CoPower *SELECT*™

CoPower Administration and Plan Selection Form

This form is to be completed for groups who wish to enroll in Anthem's ancillary offerings through CoPower. Groups will receive separate group numbers and bills if enrolled in both Anthem Medical and Anthem Ancillary with administration through CoPower.

Group Information - CoPower communication is by electronic mail

Company:			
Contact Name:		E-mail:	
If you wish to opt out of E-mail communication, check this box ☐ and provide mailing address below.			
Street Address:			
City:	State:	Zip:	HR360 Enrollment *(Free Online HR Support)*: ☐ Yes ☐ No

Dental (2-100)

Please complete dental contribution on **page 3** and Eligibility on **page 6** of the Anthem application.

PPO Complete		PPO Prime	HMO Plans	
☐ Classic 2N	☐ Enhanced 3B	☐ Classic 5A (10+ EE)	☐ Dental Net 2000A	☐ Dental Net Vol 2000A
☐ Classic 2Q (10+ EE)	☐ Enhanced 3C (10+ EE)	☐ Classic 5B (10+EE)	☐ Dental Net 2000B	☐ Dental Net Vol 2000B
☐ Voluntary 4B (5+ EE)			☐ Dental Net 2000C	☐ Dental Net Vol 2000C

Vision (2-100)

Please complete vision contribution on **page 4** and Eligibility on **page 6** of the Anthem application.

☐ Blue View Vision A6	☐ Blue View Vision A6 Voluntary (5+ EE)	☐ Blue View Vision MO5 Voluntary (5+ EE) (materials only)
☐ Blue View Vision B6	☐ Blue View Vision B6 Voluntary (5+ EE)	
☐ Blue View Vision C8	☐ Blue View Vision C8 Voluntary (5+ EE)	☐ Other _____

Life (2-100)

Please complete life contribution on **page 4** and Eligibility on **page 6** of the Anthem application.

CoPower *BLUE* Large Group Bundles (51-100) *Dental and Vision only plan.*

Please complete dental contribution on **page 3,** vision contribution on **page 4** and Eligibility on **page 6** of the Anthem application

☐ Classic PPO Classic-2Q Blue View Vision B6	☐ Preferred PPO Classic-3C Blue View Vision B6	☐ Elite PPO Classic-3B Blue View Vision A6	☐ Classic DHMO Dental Net 2000A Blue View Vision B6	☐ Preferred DHMO Dental Net 2000B Blue View Vision B6	☐ Elite DHMO Dental Net 2000C Blue View Vision A6

Payment/Invoice - CoPower communication is by electronic mail

Invoices If you wish to opt out of E-mail invoices, check this box ☐

Contact Name _____ Email address _____

The above information will be used to authenticate access to the invoice. You must notify CoPower if this contact or e-mail address changes.

Initial Payment Do you wish to have your initial payment debited from your company account?

☐ Yes Please complete the bank information below, enter the premium amount and attach a copy of a voided check.

☐ No Please submit a company check made payable to CoPower.

Ongoing Payment Do you wish to have your monthly invoice amount automatically debited from your company account?

☐ Yes Please complete the bank information below and attach a copy of a voided check. ***(****Allow up to one billing cycle to process your request. You must continue to submit your payment until your invoice indicates that the amount due will be debited from your account.)*

☐ No

Bank Account Information *(must be a Checking Account)*

Account Holder's Name (if different from above): _____

Name of Bank: _____

Bank Address: _____

Bank Routing Number: _____

Account Number: _____

Premium Amount – Number (e.g. $50): $ _____

Premium Amount – Written (e.g. fifty dollars) _____ dollars

I hereby authorize CoPower to initiate debits from the account identified above. I understand it remains in effect until I give written notice to CoPower, which I must do by the 25th of the month prior to the month coverage. If I want to change the banking information that CoPower debits, I will submit a new Direct Debit Authorization form by the 25th of the month prior to the month of coverage. In the event a debit is made to my account in error, I authorize CoPower to make a correcting entry to my account. CoPower will notify me of payments returned for insufficient funds or close accounts, and repayment instructions.

Employer Signature

My signature on this document certifies that all of the information contained in this application is true and correct to the best of my knowledge. I confirm that all enrollees are eligible employees, COBRA participants, and/or their dependents. In addition, my group complies with all the rules and regulations as set forth by the applicable carrier(s).

Signature of Company Officer:	Date:
Name (print):	Title (print):

Employer Enrollment Application
For 1–100 Employee Small Groups
California

Anthem BlueCross

Health care plans offered by Anthem Blue Cross (Anthem). Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company (Anthem Life).
You, the employer, 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 the application.
Note: Employer Tax ID Numbers are required under Centers for Medicare & Medicaid Services (CMS) regulations.

Group/Case no. (if known)	Requested effective date

Please complete in black ink only.

Section A: Application Type

☐ New enrollment ☐ Change(s)

Section B: Company Information

Company name		Employer tax ID no. (required)

Doing Business As (DBA)

Company street address

City	County	State	ZIP code

Billing address – If different from above

City	County	State	ZIP code

Is this for coverage as a member of an association plan? ☐ Yes ☐ No If yes, association name: _____

Organization type: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Limited Liability Company (LLC) ☐ Other: _____

SIC code – Required	Type of business (be specific)	Date business established

Company contact name	Title

Primary phone no.	Fax no.

Email address

Additional company contact name	Title

Do you want to enroll in Premium Only Plan (P.O.P.)? ☐ Yes ☐ No

P.O.P. is a payroll administration service offered by Wage Works, Inc. (Wage Works) (an independent company not affiliated with Anthem) that helps companies receive IRS Section 125 tax advantages. If you choose to enroll, download the POP application at www.anthem.com/easyrenew and complete.

Do you have any affiliates that qualify as a single employer under subsection (b), (c), (m) or (o) of Internal Revenue Code Section 414? ☐ Yes ☐ No
If yes, please give the legal names, federal tax ID no. and number of employees employed by each.

Legal name	Federal tax ID no.	No. of employees employed

Employer tax ID no. (required)

Section C: Type of Coverage

1. Medical Coverage — Medical plans offered by Anthem Blue Cross.

Step 1 – Select a network. You may choose one PPO and/or one HMO network.
PPO: ☐ Prudent Buyer PPO ☐ Select PPO **HMO:** ☐ CaliforniaCare HMO ☐ Select HMO

Step 2 – Select one or more plan(s) designs within the network(s) you selected.

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	☐ 20/10%/4000 ☐ 200/10%/4000	☐ 20/30%/6500 ☐ 500/20%/6500 ☐ 700/20%/6600 ☐ 1000/20%/6000 ☐ 2000/20%/4000	☐ 1250/40%/7150 ☐ 1750/35%/7150 ☐ 2000/20%/5400 w/HSA - RxC ☐ 2000/35%/7150	☐ 5000/30%/7150 ☐ 5000/35%/6550 w/HSA ☐ 6000/35%/7150 ☐ 6500/0%/6500 w/HSA
PPO: Select PPO Network	☐ 15/10%/4000 ☐ 20/10%/4000 ☐ 200/10%/4000	☐ 20/30%/6500 ☐ 30/20%/6750 ☐ 500/20%/6500 ☐ 700/20%/6600 ☐ 1000/20%/6000 ☐ 2000/20%/4000	☐ 1250/40%/7150 ☐ 1750/35%/7150 ☐ 2000/20%/6800 ☐ 2000/20%/5400 w/HSA - RxC ☐ 2000/35%/7150	☐ 4800/40%/6550 w/HSA ☐ 5000/30%/7150 ☐ 5000/35%/6550 w/HSA ☐ 6000/35%/7150 ☐ 6500/0%/6500 w/HSA
HMO: CaliforniaCare HMO Network	☐ 10/10%/2700	☐ 25/20%/6600 ☐ 40/20%/6500 ☐ 500/20%/6500	☐ 1500/35%/7150 ☐ 1750/40%/7150 ☐ 2000/40%/7150	
HMO: Select HMO Network	☐ 10/10%/2700	☐ 25/20%/6600 ☐ 40/20%/6500 ☐ 500/20%/6500	☐ 1500/35%/7150 ☐ 1750/40%/7150 ☐ 2000/40%/7150	

☐ Other: _____

For HSA plans – Only one choice is allowed.
☐ Group will establish Health Savings Account (HSA) with Anthem facilitating with a banking services provider.
☐ Group will establish Health Savings Account (HSA) but does not want Anthem to facilitate in the creation of the account.

Note: PPO plans – Prudent Buyer PPO and Select PPO network plans can only be offered alongside other plans with the same network type. (For example, plans on the Select PPO network can be offered alongside other plans on the Select PPO network, but they cannot be offered alongside plans on the Prudent Buyer PPO network. Not all network options are available in every area.)

HMO plans – CaliforniaCare HMO and Select HMO network plans can only be offered alongside other plans with the same network type. (For example, plans on the Select HMO network can be offered alongside other plans on the Select HMO network, but they cannot be offered alongside plans on the CaliforniaCare HMO network. Not all network options are available in every area.)

Riders/Optional Benefits – Select additional optional benefits

☐ Infertility Benefits ☐ Women's Contraceptive Opt-out Benefits – Submit appropriate Religious Self-Certification Form. The forms can be found on the www.anthem.com/easyrenew site.

Choose your medical contribution for each month – only **one** choice is allowed.
Contribution option 1: Traditional option – We will contribute (50% to 100%): _____% per employee _____% per dependent (optional)
Contribution option 2: Fixed Dollar Option – We will contribute (at least $100 in $5 increments): $_____
Contribution option 3: Percentage of plan option – We will contribute (50% to 100%): _____% to the following plan: _____

Employer tax ID no. (required)

2. Dental Coverage — Employer-sponsored plans (available for 2–100 Employee Small Groups, a minimum of two subscribers must enroll.)
Voluntary Dental plans (available for 5–100 Employee Small Groups, a minimum of five subscribers must enroll.)

Anthem Dental Net DHMO[1], and Anthem Dental Prime and Complete[2,4] with product families including Classic, Enhanced, and Voluntary do not include certified pediatric dental essential health benefits.

☐ Employer sponsored ☐ Voluntary[3]

Plan name: _____ Contract code: _____

Plan name: _____ Contract code: _____

Other: _____

1 Offered by Anthem Blue Cross.
2 Offered by Anthem Blue Cross Life and Health Insurance Company.
3 Not available in conjunction with the employer sponsored Dental Prime and Complete PPO or employer sponsored Dental Net DHMO dental plans.
4 Orthodontia coverage is only available for groups with five or more enrolled employees.

Choose your dental contribution for each month.
Employer-sponsored plans require employer to contribute between 50% and 100%.
For Voluntary plans, employers may contribute between 0% and 49%.
Traditional option — We will contribute: _____% per employee _____% per dependent (optional)

Is this plan intended to replace any existing group dental coverage? ☐ Yes ☐ No
If yes, please complete the information in section G for each group dental insurance plan you now have.

☐ Medical Lock (Packaged Enrollment): All members enrolled in the Anthem medical plan must enroll in Anthem Complete PPO dental plan. The medical plan billing must be included with new group submission materials. Dental tiering must be identical on the medical and dental plans. Example: enrollees with Single medical coverage must also have Single dental coverage; enrollees with Family medical coverage must also have Family dental coverage.

3. Vision Coverage — Employer-sponsored plans (available for 2–100 Employee Small Groups, a minimum of two subscribers must enroll.)
Voluntary Vision plans (available for 5–100 Employee Small Groups, a minimum of five subscribers must enroll.)

☐ Employer sponsored[1] ☐ Voluntary[1]

Indicate the plan name and contract code for the vision plans selected.

Plan name: _____ Contract code: _____

Plan name: _____ Contract code: _____

1 Offered by Anthem Blue Cross Life and Health Insurance Company.

Choose your vision contribution for each month.
Employer-sponsored plans require employer to contribute between 50% and 100%.
For Voluntary plans, employers may contribute between 0% and 49%.
We will contribute: _____% per employee _____% per dependent (optional)

☐ Medical Lock (Packaged Enrollment): All members enrolled in an Anthem medical plan must enroll in Anthem vision. Tiering must be identical on the medical and vision plans. Example: enrollees with Single medical coverage must also have Single vision coverage; enrollees with Family medical coverage must also have Family vision coverage.

Employer tax ID no. (required)

4. Life and Disability Coverage — Check all that apply. A minimum of two employees must enroll. Offered by Anthem Blue Cross Life and Health Insurance Company.

Life products		Disability products	
Select Life products and group contribution percentage:		**Select Disability products and group contribution percentage:**	
Product choice	**Percentage**	**Product choice**	**Percentage**
☐ None		☐ None	
☐ Basic Life & AD&D	_____%	☐ Short Term Disability	_____%
☐ Basic Dependent Life	_____%	☐ Long Term Disability	_____%
☐ Optional Supplemental/Voluntary Life and AD&D*	_____%	☐ Voluntary Short Term Disability*	_____%
☐ Optional Supplemental/Voluntary Dependent Life*	_____%	☐ Voluntary Long Term Disability*	_____%
*Available for Groups of 10+		*Available for Groups of 10+	

Life and/or Disability Eligibility Waiting Period

Would you like to waive the eligibility waiting period for ALL existing employees at initial group enrollment? ☐ Yes ☐ No

Is the eligibility waiting period for new eligible employees enrolling in Life and/or Disability plans after the group's coverage effective date the same as the Anthem medical policy waiting period? ☐ Yes ☐ No

If no, enter the Life and Disability eligibility waiting period below.

Class number	Coverage description (Ex. Life, Short Term Disability, Long Term Disability, etc.)	Description of eligibility waiting period (Ex. Date of hire, First of month following 60 days of continuous employment, etc.)

Eligible employees must be actively at work, and must satisfy any eligibility waiting period. Minimum work hours required for eligible full-time employees is 30 hours per week unless otherwise indicated.

Participation Requirements

Basic Life, Basic Accidental Death & Dismemberment, Short Term Disability: 100% participation required on non-contributory plans and 75% participation required on contributory plans.

Long Term Disability: 100% participation required on all non-contributory plans. 100% participation required for contributory plans of two or three eligible employees. 75% participation required on contributory plans with four or more eligible employees.

Basic Dependent Life: 100% participation required on non-contributory plans.

Optional/Voluntary Life/Accidental Death & Dismemberment: The greater of five enrolled employees or 20% participation required.

Voluntary Short Term Disability and Voluntary Long Term Disability: The greater of 10 enrolled employees or 20% participation required.

Life and Disability Authorization — Read carefully before signing.

The undersigned employer and/or authorized representative hereby requests that it be approved for Life and/or Disability insurance coverage through Anthem Life. Employer understands and represents to the best of his knowledge and belief the following, and if approved for coverage, agrees by payment of the required premiums; and the authorized representative certifies on behalf of the employer:

1. To provide notice of applicable conversion rights to eligible employees and eligible dependents;
2. That statements of medical history will be required of employees, and dependents, when applying for coverage within or outside the time frames or amount of coverage limits established by Anthem Life.
3. That approval for this life and/or disability insurance may cancel any prior contracts and/or coverage with Anthem Life effective immediately preceding the effective date of the employer's coverage;
4. That in order for Anthem Life to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem Life, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. The employer understands that the coverage issued by Anthem Life may be different than the coverage applied for herein. In that event, Anthem Life shall notify the employer of such differences, and by payment of the appropriate premiums, the employer will accept the coverage as issued.

Employer tax ID no. (required)

Section D: Eligibility

1. Does your group meet the definition of a small employer, as defined under applicable law?[1] ☐ Yes ☐ No
2. Total number of employees[2] (including employed owners/officers):
3. Number of eligible full-time employees (minimum 30 hours per week):
4. Number of part-time employees:

   Are permanent employees who work between 20-29 hours weekly to be covered? ☐ Yes ☐ No

   If yes, number of eligible part-time enrollees:
5. Number of employees enrolling in:

   Medical: Dental: Vision:

   Life: Disability:
6. Number of eligible DECLINING employees:
7. Number of INELIGIBLE employees:
8. Waiting period for **new employees**:

   ☐ First of month after hire date

   ☐ First of month following one month from the date of hire

   ☐ First of the month following two months from date of hire, not to exceed 90 days
9. Does your business have additional employees in another state? ☐ Yes ☐ No

   If yes, specify state: _____
10. 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).

    California law also requires plans to offer an enrollee who has exhausted continuation coverage under COBRA the opportunity to continue coverage for up to 36 months from the date the enrollee's continuation coverage began, if the enrollee is entitled to less than 36 months of continuation coverage under COBRA.

    Number of Cal-COBRA enrollees:
11. 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)

    Number of COBRA enrollees:
12. Under the Medicare Secondary Payer rules, which one applies for your group?

    ☐ Medicare is primary (less than 20 employees)
    ☐ Anthem is primary (20 or more employees)

    Medicare is primary coverage for groups with less than 20 employees; Anthem is primary coverage for groups with 20 or more total employees on each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year.
13. Is your group currently subject to the Family Medical Leave Act of 1993 (50 or more total employees)? ☐ Yes ☐ No

Section E: Ownership

Please account for 100% of the ownership, regardless of eligibility. Insert an additional sheet if necessary.

Last name	First name	M.I.	Percentage of ownership	Eligible
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No
			_____%	☐ Yes ☐ No

1 For plan years commencing on or after January 1, 2016, a small employer is defined as an employer employing an average of at least one but no more than 100 full-time, including full-time equivalent, employees during the preceding calendar year and who employs at least one employee on the first day of the plan year. For purposes of determining employer eligibility in the small employer market, California adopted the federal method for counting full-time employees and full-time-equivalent employees. For specific guidance concerning the Affordable Care Act, the Internal Revenue Code or California State laws or regulations, you should consult with your attorney, Certified Public Accountant or other authorized consultant or advisor.

2 The following do not qualify as an employee for purposes of group eligibility: (1) an individual that wholly owns the above-named company on his/her own or with his/her spouse/domestic partner; (2) a partner in a partnership; (3) a 2-percent S corporation shareholder; (4) a worker described in Section 3508 of Title 26, Internal Revenue Code.; or (5) a leased employees (as defined in 26 U.S.C. § 414(n)(2)).

Employer tax ID no. (required)

Section F: Leaves of Absence

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 ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ 5 months ☐ 6 months

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 ☐ 1 month ☐ 2 months ☐ 3 months

Section G: Prior Coverage

Has this group had coverage within 12 months of this application's signature date? ☐ Yes ☐ No

Will this plan replace current	If yes, carrier name			Termination date (MM/DD/YY)
Medical coverage ☐ Yes ☐ No				
Vision coverage ☐ Yes ☐ No				
Life coverage ☐ Yes ☐ No				
Disability coverage ☐ Yes ☐ No				
Dental coverage ☐ Yes ☐ No	Carrier name	Type of plan (DHMO, PPO)	Effective date	

Section H: Workers' Compensation

Current Carrier	Next renewal date

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

Last name	First name	M.I.	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.

Employer tax ID no. (required)

Section I: Cal-COBRA/COBRA/FMLA Questionnaire

Cal-COBRA: For employers with 2-19 eligible employees, California law requires plans to offer continuation coverage to qualified beneficiaries under the contract when a qualifying event occurs. California law also requires plans to offer an enrollee who has exhausted continuation coverage under COBRA the opportunity to continue coverage for up to 36 months from the date the enrollee's continuation coverage began, if the enrollee is entitled to less than 36 months of continuation coverage under COBRA.

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.

1. Cal-COBRA and COBRA – Complete for each employee or family member currently on Cal-COBRA or COBRA. Insert an additional sheet if necessary.

Name	Birthdate	Social Security no.*	Type	Qualifying event	
				Description	Date
			☐ Cal-COBRA ☐ COBRA		
			☐ Cal-COBRA ☐ COBRA		

2. 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. Insert an additional sheet if necessary.

Last name	First name	M.I.	Social Security no.*		Termination date
				☐ Cal-COBRA ☐ COBRA	

Describe qualifying event: _____

To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? ☐ Yes ☐ No
Is this employee/dependent presently disabled? ☐ Yes ☐ No If yes, disabling condition: _____

Last name	First name	M.I.	Social Security no.*		Termination date
				☐ Cal-COBRA ☐ COBRA	

Describe qualifying event: _____

To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? ☐ Yes ☐ No
Is this employee/dependent presently disabled? ☐ Yes ☐ No If yes, disabling condition: _____

3. FMLA – Complete for each employee on family or medical leave.

Last name	First name	M.I.	Social Security no.*	Beginning date of leave

To the best of your knowledge, will this employee return to work? ☐ Yes ☐ No
If no, is this employee presently disabled? ☐ Yes ☐ No If yes, disabling condition: _____
To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? ☐ Yes ☐ No

Last name	First name	M.I.	Social Security no.*	Beginning date of leave

To the best of your knowledge, will this employee return to work? ☐ Yes ☐ No
If no, is this employee presently disabled? ☐ Yes ☐ No If yes, disabling condition: _____
To the best of your knowledge, will this employee/dependent exercise their Cal-COBRA/COBRA option? ☐ Yes ☐ No

Company officer signature	Title	Company name	Date
X			

If additional space is needed to include all applicable employees, please use a photocopy of this page.
***Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid Services (CMS) to collect this information.**

Section J: Electronic Access of Group Information by Agent/Producer/Broker/General Agent

We, the employer, hereby authorize the agent/producer/broker/general agent whose name is attached to this application to use the EmployerAccess system of Anthem or Anthem Life to access the group's information, such as but not limited to enrollees, plan selections, and bills/invoices. Such agent/producer/broker/general agent is also hereby authorized to use the EmployerAccess system of Anthem and/or Anthem Life to make changes to the group's information on behalf of the group, such as but not limited to adding/deleting plans, adding/deleting employees, and or changing employee demographic information. These authorizations shall terminate if the group's designated agent/producer/broker/general agent changes.

☐ Check this box **ONLY** if the group elects to opt-out of authorizing the agent/producer/broker/general agent to access and change the group's information on behalf of the group.

Employer tax ID no. (required)

Section K: General Agreement

Please read this section carefully before signing the application.

Please check the box that applies:

☐ We, the employer, as administrator of an Employee Welfare Benefit Plan under ERISA (Employee 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 (Employee Retirement Income Security Act of 1974) and therefore not subject to ERISA, apply to obtain the coverage indicated.

Employer understands and certifies the following, and if approved for coverage, agrees by payment of the required premiums, and the authorized representative certifies on behalf of the employer:

1. To comply with all terms and provisions of the Group Contract(s) issued, and trust agreements, if applicable, and also accepts enrollment under the Anthem Blue Cross (Anthem) and/or Anthem Blue Cross Life and Health Insurance Company (Anthem Life) trust policy(ies), if applicable.
2. To make the coverage available to all eligible employees and their eligible dependents and to distribute information and documents to enrolled employees as needed.
3. To maintain records and furnish to Anthem or their designated agent(s), any information required in connection with administration of the coverage.
4. To provide notice of applicable conversion rights and rights to continue health coverage under COBRA to eligible employees and eligible dependents.
5. To pay Anthem by the premium due date, the premiums on behalf of each member covered under the contract, unless otherwise stated in any financial agreement between the parties, to submit applications of employees prior to their date of eligibility, to keep all necessary records regarding membership, to assume responsibility for handling the COBRA and state-mandated continued group coverage and/or conversion process, if applicable.
6. We, the employer, understand that Anthem and Anthem Life's standard process is to issue bills (invoices) and accept premium payments online via the EmployerAccess system. We understand and agree that if we, the employer, need to opt-out of online invoices and/or payments, we must send an email with "Opt-Out" in the subject line to employeraccesssupport@anthem.com and provide the group number, contact name, email address, phone number and reason for opting out of the electronic billing and payment process.
7. By signing below, we, the employer, agree that Anthem can deliver plan materials and related items, including but not limited to benefit booklets, summaries, billing statements, notices of nonpayment and cancellation and other notices, via email or other electronic means as permitted by law. We agree that we will provide and update Anthem with a current email address. We understand that at any time we can request a free copy of these materials by mail, by contacting Anthem Enrollment and Billing or via the EmployerAccess system.
8. If applicable, employer will receive on behalf of members, all notices delivered by Anthem, and immediately forward such notices to persons involved, at their last known address.
9. We understand and agree that no coverage will be effective before the date determined by Anthem and/or Anthem Life, and that such coverage will be effective only if we have paid our first month's premium and this application is accepted.
10. That in order for Anthem to accept or decline this application, all the information requested on this application must be completed. In the event the application is not complete, Anthem, or its designated agent(s), is authorized to obtain the necessary information and to complete that information on this application. If the application is not complete, Anthem and/or Anthem Life reserve(s) the right to reject it and notify us in writing.
11. The premium rates calculated for the employer are contingent, based upon the accuracy of the eligibility data submitted on employees and covered dependents to Anthem by the employer. Anthem reserves the right to review such rates upon receipt of all individual applications for employers' employees and to modify the rates, if the enrollment information so warrants. Any fraud or intentional misrepresentation of material fact on the employees' applications may, within the first 24 months following the issuance of the coverage, result in a material change to the group's coverage or premium rates as of the effective date of the group coverage.
12. The entire application for Group coverage has been reviewed, and all answers contained herein are true and complete to the best of the employer's and/or authorized representative's knowledge and belief.
13. All employees applying for coverage are employees of the employer and receive salary or wages documented on state and/or federal payroll reports. Eligible full-time employees must work at least 30 hours per week, must be actively at work, must have satisfied any applicable eligible waiting period.
14. The requested coverage is not in effect unless and until this application is approved by Anthem, that approval of coverage shall be evidenced by issuing Group contracts and/or policies to the employer, and an employee's coverage is not in effect unless and until the employee applies and is approved for coverage by Anthem.
15. The broker listed below is authorized to make enrollment and eligibility changes on behalf of the employer's group health plan, and employer will immediately inform Anthem if this authorization is revoked.
16. This small group off-exchange product is not eligible for a premium tax credit.
17. 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 high-deductible plans are qualifying high-deductible health plans. Consultation with a tax advisor is recommended.
18. If we decide to cancel our group coverage after coverage has been issued, we understand that the cancellation will become effective on the last day of the month in which Anthem and/or Anthem Life received the written notification of cancellation, and that no premiums will be refunded for any period between Anthem's receipt of the notification and the last day of the month when the cancellation takes effect. If there are any premiums after the cancellation date, we understand that Anthem and/or Anthem Life will refund these premiums after 45 days from the premium deposit date.
19. We further understand and agree that we should keep prior coverage in force until notified of acceptance in writing by Anthem and/or Anthem Life and that no agent has the right to accept this application or bind coverage.
20. If this application is accepted, it becomes a part of our contract with Anthem and/or Anthem Life.
21. If applying for Life and/or Disability insurance, the authorized representative certifies, on behalf of the employer, that it has read and agrees to the terms in the ***Life and Disability Authorization*** in Section 4.
22. We understand that Anthem small group plans cannot be sold or utilized in conjunction with any other product, whether insured or self-funded, that funds any annual deductible, copayment, coinsurance, or out-of-pocket expense of the health benefit plan (i.e. "wrapping").

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.

Employer tax ID no. (required)

Section K: General Agreement — Continued.

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage.)

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By signing, writing or typing your name below you agree to the terms of this agreement and acknowledge that your signed, written or typed name is a valid and binding signature.

Sign here	Company officer signature X	Printed name	
	Title		Date (MM/DD/YYYY)

Employer tax ID no. (required)

Section L: Agent/Producer/Broker Attestation — To be completed by the agent/broker

1. To the best of my knowledge, the information on this application is complete and accurate.
2. I am not aware of any information not disclosed by the client in this application that may have bearing on this risk.
3. I have not completed any of the information contained in the application except with the permission of the applicant and as noted by my initials and date on the application.
4. I have not signed any of the applications for an employer representative or individual applicant. If after submission of this application, I request any additions or changes to any of the above information, I will do so only with the written consent of the applicant, and I authorize Anthem Blue Cross (Anthem) and/or Anthem Blue Cross Life and Health Insurance Company (Anthem Life) to attribute such additions or changes to me.
5. I have advised the employer, in easy-to-understand language, that a failure to provide complete and accurate information that constitutes fraud or intentional misrepresentation of material fact may, within 24 months following the issuance of the coverage, result in a loss of coverage retroactive to the effective date of coverage or re-rating of the employer's premium retroactive to the coverage effective date and that coverage shall not be effective until Anthem reviews and approves the application and the employer receives a written notice from Anthem and/or Anthem Life. The employer understood my explanation.
6. I am the appointed agent/broker and am receiving commissions for the submission of this client. No portion of my commission payments from Anthem and/or Anthem Life shall be paid to an agent/broker/producer not appointed/approved by Anthem and/or Anthem Life.
7. I have advised the client not to terminate any existing coverage until receiving written notification from Anthem and/or Anthem Life that the coverage being applied for by this application is accepted.
8. I understand that if I have willfully stated as true any material fact I know to be false, I shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000).
9. I represent that I have not advised, and will not advise, the employer to buy or utilize Anthem's small group plans in conjunction with any other product whether insured or self-funded, that funds any annual deductible, copayment, coinsurance or out-of-pocket expense of the health benefit plan (i.e., wrapping).
10. By providing your "wet or electronic" signature below, you acknowledges that such signature is valid and binding.

Writing payable/sub-agent/producer/broker		**%**	**Second writing payable/sub-agent/producer/broker**		**%**
Agency name	Agency ID no.		Agency name	Agency ID no.	
Agent/producer/broker name			Agent/producer/broker name		
Agent/producer/broker ID no.			Agent/producer/broker ID no.		
Payable/sub-agent/producer/broker ID no. if different			Payable/sub-agent/producer/broker ID no. if different		
Street address			Street address		
City	State / ZIP code		City	State / ZIP code	
Phone no.	Fax no.		Phone no.	Fax no.	
Email address			Email address		
Signature	Date (MM/DD/YYYY)		Signature	Date (MM/DD/YYYY)	

For General Agent use only

General agent LISI		General agent ID no. 94-2757978	
Street address 1600 W. Hillsdale Blvd	City San Mateo	State CA	ZIP code 9 4 4 0 2
Email address			

Account Manager

Account manager name	Account manager ID no.

Administration kit will be sent to the Group.

Submit application to: Small Group Services
Anthem Blue Cross
P.O. Box 9042
Oxnard, CA 93031-9042

New business can also be submitted by email to: newsguwca@anthem.com

Employers are responsible for sending an electronic or printed copy of the summary of benefits and coverage (also called an "SBC") to plan participants and beneficiaries. To access your group's SBCs, go to www.sbc.anthem.com.