



**EmployeeElect for 2-50 Member Small Groups**  
 Health care plans offered by Anthem Blue Cross  
 Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company

# Employee Application

anthem.com/ca

Please complete using black ink/type, seal the inside pages for privacy 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 your application.

Group No.

### 1a. Medical Coverage - please ask your employer which Medical options are available before checking your selection:

<input type="checkbox"/> Premier PPO \$10 Copay*	<input type="checkbox"/> Solution 2500 PPO**	<input type="checkbox"/> Lumenos HSA 2000 (100/70)**	<input type="checkbox"/> HMO \$10 100%*	<input type="checkbox"/> Lumenos HSA 1500 (100/70)**	If HMO, be sure to provide physician number in section 3  *offered by Anthem Blue Cross  **offered by Anthem Blue Cross Life and Health Insurance Company
<input type="checkbox"/> Premier PPO \$20 Copay*	<input type="checkbox"/> Solution 3500 PPO**	<input type="checkbox"/> Lumenos HSA 3000 (100/70)**	<input type="checkbox"/> HMO \$25 100%*	<input type="checkbox"/> Advantage PPO \$25 Copay**	
<input type="checkbox"/> Premier PPO \$30 Copay*	<input type="checkbox"/> Solution 5000 PPO**	<input type="checkbox"/> Lumenos HSA 5000 (100/70)**	<input type="checkbox"/> Classic \$20 HMO*	<input type="checkbox"/> Saver PPO **	
<input type="checkbox"/> PPO \$20 Copay**	<input type="checkbox"/> Elements Hospital Preferred**	<input type="checkbox"/> Lumenos HSA 1500 (80/50)**	<input type="checkbox"/> Classic \$30 HMO*	<input type="checkbox"/> Basic PPO **	
<input type="checkbox"/> PPO \$30 Copay*	<input type="checkbox"/> Elements Hospital Plus**	<input type="checkbox"/> Lumenos HSA 2500 (80/50)**	<input type="checkbox"/> Classic \$40 HMO*	<input type="checkbox"/> PPO 2400 (HSA-Compatible)**	
<input type="checkbox"/> PPO \$40 Copay*	<input type="checkbox"/> Elements Hospital**	<input type="checkbox"/> Lumenos HSA 3500 (80/50)**	<input type="checkbox"/> Saver \$20 HMO*	<input type="checkbox"/> PPO 3500 (HSA-Compatible)**	
<input type="checkbox"/> PPO \$25 Copay GenRx**	<input type="checkbox"/> Lumenos HIA Plus 750**	<input type="checkbox"/> High Deductible EPO*	<input type="checkbox"/> Saver \$30 HMO*	<input type="checkbox"/> Lumenos HIA Plus 3000**	
<input type="checkbox"/> PPO \$35 Copay GenRx**	<input type="checkbox"/> Lumenos HIA Plus 500**		<input type="checkbox"/> Saver \$40 HMO*	<input type="checkbox"/> Power HealthFund 750**	
<input type="checkbox"/> PPO \$45 Copay GenRx**			<input type="checkbox"/> Select \$25 HMO*	<input type="checkbox"/> Power HealthFund 500**	
			<input type="checkbox"/> Select \$35 HMO*	<input type="checkbox"/> Other: _____	

+ Plans may not be available at renewal or for new groups beginning in 2010.

### 1b. Dental Coverage - please ask your employer which Dental options are available before checking your selection:

<input type="checkbox"/> Dental Blue Silver 100-80**	<input type="checkbox"/> High Option PPO**	<input type="checkbox"/> Dental Net*	<input type="checkbox"/> Other _____
<input type="checkbox"/> Dental Blue Silver Plus 100-80**	<input type="checkbox"/> Standard Option PPO**	For above Dental Net plan, you must select a Dental Office Number:  <div style="border: 1px solid black; width: 100px; height: 20px; margin: 5px;"></div>	
<input type="checkbox"/> Dental Blue Gold 100-80**	<input type="checkbox"/> Basic Option PPO**		
<input type="checkbox"/> Dental Blue Gold Plus 100-80**			
<input type="checkbox"/> Dental Blue Platinum 100-80**			
<input type="checkbox"/> Dental Blue Platinum Plus 100-80**			
<input type="checkbox"/> Dental Blue Platinum Plus 100-80**			

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

**Voluntary Dental Coverage**

Dental PPO\*\*

Dental Saver SelectHMO\* - You must select a Dental Office Number (to the left)

### 1c. Vision Coverage - please check with your employer to make sure these options are available before selecting:

Blue View OR  Blue View Plus offered by Anthem Blue Cross Life and Health Insurance Company

### 1d. Life Coverage - please check with your employer to make sure these options are available before selecting:

Optional Dependent Life Insurance (only if offered by your employer)	Supplemental Life Insurance (in addition to Term Life, if it is offered) <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> \$10,000/\$1,000 (\$10,000 spouse/child 6 months-26 yrs; \$1,000 less than 6 months)	Amount: <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000
<input type="checkbox"/> \$5,000/\$500 (\$5,000 spouse/child 6 months-26 yrs; \$500 less than 6 months)	offered by Anthem Blue Cross Life and Health Insurance Company

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

<input type="checkbox"/> New group enrollment	<input type="checkbox"/> New hire	<input type="checkbox"/> COBRA	COBRA/Cal-COBRA Effective Date: <div style="border: 1px solid black; width: 100px; height: 20px;"></div>
<input type="checkbox"/> Family addition	<input type="checkbox"/> Change of coverage	<input type="checkbox"/> Cal-COBRA	
<input type="checkbox"/> Late enrollment	<input type="checkbox"/> Other: _____		

(Cal-COBRA applicants must submit first month's premium)

Last Name		First Name		M.I.	Social Security or ID No.	
Home Address (P.O. Box not acceptable unless rural P.O. Box)			Apt No.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner (DP)		Spouse/DP Social Security or ID No.
City		State	ZIP Code		Home Phone No. ( )	
Employer Name		Occupation/ Job Title			Business Phone No. ( )	
Hire Date		<input type="checkbox"/> Part time <input type="checkbox"/> Full time	Salary (Required) \$		<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	
Life Insurance Beneficiary - Last Name		First		M.I.	Relationship	



Social Security or ID No. \_\_\_\_\_

Spouse/DP Social Security or ID No. \_\_\_\_\_

**3. 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 a 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 Name	MI	Height	Weight	Mo.	Birthdate Day	Year	Disabled	HMO PLANS ONLY:	
										Primary Care Physician No. or 3-digit Medical Group/IPA No.	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"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter									<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 2 on previous page, please provide their address(es) on a separate piece of paper.

**4. Please complete if you want to decline coverage for yourself and/or any eligible dependents:**

Type of Coverage:	Declined for:	Reason for declining: (proof of coverage may be required)
Medical coverage	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<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"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Covered by Individual Policy; Carrier name: _____ ID#: _____
Vision coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Covered by Tricare <input type="checkbox"/> Covered by Medicare <input type="checkbox"/> MediCal
Life coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Enrolled in any other insurance plan; Carrier name: _____ ID#: _____ <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 decline coverage. BY DECLINING 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 declining 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 declined 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 declined 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 declining 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 declining coverage for self/dependents

Date (Month/Day/Year)



MCAFR1167CEN 10/10 02

Social Security or ID No. \_\_\_\_\_

**5. Health Questionnaire for Groups Enrolling 1-10 Employees - this confidential information will not be seen or given to your employer**

Groups with 11-50 Enrolling Employees: Do not complete this section. Please skip to Section 5A.

All questions must be answered "Yes" or "No".

INCOMPLETE APPLICATIONS WILL BE RETURNED TO YOU FOR COMPLETION WHICH MAY DELAY THE EFFECTIVE DATE OF YOUR COVERAGE.

Has any person listed on this application ever had, consulted for, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions?

- 1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins, or any other disorder of the heart, blood, blood vessels, hyperlipemia or arteriosclerosis?.....  Yes  No
- 2. Ulcer, colitis, gall stone, hernia or any other disorder of the stomach, intestines, rectum, gall bladder, or liver?.....  Yes  No
- 3. Cancer, cyst, or tumor?.....  Yes  No
- 4. Disorder of the kidneys, blood or albumin, thyroid glands, diabetes, venereal disease or any related eye disorders, urinary systems, male or female organs, or menstrual dysfunction?.....  Yes  No
- 5. Tuberculosis, asthma, hay fever, adenoids, pleurisy or any other disorder of the lungs or respiratory system?.....  Yes  No
- 6. Epilepsy, fainting spells, mental or nervous condition, paralysis or any disorder of the brain or nervous system?.....  Yes  No  
If epileptic, date of last seizure: \_\_\_\_/\_\_\_\_/\_\_\_\_
- 7. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same?.....  Yes  No
- 8. Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles, or bones?.....  Yes  No
- 9. Any physical deformity or defect? Any serious bodily injury, fracture, concussion, burn, and/or congenital problems?.....  Yes  No
- 10. Has any person to be covered had or been told that they had an immune deficiency disorder, AIDS, or AIDS-related complex, not including the results of HIV testing?.....  Yes  No
- 11. Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner?.....  Yes  No
- 12. a. Is any female to be covered currently pregnant?.....  Yes  No  
If yes, Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
b. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application?.....  Yes  No
- 13. Does anyone listed on this application use tobacco products?.....  Yes  No

If you answer "Yes" to all or part of above questions 1-12b, please complete the following (Insert additional sheets if necessary):

Question # \_\_\_\_ Name of patient \_\_\_\_\_  
 Condition treated \_\_\_\_\_  
 Dates of treatment: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still under treatment   
 Treatment rendered \_\_\_\_\_  
 Medication and dosage taken \_\_\_\_\_  
 Dates taken: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still taking

Question # \_\_\_\_ Name of patient \_\_\_\_\_  
 Condition treated \_\_\_\_\_  
 Dates of treatment: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still under treatment   
 Treatment rendered \_\_\_\_\_  
 Medication and dosage taken \_\_\_\_\_  
 Dates taken: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still taking

Question # \_\_\_\_ Name of patient \_\_\_\_\_  
 Condition treated \_\_\_\_\_  
 Dates of treatment: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still under treatment   
 Treatment rendered \_\_\_\_\_  
 Medication and dosage taken \_\_\_\_\_  
 Dates taken: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still taking

Question # \_\_\_\_ Name of patient \_\_\_\_\_  
 Condition treated \_\_\_\_\_  
 Dates of treatment: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still under treatment   
 Treatment rendered \_\_\_\_\_  
 Medication and dosage taken \_\_\_\_\_  
 Dates taken: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still taking





Social Security or ID No. \_\_\_\_\_

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

1. 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: \_\_\_\_\_

2. 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: \_\_\_\_\_

3. 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: \_\_\_\_\_

4. 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 preexisting 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 pre-existing conditions.



Social Security or ID No.									
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**7. 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 am working at my employer's place of business in permanent employment.

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 A HEALTHCARE SAVINGS ACCOUNT (HSA) COMPATIBLE EPO PLAN:** I understand that the High Deductible EPO Plan is designed for Exclusive Provider Organization (EPO) usage, and that using nonparticipating providers could result in significantly higher out-of-pocket costs. I understand that having this coverage does not establish an HSA. To do so, I must contact a qualified financial institution. Also, I understand that I should consult my tax advisor.

**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 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	

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

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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 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 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)

**ԿԼԵՎՈՐ.** Ձեր բժշկի կամ առողջապահական ծրագրի հետ հաղորդակցվելու համար՝ Ձեզ անվճար թարգմանիչ կարող է մատակարարվել: Թարգմանիչ ստանալու կամ Ձեր լեզվով գրավոր տեղեկությունների մասին հարցնելու համար՝ խմբավում է զանգահարել Ձեր ինքնուրույն բարտի ետՖի 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ず。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下さい。(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 ਵਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਆਈ.ਡੀ. ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਆਪਣੇ ਗਰੁੱਪ ਪ੍ਰਬੰਧਕ ਨੂੰ ਸੰਪਰਕ ਕਰੋ। (Punjabi)

**សារៈសំខាន់ :** បើបើអាចផ្តល់អ្នកបកប្រែជូនអ្នកដោយឥតគិតថ្លៃ សំរាប់ប្រាស្រ័យទាក់ទងជាមួយនឹងគ្រូពេទ្យ ឬគំរោងសុខភាពរបស់អ្នក ។ ដើម្បីទទួលបានអ្នកបកប្រែ ឬសាកសួរអំពីព័ត៌មានដែលសរសេរជាភាសាខ្មែរ សូមទូរស័ព្ទទៅលេខដែលមានកំពុងនៅលើខ្នងអត្តសញ្ញាណប័ណ្ណរបស់អ្នក 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 nrhiv 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 ntwav 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)

## **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)

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**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)