322****Los Angeles, CA 90074-3322**To assure proper credit make sure to include the top portion of the billing statement with your payment. Also enter the full Subscriber's name in the memo field of your check.**On-Line Bill Payment**

Premiums are payable in advance of the month of coverage.

To use On-Line Bill Payment, you will need to arrange for your financial institution to generate a check in payment for your coverage.

As an example, the following links will connect you with major banks for establishing this service

[www.Bankofamerica.com](http://www.Bankofamerica.com)[B of A - Online Banking Info](#)[www.Wellsfargo.com](http://www.Wellsfargo.com)[Wells Fargo - Online Banking Information](#)Your full payment must be received by the 20<sup>th</sup> to avoid a late charge. We suggest that you initiate your on-line payment on or before the 10<sup>th</sup> of each month.Payments **MUST** be mailed to:**The Benefits Store, Inc.****P.O. Box 743322****Los Angeles, CA 90074-3322**To assure proper credit make sure to instruct your bank to show the full Subscriber's name in the memo field of your check.**Credit Card Payment Visa or MasterCard**

Premiums are payable in advance of the month of coverage.

We accept Visa, MasterCard for monthly premium payments,

Credit Card payments will be assessed the full premium rate which includes a 2.5% administration charge.

The Credit Card Authorization form may be downloaded from the **Forms section** on our web site [www.BenefitsStore.com](http://www.BenefitsStore.com)To do so, click on the "Forms" tab located in the bar crossing our home page or select the following link [Credit Card Authorization Form](#)Your full payment must be received by the 20<sup>th</sup> to avoid a late charge. We suggest you initiate your credit card payment on or before the 17<sup>th</sup> of each month.**For processing, Credit Card Authorization forms must be faxed to (925) 855-2051**Contact us at (888) 226-8373 with any questions about completing this form.