Information for Applicants Requesting a Special Enrollment Period

When applying to enroll for coverage during a Special Enrollment Period (SEP), an applicant must be eligible to enroll and provide supporting documentation of a qualifying event. Without this documentation the applicant may not be able to enroll.

Please review the list below which outlines examples of what may be used as supporting documentation. Be sure to send in a copy of the documentation supporting the qualifying event when the completed application is submitted or upload a copy of the documentation when submitting an online application.

For paper applications, please submit legible copies of everything and keep all original documents for your personal records, because no original documentation will be returned. Please write the applicant's name on the top of each page of the supporting documentation.

After reviewing the information provided, we may request additional documentation to confirm eligibility. Please note that loss of health coverage due to fraud, intentional misrepresentation of a material fact or failure to pay a premium do not constitute qualifying events.

If you have further questions about qualifying events or the supporting documentation that is required, please call your agent or customer service at 1-855-383-7247.

Supporting documentation by type of qualifying event
OFF Exchange for all SEP applicants for Anthem Blue Cross plans

Qualifying Event	Description and examples of supporting documentation
Lost or will lose Minimum Essential Coverage: Involuntary loss of Minimum Essential Coverage for any reason other than fraud, intentional misrepresentation of a material fact or failure to pay a premium	**Loss of Minimum Essential Coverage due to change in employment status:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming loss of coverage (date and individuals) and reason for loss of Minimum Essential Coverage (i.e., reduction in employment hours, etc.) **or** • Letter that provides notice of **offer** of COBRA or state continuation benefits **Loss of Minimum Essential Coverage due to loss of dependent eligibility status:** **Due to death:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming loss of coverage (date and individuals) and • Copy of death certificate or obituary **Due to Medicare enrollment:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming loss of coverage (date and individuals) and • Copy of Medicare card or approval letter from Social Security **Due to an over-age dependent:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming loss of coverage (date and individuals) **Due to legal separation, divorce, dissolution of domestic partnership:** • Letter from employer on business letterhead or information from previous carrier (recent billing statement, ID card) confirming loss of coverage (date and individuals) and • Divorce decree, legal separation agreement, or notarized/legal termination of domestic partnership **Loss of Minimum Essential Coverage due to exhaustion of COBRA or state continuation benefits:** • Letter that provides notice of termination of COBRA or state continuation benefits

Qualifying Event	Description and examples of supporting documentation
Permanent move to new service area	◦ Documentation of applicant's old address and new address (if not present on employer letter or previous carrier documentation) which may be validated by any of the following: — Recent utility bill (electric, water, phone, internet, cable) — Signed residential lease, rental agreement/contract, mortgage or nursing home/assisted living facility residency documentation — A deed showing applicant ownership of property in the new service area — New driver's license with new address in the service area — Receipt of property tax paid — Insurance documents, such as homeowner's, renter's, or life insurance policy or statement — Mail from the Department of Motor Vehicles, such as a driver's license, vehicle registration, or change of address card — State ID — Official school documents, including school enrollment, report cards, or housing documentation — Mail from a government agency to your address, such as a Social Security statement, or a notice from TANF or SNAP agency — Mail from a financial institution, such as a bank statement — U.S. Postal Service change of address confirmation letter — Pay stub showing address — Voter registration card showing name and address — Moving company contract or receipt showing address — Document from the Department of Corrections, jail, or prison indicating recent release or parole, including an order of parole, order of release, or an address certification — If you are homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify your residency. This person must prove their own residency by including one of the documents listed above. — If you are living in the home of another person, like a family member, friend or roommate, a letter/statement from that person stating you are living with them. This person must prove their own residency by including one of the documents listed above. — Letter from a local non-profit social services provider, certified application counselor, navigator or federally qualified health center that can verify your address. If you are homeless, you can provide a letter from a government entity or not-for-profit organization, including shelters, verifying your address. — Consumers living in rural areas may provide a rural route mail delivery address. The supporting documentation needs to include the name of the applicant along with the residential address listed on the application (the new address), and documentation of the previous address, which should include the applicant's name and the residential address before the move. For **child only applications**, the name of the parent/guardian in the signature section of the application must match the name on the supporting documentation.
Required by a court order to provide an eligible child(ren) coverage, including a child support order, filed an application for appointment of guardianship of a child or appointment of guardianship of a child	Legal documentation of guardianship that indicates the subscriber or the subscriber's spouse is a guardian of the applicant or court order that indicates the subscriber is required to cover the applicant. Contact us if you are applying for a child only policy.
Had a baby, adoption of a child or placement of a child with you for adoption	**Birth:** Birth certificate **or** medical records from hospital or pediatrician which indicate the names of the parents, the name of the baby, and date of birth. NOTE: *For current Anthem members, a mother's delivery claim may be considered as supporting documentation.* **Adoption/placement for adoption:** Adoption certificate or document establishing placement of a child with applicant for adoption.

Qualifying Event	Description and examples of supporting documentation
Got married or in a domestic partnership resulting in eligibility for coverage	Certificate of marriage, or declaration of domestic partnership
Moved to the U.S. from a foreign country or U.S. territory	◦ Documentation of the move (including date of move) which may be validated by a passport, VISA, or plane ticket, **and** ◦ Documentation of the new address which may be validated by any of the following: — Signed residential lease, rental agreement/contract, mortgage — A deed showing applicant ownership of property in the new service area — If you are homeless or in transitional housing, you may submit a letter or statement from another resident of the same state, stating that they know where you live and can verify your residency. This person must prove their own residency by including one of the documents listed above. — If you are living in the home of another person, like a family member, friend or roommate, a letter/statement from that person stating you are living with them. This person must prove their own residency by including one of the documents listed above. — Letter from a local non-profit social services provider, certified application counselor, navigator or federally qualified health center that can verify your address. If you are homeless, you can provide a letter from a government entity or not-for-profit organization, including shelters, verifying your address. ◦ **And** one additional supporting document of new address which may be validated by one of the following in the applicant's name: — Recent utility bill (electric, water, phone, internet, cable) — New driver's license with new address in the service area — Receipt of property tax paid — Insurance documents, such as homeowner's, renter's, or life insurance policy or statement — Mail from the Department of Motor Vehicles, such as a driver's license or vehicle registration — State ID — Official school documents, including school enrollment, report cards, or housing documentation — Mail from a government agency to your address, such as a Social Security statement, or a notice from TANF or SNAP agency — Mail from a financial institution, such as a bank statement — Pay stub showing address or letter/employment contract from employer — Voter registration card showing name and address — Moving company contract or receipt showing address
Release from jail or prison (incarceration)	Papers from local, state or federal department of corrections or prisons showing the applicant's date of legal discharge.
Death of a family member enrolled under current coverage	◦ Letter from employer on business letterhead or information from a previous carrier (recent billing statement, ID card) confirming coverage (date and individuals), **and** ◦ Copy of death certificate or obituary
Current policy does not renew on a calendar year basis (renews on a date other than January 1st)	Information from previous carrier (recent billing statement, ID card, renewal letter) confirming coverage (date and individuals) and renewal date of coverage.
Health coverage issuer substantially violated material provision of health coverage contract	Letter from the member and supporting documentation from insurance carrier or Exchange.
Loss of services from contracting provider for an acute condition, serious chronic condition, pregnancy, terminal illness, care of newborn between birth and 36 months of age,	Letter from the previous insurance carrier OR provider.

Qualifying Event	Description and examples of supporting documentation
or performance of a surgery or other procedure that has been recommended and documented by the provider and that provider is no longer participating in the health benefit plan.	
Member of the Reserve Forces of the U.S. military returning from active duty or member of the California National Guard returning from active duty	Discharge papers that indicate date of discharge from active duty.
Any other event or circumstance as set forth in the rules established by applicable state or federal law in defining qualifying events.	An official form such as a letter or other supporting documentation from the source (employer, state or federal agency, for example) confirming the qualifying event occurred, the date the event happened, and the names of all applicants affected.
Employees and their dependents who gain access to an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) for the first time, or who had or were offered QSEHRA or ICHRA in the past, ceased coverage (or turned it down) and are then offered it again – either during the employer's annual open enrollment period, or because the employee switches to a different class of employees who are eligible for the coverage.	Copy of the ICHRA or QSEHRA offer.
Applicant did not enroll in a health benefit plan during the immediately preceding period because he or she was misinformed that he or she had minimum essential coverage.	Letter from Department of Health Care Services or Exchange confirming that the applicant(s) was misinformed that he or she had Minimum Essential Coverage and did not enroll in a plan during the immediately preceding enrollment period.

Primary applicant name: _____

Welcome

California Individual Application

Thanks for choosing us. We're glad you're here.

If you have any questions while filling out this form, give us a call at 1 (877) 212-1796. But if you've worked with an agent or broker, contact them first.

About this form

Use this form to apply for **new** medical coverage or to **change** existing coverage with Anthem Blue Cross (Anthem).

You can apply or change coverage:

1. **During the annual Open Enrollment period**
   Your coverage will start based on when we receive your complete application. The earliest date coverage can start is January 1st.
   If we get your application:
   - Between November 1 through December 15, coverage starts January 1.
   - Between December 16 through January 31, coverage starts February 1.
2. **When you have a Special Enrollment period due to a qualifying event**
   When you're done with this form, fill out **Appendix A: Special Enrollment,** which includes information about qualifying events and when coverage starts.

Tips for filling out this form

- Answer all questions. Please print clearly using blue or black ink only.
- Please submit all pages.
- You can also apply online at anthem.com/ca.
- Refer to your Product Guide for plan and enrollment details. Don't have a copy? Ask your agent or contact us.
- If you're enrolling in a medical plan, you must choose a Primary Care Physician (PCP). View a list of doctors for your plan on anthem.com/ca or call us. If you don't choose a PCP, we'll pick one located close to you.

Some frequently asked questions

1. **Do I need to include a payment?**
   Yes. We can't process your application without your first month's premium payment. Without it, your enrollment will be delayed. We won't charge your card or cash your check or money order until you've been enrolled.
2. **Why do you need my Social Security Number (SSN)?**
   The IRS requires us to collect it. It won't be shared unless required by law.
   If you enroll in a health savings account (HSA) compatible plan with us, we may give it to our HSA banking partner.

California Individual Application

Please indicate the reason for this application:
☐ Open Enrollment
☐ Special Enrollment Period (also complete Appendix A)

Step 1: Who is applying?

☐ New coverage

☐ Change coverage
☐ Add dependent to existing coverage

Subscriber ID no. _____

Primary Applicant

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security Number** - -
Marital status ☐ Single ☐ Married ☐ Domestic Partner	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	**County** (for home address)

Home address (applicant, custodial parent, or legal guardian) (not a P.O. Box)	**City**	**State**	**ZIP**
Billing address (optional — if different than home address)	**City**	**State**	**ZIP**
Mailing address (optional — if different than home address)	**City**	**State**	**ZIP**

Email address: _____

I'm providing my email address because **I, and my enrolled dependents, want to receive information about our benefits electronically.** These communications may include Identification (ID) Cards, Contracts or Certificates of Coverage, billing invoices, Explanation of Benefits, required notices including cancellations and renewals, and helpful or specific personalized information to help get the most out of the benefits. I understand I need to register on anthem.com/ca or the Anthem mobile app to get the most out of my plan's digital tools, and I will make sure Anthem has my most up to date email address. I, and my enrolled dependents, understand that we can update our email addresses, change our communication preferences, and request free copies of any materials at any time by going to anthem.com/ca or calling the Member Services number on my ID Card.

Primary phone	☐ Applicant DOES speak, read and/or write English. If applicant does not speak, read or write English, the interpreter must sign and submit a "Statement of Accountability" (Appendix B).
Preferred written language	☐ English (ENG) ☐ Spanish (SPA) ☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Tagalog (TGL) ☐ Vietnamese (VIE) ☐ Other (write-in) _____
Preferred spoken language	☐ English (ENG) ☐ Spanish (SPA) ☐ Chinese (ZHO) (C/M) ☐ Korean (KOR) ☐ Tagalog (TGL) ☐ Vietnamese (VIE) ☐ Other (write-in) _____

PCP	**PCP ID**	**Current patient** ☐ Yes ☐ No

Spouse or Domestic Partner

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security Number** - -
Relationship to applicant ☐ Spouse ☐ Domestic Partner	**Sex** ☐ M ☐ F		**Date of birth** (mm/dd/yyyy) / /
PCP	**PCP ID**		**Current patient** ☐ Yes ☐ No

Dependent

Children must be under age twenty-six (26). Children over the age of 26 may be eligible for coverage as a dependent if they are incapable of self-sustaining employment by reason of a physically or mentally incapacitating injury, illness, or condition, and chiefly dependent upon the policyholder or subscriber for support and maintenance. To qualify as an overage dependent, the dependent's impairment must start before the end of the period he or she would become ineligible for coverage.

Parent/Stepparent must meet the definition of a qualifying relative under federal law, which includes relying on the child/stepchild for over 50 percent of their financial support, in order to be eligible. There is no age requirement.

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security Number** - -
Relationship to applicant ☐ Child ☐ Parent/Stepparent ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	
PCP	**PCP ID**	**Current patient** ☐ Yes ☐ No	

Dependent

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security Number** - -
Relationship to applicant ☐ Child ☐ Parent/Stepparent ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	
PCP	**PCP ID**	**Current patient** ☐ Yes ☐ No	

Dependent

☐ **Check here if you have more dependents.** Print an extra copy of this page and attach to your application.

Last name (legal name)	**First name** (legal name)	**M.I.**	**Social Security Number** - -
Relationship to applicant ☐ Child ☐ Parent/Stepparent ☐ Other _____	**Sex** ☐ M ☐ F	**Date of birth** (mm/dd/yyyy) / /	
PCP	**PCP ID**	**Current patient** ☐ Yes ☐ No	

Eligibility

The answers to these questions are needed to determine your eligibility.

Are any applicants enrolled in Medicare? ☐ No ☐ Yes **If yes, who?***

Are any applicants currently incarcerated (with more than 60 days left to serve before release) as a result of a conviction? (not just pending disposition of charges) ☐ No ☐ Yes **If yes, who?**

Do you have a child age 26 or over who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition for whom coverage is being requested under this contract?

☐ No ☐ Yes **If yes,** you must submit a separate disabled dependent form to determine eligibility.
☐ Check this box and we'll send you the form.

*If you are seeking to add a dependent parent or stepparent who is eligible for or enrolled in Medicare at the time of this application, the CA Health Insurance Counseling and Advocacy Program (HICAP) can provide health insurance counseling to senior California residents free of charge. You can call HICAP at 1-800-434-0222 for more details.

Step 2: What coverage would you like?

Medical Plans

Choose only one medical plan. If you selected an EPO product, be sure to select a Primary Care Physician (PCP) in Step 1.

Medical applicants must reside in one of these counties to enroll: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Glenn, Humboldt, Imperial, Inyo, Kern, Lake, Lassen, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo, or Yuba.

Anthem Bronze	Anthem Silver	Anthem Gold	Anthem Platinum
☐ 60 D EPO (6R4V) ☐ 60 D HDHP EPO (6R4G)	☐ 70 Off Exchange EPO (6R57)	☐ 80 D EPO (6R4H)	☐ 90 D EPO (6R5K)

Anthem Catastrophic	Only available to applicants under age 30, unless otherwise qualified.
☐ Minimum Coverage D EPO (6R5J)	

Medical Plans

Choose only one medical plan. If you selected an HMO product, be sure to select a Primary Care Physician (PCP) in Step 1.

Medical applicants must reside in one of these counties to enroll: Fresno, Kings, Los Angeles East, Los Angeles West, Madera, Orange, Riverside, San Bernardino, or San Diego.

Anthem Bronze	Anthem Silver	Anthem Gold	Anthem Platinum
☐ 60 D HMO (6R5G)	☐ 70 Off Exchange HMO (6R5A)	☐ 80 D HMO (6R4D)	☐ 90 D HMO (6R5L)

Anthem Catastrophic	Only available to applicants under age 30, unless otherwise qualified.
☐ Minimum Coverage D HMO (6R5E)	

Health Savings Account (HSA) Enrollment	If you choose an HSA compatible plan, please select one of the options below:

☐ I request that Anthem facilitate opening my HSA with its service provider and, as part of that transaction, I understand Anthem will disclose my name, SSN, and claims data, and that of my dependents if applicable, to its service provider to support my HSA.
☐ I request that Anthem NOT facilitate opening an HSA with its service provider for me.

Current medical coverage	☐ One or more of the applicants currently have healthcare coverage (Please fill out the info below.)

Name of person covered (Last, First, M.I.)	Coverage Type	Insurer name	Policy ID no.	Coverage Dates (if applicable) (mm/dd/yyyy) Termination Date (if different from coverage end date)
	☐ Group ☐ Individual			**Start:** / / **End:** / / **Termination Date:** / /
	☐ Group ☐ Individual			**Start:** / / **End:** / / **Termination Date:** / /
	☐ Group ☐ Individual			**Start:** / / **End:** / / **Termination Date:** / /
	☐ Group ☐ Individual			**Start:** / / **End:** / / **Termination Date:** / /

	☐ Group ☐ Individual			**Start:** / / **End:** / / **Termination Date:** / /

NOTE: Enrollment in the selected plan is dependent upon you residing or working within a plan's geographical service area, and the network, provider, and physician availability within the geographical service area. If at the time of your enrollment, the network or physician/medical group is not available or you do not reside or work in the geographical service area of the plan, you may be assigned to or be required to choose a different provider, network, and/or plan.

Step 3: Please read and sign

Important legal information

All Applicants
I, the undersigned, understand that under the Anthem plan/policy in which I am enrolling, I will have considerably higher personal financial costs if I use an out-of-network hospital or physician than if I use a network hospital or physician. Contact customer service at 1 (855) 383-7247 with any questions about the use of network providers and the financial impact of using out-of-network providers.

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.

I understand that:

- I must include my first premium payment with this application, but that does not mean coverage has been approved. I'm applying for the coverage I chose in Step 2. To the extent permitted by law, Anthem has the right to accept or decline this application. If my application is denied, my bank account or credit card will not be charged, and if I paid with a money order, it will be returned to me.
- I'm responsible to let Anthem know, in a timely manner, of any change that would make me or any dependent ineligible for coverage.
- Check payments may be handled as Automated Clearinghouse (ACH) debit transactions. That means if I pay by check, the paper check will be destroyed and the debit payment will appear on my bank statement. My check won't be given to my financial institution or sent back to me. This does not mean I will be enrolled in an automatic debit process to pay my premium. Any resubmissions due to insufficient funds may also be electronic. All checking transactions will remain secure, and my payment by check means I agree to these terms.
- I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and me.
- By providing a phone number, I agree and consent that Anthem and its affiliates may call or text me at the phone number included on this application using an automated telephone dialing system and/or prerecorded message to help keep me informed about my benefits.
- I'm applying for individual health coverage which is not part of any employer sponsored plan and I'm responsible for all of the premium payments and making sure that all premiums are paid on time.
- I certify that each Social Security Number listed on this application is correct.
- My Domestic Partner, if applicable, is eligible for coverage only if he or she has established a domestic partnership with me pursuant to California law.
- I represent that I have read the Important Legal Information section, and I agree to the coverage conditions. I represent 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 are being relied on by Anthem in accepting this application. Any act, or practice that constitutes fraud or intentional misrepresentation of material fact found in this application may result in denial of benefits, rescission or cancellation of my coverage(s).

I sign this application for and on behalf of any eligible dependents and myself if covered by Anthem. I am acting as their agent and representative. This application cannot be altered by the applicant after submission to Anthem absent the acknowledgement and consent of Anthem.

Rescission of Membership
Every applicant age 18 or older acknowledges the following: I have provided true and complete answers to all questions in the application to the best of my knowledge and understand that all answers are important and will be considered in the acceptance or denial of this application. I understand that all information I know, that is responsive to a question on this application, must be provided in my answers consistent with California law.

The primary applicant additionally acknowledges the following: All of my dependents listed on this application who are 18 years of age or older have read this application and have provided complete and accurate information for this application to the best of my knowledge and have signed the application below. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about all applicants, including my children under the age of 18, listed on this application is true and complete.

I understand that if my plan/policy is rescinded, I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be considered for benefits. I also understand that, consistent with California law, I will be required to pay for any services Anthem Blue Cross paid on my behalf and that Anthem Blue Cross will refund any premium paid by me, less my medical expenses that Anthem Blue Cross paid.

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE AGREEMENT OR ANY OTHER ISSUES RELATED TO THE AGREEMENT 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. FOR CLAIMS THAT EXCEED THE JURISDICTION OF THE SMALL CLAIMS COURT THAT ARE SUBJECT TO BINDING ARBITRATION UNDER THIS AGREEMENT, CALIFORNIA HEALTH AND SAFETY CODE SECTION 1363.1 AND INSURANCE CODE SECTION 10123.19 REQUIRE SPECIFIED DISCLOSURES IN THIS REGARD: 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 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. IF YOUR AGREEMENT IS SUBJECT TO 45 CFR 147.136, THIS AGREEMENT DOES NOT LIMIT YOUR RIGHTS TO INTERNAL AND EXTERNAL REVIEW OF ADVERSE BENEFIT DETERMINATIONS AS REQUIRED BY THAT LAW. 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.

Please sign below

	Primary Applicant (or legal representative)	Date (mm/dd/yyyy) / /
	Spouse/Domestic Partner (or legal representative)	Date (mm/dd/yyyy) / /
	Dependent (age 18 or over)	Date (mm/dd/yyyy) / /
	Dependent (age 18 or over)	Date (mm/dd/yyyy) / /
	Dependent (age 18 or over)	Date (mm/dd/yyyy) / /

Did an agent or broker help you?

☐ Yes ☐ No If yes, make sure they fill out this section.

Agent (or Broker) Certification All fields required.

I certify to the best of my knowledge and belief, the responses herein are accurate.

☐ I have not had any interactions whatsoever with this applicant either by phone, email or in person and did not provide any information, advise or assist the applicant in any manner in providing answers or responses to any questions in the application.

☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code Section 1389.8(c)/Insurance Code Section 10119.3.

Agent/Broker signature	**Date** (mm/dd/yyyy) / /

Agent name (please print clearly)

***(A) Writing Agent TIN/SSN** (encrypted TIN is ok)	****(B) Writing Agent/Agency/ TIN** (encrypted TIN is ok)

Agent address	**City**	**State**	**ZIP**

Agent phone no.	**Agent fax no.**	**Agent email**

***Field (A)** — If you are a Direct Agent, provide your Writing Agent TIN/SSN. ****Field (B)** — If this policy is sold through an Agency without a Writing Agent, enter the selling Agency TIN in Field (A) and Field (B); If you are a Writing Agent and this policy is sold through an Agency, enter the Writing Agent TIN/SSN in Field (A) and the selling Agency TIN in Field (B).

Medical only: For information on how your broker is compensated, please visit anthem.ly/ca-aca-58152.

Here's what's next.

1) Can you check a few items? When illegible or missing, they can cause enrollment delays.
   - Your name and address is clear and complete.
   - You've included your first month's premium payment.
   - Everyone 18 and older applying for coverage signed this form.
   - Please make sure you submit all the pages of the application, including this page, even if you don't have an agent.
   - If enrolling due to a qualifying event, you've completed Appendix A: Special Enrollment.

2) All good? Send this to us by mail to Anthem Blue Cross, P.O. Box 659960, San Antonio, TX 78265-9146 or by fax to 1 (800) 848-2512.

3) We'll be in touch in the next few weeks (or sooner). If you have questions before then, call us at 1 (855) 383-7247.

Thank you!

Appendix A: Special Enrollment

If you're applying for coverage due to a qualifying event, please fill out this section along with your application.

Qualifying event date	
Date of qualifying event (mm/dd/yyyy) / /	For Loss of Coverage, this is the last date of existing or prior coverage. For all other events, please enter the date based on the qualifying event.

You must apply for coverage within 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
☐ **1. Marriage or Domestic Partnership** Got married or in a domestic partnership that becomes eligible for coverage (see step 3 for description of eligibility).	First day of the month after we receive your complete application
☐ **2. Birth or adoption** Had a baby, adoption of a child or placement of a child with you for adoption	**Select an effective date:** ☐ Same as the event date ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application* ☐ First day of month after the event date
☐ **3. Court order or guardianship** Required by a court order to provide an eligible child(ren) coverage, including a child support order, filed an application for appointment of guardianship of a child or appointment of guardianship of a child	**Select an effective date:** ☐ Same as the event date ☐ Based on when we receive your complete application*
☐ **4. Death** Death of a family member enrolled under current coverage	**Select an effective date:** ☐ First day of the month after we receive your complete application ☐ Based on when we receive your complete application*
☐ **5. Problem with previous health coverage issuer** Health coverage issuer substantially violated material provision of health coverage contract ☐ **6. Lost service from contracted provider** Loss of services from contracting provider under another health benefit plan, as defined in Sections 10965 of the Insurance Code or 1399.845 of the Health and Safety Code, for a condition described in Health and Safety Code § 1373.96(c) (an acute condition, serious chronic condition, pregnancy, terminal illness, care of newborn between birth and 36 months of age, or performance of a surgery or other procedure that has been recommended and documented by the provider) and that provider is no longer participating in the health benefit plan ☐ **7. Returning from active duty** Member of the Reserve Forces of the U.S. military returning from active duty or member of the California National Guard returning from active duty under Title 32 of the U.S. Code ☐ **8. Misinformed about prior coverage** He or she demonstrates to the Exchange, with respect to health benefit plans offered through the Exchange, or to the department, with respect to health benefit plans offered outside the Exchange, that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage.	Based on when we receive your complete application*

* If the coverage date is based on when we receive your complete application, then if we receive it:

- Between the 1st and 15th day of the month, coverage starts the 1st day of the following month.
- Between the 16th and the last day of the month, coverage starts the 1st day of the second following month.

Qualifying events	Coverage effective date
☐ **9. Other qualifying event** If you can't find your situation, contact your agent/broker or call us. We can only enroll based on events defined by state and/or federal law Comments _____	Based on when we receive your complete application*

You must apply for coverage within 60 days before or 60 days after your qualifying event for the following events.

Qualifying events	Coverage effective date
☐ **10. Loss of coverage:** Lost or will lose Minimum Essential Coverage: Involuntary loss of coverage (loss of minimum essential coverage includes loss of eligibility of coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, permanent move, etc.). Loss of eligibility for coverage does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).	First day of the month after we receive your complete application
11. Permanent move ☐ Moved to U.S. from a foreign country or a U.S. territory ☐ Permanent move to a new service area (within the U.S.). ☐ **12. Non-calendar renewal** Current policy does not renew on a calendar year basis (renews on a date other than January 1) ☐ **13. Jail or prison** Released from jail or prison (incarceration)	Based on when we receive your complete application*
☐ **14. ICHRA or QSEHRA** Offered or gained access to Individual Coverage Health Reimbursement Arrangement (ICHRA)/Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) during your employer's annual open enrollment period or because of a change in employee status	If we receive your complete application before the qualifying event date: • Coverage will be effective on the qualifying event date if the qualifying event occurs on the first day of a month • Coverage will be effective on the first day of the month after the qualifying event if the qualifying event does not occur on the first day of a month If we receive your complete application on or after the qualifying event date: • Coverage will be effective on the first day of the month after receipt of your complete application

* If the coverage date is based on when we receive your complete application, then if we receive it:

- Between the 1st and 15th day of the month, coverage starts the 1st day of the following month.
- Between the 16th and the last day of the month, coverage starts the 1st day of the second following month.

Almost there! We may need a bit more info.

We need supporting documentation for most qualifying events, such as a letter or official form from the source (employer, state or federal agency, for example) to confirm the qualifying event occurred. It should also include the date the event happened, and the names of all applicants affected. If you're applying because you've lost coverage, we need supporting documentation with the reason coverage was lost. In all cases, we might need additional documentation to confirm eligibility.

Give us or your agent a call if you have any questions.

Appendix B: Statement of Accountability

Statement of Accountability Fill out when applicant cannot complete application.

Note: Interpreter must be 18 years or older to translate the application on behalf of the applicant.

I, _____, personally read and completed this Individual Application for the applicant named below because:

- ☐ Applicant does not read English
- ☐ Applicant does not speak English
- ☐ Applicant does not write English
- ☐ Applicant is Limited English Proficient
- ☐ Other (explain) _____

I interpreted the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by the

- ☐ Applicant or by: _____

Language interpreted

☐ Spanish ☐ Chinese ☐ Korean ☐ Tagalog ☐ Vietnamese ☐ Other _____

I also interpreted and fully explained the "Important legal information" and the "Payment Method".

Signature of interpreter (required)	**Date** (mm/dd/yyyy) (required) / /
I confirm that the application was interpreted on my behalf	
Signature of applicant (required)	**Date** (mm/dd/yyyy) (required) / /

Payment Methods for Individual Applications

Applicant/Member name	Primary applicant's Social Security number

I, the applicant am responsible for monthly payments to Anthem. I authorize Anthem to debit the bank account listed or charge the credit/debit card listed for my first monthly payment on or after the day that my coverage is approved. By signing this form, I understand that the amount of the first payment may change from what I was told because my coverage has not been approved yet. In addition if I select Option 1 or Option 2 below, I understand that my future payments may vary as a result of changes(s) I make once enrolled, including but not limited to, adding and deleting dependents, moving my residence, changing coverage and/or changes made by Anthem of which I am notified according to my plan/policy. In addition, I understand if changes I make are close to the auto withdrawal date, Anthem may not be able to notify me before the withdrawal is made. **I agree to pay any service charge that Anthem may bill me because the debit/charge was not honored.** I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Please choose how you want to pay your monthly payments for all of your plans. Put a check in the box for either Option 1, Option 2 or Option 3.

☐ **Option 1 Bank Account Authorization: Have your first and future monthly payments automatically deducted from your bank account.**

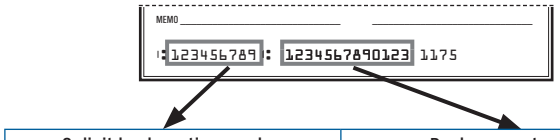
All of your monthly payments will be taken out of the **bank account** you check below.

Checking account: ☐ Business ☐ Personal

Savings account: ☐ Business ☐ Personal

Enter the requested debit date from your bank account ___ (1st to 6th of each month). If no date is requested your monthly payments will be debited on the first of each month.

Write the routing and account numbers that are on your check here: →



I authorize Anthem to automatically debit the **bank account** listed above each month to make my monthly payments. I agree that **Anthem's rights with each debit are the same as if the debit was a check that I signed.** I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem to automatically debit my account (and to make corrections to previous debits). This authority stays in effect until I let Anthem know that I no longer want them to debit my account by giving them a 30-day advance written notice. I understand that if my bank does not allow Anthem to debit my account for any reason, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Authorized signature (as it appears on bank's records)	Printed bank account holder's name (as it appears on account)	Date (MM/DD/YY)
X		

☐ **Option 2 Credit/Debit Card Authorization: Have your first and future monthly payments automatically charged to your credit/debit card.**

Complete the information below

Enter the requested charge date for your credit/debit card ___ (1st to 6th of each month).

I authorize Anthem to automatically charge my **credit/debit card** listed below each month to make my monthly payments. I understand monthly payments will be made on the day I've indicated or within 3 business days thereafter. I authorize Anthem to charge my credit/debit card until I let them know that I no longer want them to charge my credit/debit card by giving them a 30-day advance written notice. I agree that Anthem, in honoring the monthly payments charged to my credit/debit card, is not responsible for any fees charged by my bank. I understand if that if any Anthem credit/debit transaction is not honored, I will automatically be removed from automatic monthly payments and will be billed by mail. I understand if my monthly payment increases based on a certain percentage, Anthem will stop my automatic payments and send notification to me. I will have the option to restart the automatic monthly payments.

Anthem accepts ☐ **Visa or** ☐ **Mastercard (Note to applicant: Please check one.)**

Card number	Expiration date ___ (MM/YY)

Billing address for this credit/debit card	City	Zip code

Authorized signature (as it appears on card)	Printed card holder's name (as it appears on card)	Date (MM/DD/YY)
X		

See page two for *Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.*

Payment Methods for Individual Applications

Applicant/Member name	Primary applicant's Social Security number

☐ **Option 3 First Monthly Payment Only: Send us your first monthly payment now and receive a bill each month for your future monthly payments.**

Choose one of the ways below that you would like to pay only your first monthly payment.

☐ Check (enclose your paper check with application) ☐ Electronic check (fill out section A below) ☐ Credit/Debit card (fill out section B below)

A. **Electronic check:** Instead of sending us a paper check, you can use an electronic check that allows Anthem to take the money right from your bank account to make your first payment on the day that your coverage is approved. You will not get the check back from your bank. (We will not keep this information on file or use it for any future payments.) Please fill out this information.

Printed account holder name	Routing number	Account Number	Amount of first payment
			$

B. **Credit/Debit card:** I allow Anthem to charge the credit or debit card I listed below one time for my first monthly payment. This payment will cover the first monthly payment for all of the plans I have with Anthem.

Anthem accepts ☐ Visa or ☐ Mastercard (Note to applicant: Please check one.)

Card number	Expiration date (MM/YY)

Billing address for this credit/debit card	City	Zip code

I authorize Anthem to debit/charge the bank account or credit/debit card listed above **to make my first monthly payment only.**

I agree that Anthem will not have to pay any fees that my bank may charge because my electronic check or credit/debit card was rejected even if I can no longer continue coverage. I understand that **this is a one-time payment and that I am responsible for making sure Anthem receives my future monthly payments after this first payment.**

Authorized signature (as it appears on bank account/card)	Printed bank account/card holder's name (as it appears on account/card)	Date (MM/DD/YY)
X		

Get help in your language

Language Assistance Services

Anthem.

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721. (TTY/TDD: 711)

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese
重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。 1-888-254-2721 (TTY/TDD: 711)

107750CAMENABC 05/18 DMHC3 DMHCW #CA-DMHC-001#

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។
អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ
សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는 언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ। (TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้ เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.