



Benefits from Anthem Blue Cross
Small business solutions. A package that fits.

Employee Application

anthem.com/ca

Health care plans offered by Anthem Blue Cross. Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company.

Please complete using black ink/type and return to your Group Administrator. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, please answer all questions and be sure to sign and date this application.

Group No.

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

1. Please ask your employer which Benefits plans are offered, and check your selection:

From Anthem Blue Cross Life and Health Insurance Company:

- Hospital Benefits Hospitalization only benefits
- Hospital Benefits Plus Hospitalization plus limited doctor visit benefits
- Hospital Benefits Preferred Hospitalization and limited doctor visit, dental & vision benefits
- PPO \$35 Copay GenRx Comprehensive PPO coverage with generic-only drug benefits
- Lumenos HSA 3000 (100/70*) Health Savings Account (HSA-Compatible)

From Anthem Blue Cross:

- Select \$25 HMO Comprehensive HMO coverage
- Lumenos HSA 2500 (80/50) Health Savings Account (HSA-compatible)
- Other: _____

If directed by your employer, Anthem Blue Cross will facilitate the opening of a Health Savings Account in your name.

Other: _____

* Plan will not be available for new group sales or renewals beginning July 2011.

2. Please ask your employer if other coverage is offered:

Dental: (Skip this section if you checked the Hospital Benefits Preferred plan in Section 1.)

Please check one if you would like to enroll:

From Anthem Blue Cross Life and Health Insurance Company:

Dental Blue Benefits

Other: _____

From Anthem Blue Cross:

Dental Net - please select a Dental Office number:

Vision: (Skip this section if you checked the Hospital Benefits Preferred plan in Section 1.)

Please check one if you would like to enroll:

From Anthem Blue Cross Life and Health Insurance Company:

Blue View Vision OR Blue View Plus

Life: Ask your employer if Life coverage from **Anthem Blue Cross Life and Health Insurance Company** is offered.

If not, please disregard questions in this application that pertain to Life coverage.

3. Please provide the following enrollment information (must be completed by the employee):

New group enrollment New hire Family addition Change of coverage Late enrollment Other: _____

Cal-COBRA/COBRA Applicants: <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> COBRA	Indicate Qualifying Event:
Cal-COBRA/COBRA Effective date: <input type="text"/>	<input type="checkbox"/> Termination of employment <input type="checkbox"/> Death of employee
(Cal-COBRA applicants must submit first month's premium)	<input type="checkbox"/> Reduction of hours <input type="checkbox"/> Child no longer eligible
	<input type="checkbox"/> Divorce/Legal separation <input type="checkbox"/> Medicare entitlement
	Date of Qualifying Event: <input type="text"/>

Last Name	First Name	M.I.	Social Security No.
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Home Address (Must be complete)	City	State	ZIP code
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Mailing Address (If different than above) or P.O. Box Private Mail Box (PMB) No.	City	State	ZIP code
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Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partnership (DP)	No. of Dependents including Spouse/DP	Home Phone No. ()
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Employer Name	Occupation/Job Title (Required)	Business Phone No. ()
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Hire Date (Required)	Employment Status (Required) <input type="checkbox"/> Part time <input type="checkbox"/> Full time	Salary (Required) \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	# of Hours Worked per Week (Required)
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Life Insurance Beneficiary - Last Name	First	M.I.	Relationship
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Language Choice (Optional)	<input type="checkbox"/> English (ENG) <input type="checkbox"/> Spanish (SPA) <input type="checkbox"/> Korean (KOR) <input type="checkbox"/> Chinese (ZHO)(C/M)
	<input type="checkbox"/> Vietnamese (VIE) <input type="checkbox"/> Tagalog (TGL) <input type="checkbox"/> Other (W09)

4. Please tell us about yourself and your eligible enrolling dependents:

Eligible dependents include an employee's lawful spouse, or domestic partner, and the enrolled employee's, spouse's or domestic partner's natural child, stepchild, legally adopted child, or child for whom the employee, spouse or domestic partner has been appointed permanent legal guardian by a final court decree or order, up to the child's 26th birthday. Unmarried children age 26 and over may be covered, as specified by the plan certificate or evidence of coverage. Written proof of relationship may be required for certain enrollments. For example, an existing subscriber who is initially enrolling a dependent spouse or domestic partner must provide copy of a Marriage Certificate, Declaration of Domestic Partnership or equivalent document. For enrollment of an adopted child, legal evidence of adoption (or intent to adopt) is required.

If spouse's last name is different than yours, is he/she a domestic partner? Yes No

FAMILY ADDITION: Date of marriage or domestic partnership declaration: _____ Date of adoption: _____

Sex	Last Name	First	M.I.	Social Security or ID no.	Height	Weight	Mo.	Birthdate Day	Year	Disabled	HMO BENEFITS ONLY:	
											Choose a physician for each family member from the Provider Directory which can be found at www.anthem.com/ca	Current Patient
<input type="checkbox"/> Male <input type="checkbox"/> Female		Employee									<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male <input type="checkbox"/> Female		Spouse/DP									<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male <input type="checkbox"/> Female											<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male <input type="checkbox"/> Female											<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male <input type="checkbox"/> Female											<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male <input type="checkbox"/> Female											<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: Any enrolling dependent(s) who do not live at the address listed in Section 3 on previous page, please provide their address(es) on a separate piece of paper.

5. Please complete if you want to waive coverage for yourself and/or any eligible dependents:

Type of Coverage:	Waived for:	Reason for waiving coverage: (proof of coverage will be required)
Medical coverage	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Covered by spouse's/domestic partner's sponsored group plan; Carrier name: _____ ID#: _____
Dental coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Covered by Individual Policy; Carrier name: _____ ID#: _____
Vision coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)	<input type="checkbox"/> Covered by Tricare <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> MediCal <input type="checkbox"/> Enrolled in any other insurance plan: Carrier name: _____ ID#: _____
Life coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Spouse/DP <input type="checkbox"/> Child(ren)	List names of dependents to be waived: _____ <input type="checkbox"/> Other: _____

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, as well as a six-month pre-existing condition exclusion UNLESS ENTITLED TO A SPECIAL ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT). The twelve (12) month wait will not apply if: (1) I certify at the time of initial enrollment that the coverage under another employer health benefit plan, a state child health insurance program, or a state Medicaid plan was the reason for waiving enrollment and I lose coverage under that employer health benefit plan, a state child health insurance program, or a state Medicaid plan; (2) my employer offers multiple health benefit plans and I elected a different plan during an open enrollment period; (3) a court orders that I provide coverage under this plan for a spouse or minor child or (4) if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, they may be able to be enrolled if enrollment is requested within 31 days after the marriage, birth, adoption or placement for adoption.

If I waived enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other health insurance or group health plan coverage, except coverage under a state child health insurance program, or a state Medicaid plan, I must request enrollment within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

If I waived enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of coverage under a state child health insurance program, or a state Medicaid plan, I must request enrollment for this group coverage within 60 days: (a) after the date my coverage under any of these plans ends; or (b) after the date I become eligible for state premium assistance for group coverage. **Please examine your options carefully before waiving this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.**

X _____
Signature if waiving coverage for self/dependents Date (Month/Day/Year)

7. Other Coverage – please be sure to complete this important information:

A. Do any persons on this application intend to continue other Group coverage if this application is accepted?..... Yes No

If yes:

Name of person: _____

Insurance Company: _____

B. Has any person applying for coverage had health insurance coverage at any time in the past six months? Yes No

If yes:

Applicant/family member name(s): _____

Type of coverage: Group Individual Other: _____

Insurance Company: _____

Date coverage began: _____ Date ended: _____

C. Does any person applying for coverage currently have dental insurance coverage?..... Yes No

If yes:

Applicant/family member name(s): _____

Type of coverage: Group Individual Other: _____

Insurance Company: _____

Date coverage began: _____ Date ended: _____

D. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits?..... Yes No

NOTE: If you are eligible for Medicare, Anthem Blue Cross **may not** duplicate Medicare benefits.

SUBMIT PROOF OF COVERAGE

To comply with federal and state laws, proof of this coverage must accompany this application.

Acceptable forms of proof are:

1. Certificate of coverage from prior carrier, **or**
2. Copy of ID card **and** copy of payroll stub showing medical coverage deduction, **or**
3. Copy of most recent medical premium bill

GENERAL NOTICE OF PRE-EXISTING CONDITION EXCLUSION

The pre-existing condition exclusion does not apply to HMOs; pregnancy; dependent children who are enrolled in the plan within 31 days after birth, adoption, or placement for adoption; or persons under 19 years old. If you or a family member have/had a medical condition before coming to our plan for which medical advice, diagnosis, care or treatment was recommended or received within the last six months and you do not advise and provide proof of prior coverage, you may be subject to a six-month pre-existing condition exclusion. That means that you or a family member might have to wait at least six months before the plan will provide coverage for that condition. In some cases, the exclusion may last up to 12 months, or as long as 18 months for late enrollees. However, the length of the waiting period can be reduced by the number of days of prior "creditable coverage," which means not experiencing a break in qualified prior health coverage that lasted more than 63 days for an Individual plan or 180 days for an employer-sponsored or employer-related plan. Proof of creditable coverage is required to reduce a waiting period, including a copy of the certificate or other documentation, which we can help you obtain from a prior plan/issuer if needed. You have the right to obtain proof of creditable coverage from your prior plan/issuer. Please contact our Small Group Enrollment & Billing Services at 1-800-627-8797 if you have any questions regarding preexisting conditions.

8. Agreements and Understandings - The following Agreement is to be signed by the EMPLOYEE applying for coverage.

I AGREE: To the best of my knowledge and belief, all information on this form is correct and true. I understand that this application and any information Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company obtains prior to the effective date of coverage is the basis on which coverage may be issued under the plan. I authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I work/worked as a permanent employee at my employer's place of business.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and any application made by my employer have been accepted and approved by ANTHEM BLUE CROSS and/or ANTHEM BLUE CROSS LIFE and HEALTH INSURANCE COMPANY.

I AM APPLYING FOR PPO COVERAGE: I understand that I am responsible for a greater portion of my medical costs when I use a nonparticipating provider. If a PPO Plan is selected and a nonparticipating provider is used, medical payments will be based upon the lesser percentage of the negotiated fee rate and I will be responsible for any amount over that payment.

I AM APPLYING FOR HMO COVERAGE: I understand that I am responsible for paying for services rendered that are not authorized by my primary medical group.

I AM APPLYING FOR HOSPITAL BENEFITS: I understand that the benefits of this plan are limited, with some exceptions, to inpatient hospital expenses. If I am not admitted to the hospital for inpatient treatment, this plan may not cover all my medical expenses, even if my illness is serious.

I AM APPLYING FOR HOSPITAL BENEFITS PLUS OR HOSPITAL BENEFITS PREFERRED: I understand that this plan is not designed to be a comprehensive medical or major medical plan. The benefits provided by this plan are limited, and may not cover all my medical expenses. Under this plan, I may have to pay substantial amounts of my own money for medical expenses, even if my illness is serious.

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.

CANCELLATION OR MODIFICATION OF COVERAGE. PLEASE READ CAREFULLY.

I attest by signing below that I have reviewed the information provided on this application and accept its provisions as a condition of coverage. I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and belief and I understand they will be relied upon by Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company in accepting this application. I understand that misstatements or failures to report new medical information prior to the effective date may result in a material change or premium. Material misrepresentations or significant omissions in this application may result in increased premiums, benefits being denied or coverage(s) being cancelled. I understand that Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company may cancel any coverage under this application due to any of the following: (a) any material misrepresentation discovered on an application or health statement; and/or (b) an act of fraud that has been committed.

Please Read Carefully - SIGNATURE REQUIRED

REQUIREMENT FOR BINDING ARBITRATION

I understand that if my coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from Employee Retirement Income Security Act of 1974 (ERISA) or if I have a dispute that is not governed by ERISA that I will be subject to the following binding arbitration provision.

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND/OR 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/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including 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/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.

Signature of Employee (Required)

Date (MM/DD/YY)

X

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)

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

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

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

ԿԱՐԵՎՈՐ: Ձեր բժշկի կամ առողջապահական ծրագրի հետ հաղորդակցվելու համար՝ Ձեզ անվճար քարզմանիչ 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 обратной 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できます。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। ਦੁਭਾਸ਼ੀਆਂ 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 : យើងអាចផ្តល់អ្នកបកប្រែតូចៗដោយឥតគិតថ្លៃ សំរាប់ប្រាស្រ័យទាក់ទងជាមួយនឹងគ្រូពេទ្យ ឬគំរោងសុខភាពរបស់អ្នក ។ ដើម្បីទទួលបានអ្នកបកប្រែ ឬសាកសួរអំពីព័ត៌មានដែលសរសេរជាភាសាខ្មែរ សូមទូរស័ព្ទទៅលេខដែលមានកត់នៅលើខ្នងអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ឬទាក់ទងអ្នកគ្រប់គ្រងក្រុមរបស់អ្នក ។ (Khmer)

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

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

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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 chuyển ngữ sang ngôn ngữ của quý vị, xin quý vị vui lòng liên lạc ban quản trị chương trình bảo hiểm. (Vietnamese)



Small Group Services
Anthem Blue Cross
P.O. Box 9062
Oxnard, CA 93031-9062
anthem.com/ca

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