



Dental and Vision Coverage for 2-50 Members – Small Groups

Small Group Health Coverage offered by Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company
anthem.com/ca

Employer Application

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 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		

2. Dental Coverage Preferences ... what payment option and plan choices would you like to select?

2a. 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): \$ _____

2b. 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)
 Dental Blue Silver 100-80* Basic Option PPO* Dental Net**
 Dental Blue Silver Plus 100-80* Standard Option PPO*
 Dental Blue Gold 100-80* High Option PPO*
 Dental Blue Gold Plus 100-80*
 Dental Blue Platinum 100-80* Other: _____
 Dental Blue Platinum Plus 100-80*

Voluntary Dental Coverage
Please check below to offer one or both voluntary dental plans. (not available in conjunction with any other dental plans):
 PPO Dental Plan*
 Dental Saver SelectHMO**

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

3. Vision Coverage Preferences ... what plan choices and payment percentage would you like to select?

3a. I choose to offer:
 Blue View AND/OR Blue View Plus
(not available with Hospital Benefits Preferred)

3b. My employer contribution will be (50% to 100%):
_____ % per employee _____ % per dependent

4. 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 enrolled in both Medical and Life. Please read the P.O.P. brochure for complete details. If you choose to enroll, please complete the P.O.P. enrollment form, provide a separate check (if applicable), and submit along with this application.

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5. 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. Eligibility/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 employers to offer the same access to dependent health coverage for spouses and qualified registered domestic partners as defined in AB2208; we give employers the choice of whether or not to offer dependent coverage to opposite sex domestic partners under age 62, which is not required under AB2208. 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 5.

6. What is your requested effective date?

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

7. Please tell us about your current group dental and/or vision coverage ...

Will this plan replace current: Dental Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No To receive credit for prior coverage, there must be no lapse in coverage with your current dental carrier (see the Employee Application for acceptable forms of proof.) Vision Coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, current carrier is: _____ _____	Proposed termination date is: ____ / ____ / ____ ____ / ____ / ____
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8. 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).	<input type="checkbox"/> None	<input type="checkbox"/> 2 Months
	<input type="checkbox"/> 1 Month	<input type="checkbox"/> 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).	<input type="checkbox"/> None	<input type="checkbox"/> 4 Months
	<input type="checkbox"/> 1 Month	<input type="checkbox"/> 5 Months
	<input type="checkbox"/> 2 Months	<input type="checkbox"/> 6 Months
	<input type="checkbox"/> 3 Months	



9. 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 (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) and therefore not subject to ERISA, apply to obtain the coverage indicated.

To the best of our knowledge and belief, all information on this application is true and complete, and Anthem Blue Cross/Anthem Blue Cross Life and Health may rely on this application in deciding whether to provide coverage. If the application is not complete, Anthem Blue Cross reserves the right to reject it and notify us in writing. We understand and agree that no coverage will be effective before the date determined by Anthem Blue Cross 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 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.

We understand that if we intentionally provided incomplete or false information in this application, coverage may be rescinded. We have provided the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, with an explicit written notice specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of twelve (12) months and we have received signed acknowledgment.

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'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.

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.

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. 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 provided by California law, 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."* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN.

Name of Company Officer (Please print)

Title of Company Officer

Signature of Company Officer

Date (Month/Day/Year)

X



11. Cal-COBRA/COBRA/FMLA Questionnaire ... please complete this page if any "Yes" answers to H, I or J in Section 6

Cal-COBRA: California law SB719 requires employers with 2-19 eligible (AB1672-qualified) employees to extend health coverage programs to former employees.
 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.
 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	Birth Date	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 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 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 Cal-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 Cal-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.



