

**Conditions of Enrollment
Start-Up Companies/PEO Spin-Off Groups**



Small Group Services
P.O. Box 9062
Oxnard, CA 93031-9062
800-627-8797

PART A: START-UP COMPANIES

Application date	Group name										
<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>											

I agree that if, after review, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company offers my group coverage, it is contingent on receiving the company's first 30 days' complete payroll records for all employees within 45 days of the effective date.

I understand that Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company reserve the right to cancel or not renew coverage if this payroll documentation is not provided in a timely manner, or it does not meet Anthem Blue Cross criteria for enrollment eligibility.

By signing below, I agree to the above conditions of enrollment in addition to all other terms, limitations and conditions of the *Group Benefit Agreement*.

Signature of company officer	Name of company officer (please print)
X	X

Title of company officer	Date										
X	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>										

PART B: PEO SPIN-OFF GROUPS

I certify that the company has cancelled its contract with the PEO effective	Date										
	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>										

I agree that if, after review, Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company offers my group coverage, it is contingent on receiving the company's first 30 days' complete payroll records for all employees within 45 days of the effective date.

I understand that Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company reserve the right to cancel or not renew coverage if this payroll documentation is not provided in a timely manner, or it does not meet Anthem Blue Cross criteria for enrollment eligibility.

By signing below, I agree to the above conditions of enrollment in addition to all other terms, limitations and conditions of the *Group Benefit Agreement*.

Signature of company officer	Name of company officer (please print)
X	X

Title of company officer	Date										
X	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>										