Anthem Blue Cross – HMO Provider Finder Instructions

2. Under the Heading New Member & Visitor Search, click Next (orange tab)
3. Select a Plan Type: Large Group
4. Select a Plan: Blue Cross HMO (California Care)
5. Select a Provider Type: Primary Care Physicians
6. Select a Specialty, i.e. family practice, internal medicine, pediatrics, etc.
7. Click on Next (orange tab)
8. Enter in your address or zip code
9. Then click View Results (orange tab)
10. Scroll through providers and select a provider
11. Click on Provider Name to find the PCP ID/Enrollment ID (Paper/Online)
12. Use the assigned paper/online number to enroll with that physician

Repeat the above steps if you would like to select a different primary physician for other eligible dependents.

If you are having difficulty maneuvering through this website to find the provider code contact Anthem Blue Cross – HMO Membership Services 800-227-3771
Please return the completed enrollment form to your employer.

Employer Notice: After your review of the enrollment form for completeness, please fax or mail the form to:

Anthem Blue Cross
PO Box 829
Woodland Hills, CA 91365-0829

Fax no.: 877-363-1077
Email Address: CALSEnrollIntake@wellpoint.com
SECTION 4: DECLARATION — To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependents

A. Medical coverage declined for:
   - [ ] Myself
   - [ ] Spouse/DP
   - [ ] Child(ren)
   Reason for declining coverage — check one:
   - [ ] Covered by spouse's group coverage. Carrier name and ID no.: ____________________________
   - [ ] Covered by Anthem Blue Cross individual policy
   - [ ] Spouse covered by employer's group medical coverage. Carrier name:
   - [ ] Enrolled in Ticare
   - [ ] Enrolled in any other insurance carrier plan. Carrier name:
   - [ ] Medicare
   - [ ] Other (Explain):

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 MEDICAL AND/OR GROUP LIFE INSURANCE PLAN.

Signature if declining coverage for employee/dependent(s)

X

SECTION 5: COBRA/CAL-COBRA COVERAGE INFORMATION — Complete only if enrolling in COBRA/Cal-COBRA

Reason for COBRA/Cal-COBRA coverage:

Federal COBRA qualifying event date
Federal COBRA coverage begin date
Federal COBRA coverage end date

Cal-COBRA qualifying event date
Cal-COBRA coverage begin date
Cal-COBRA coverage end date

SECTION 6: OTHER COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS — All questions must be answered

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. Does any person applying for coverage currently have health insurance coverage? [ ] Yes [ ] No
   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 names:
   Type of continuous 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 names:
   Type of continuous 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.

SECTION 7: MEDICARE SECTION — Complete if you, your spouse or dependent child(ren) have Medicare coverage. Attach additional sheets if necessary.

<table>
<thead>
<tr>
<th>Name</th>
<th>Part A Effective Date</th>
<th>Part B Effective Date</th>
<th>Reason for Disability if Under Age 65</th>
<th>Medicare Claim No.</th>
</tr>
</thead>
</table>

SECTION 8: PRIOR COVERAGE FOR PPO PLANS ONLY — Attach additional sheets if necessary

Please fill out the following information to receive proper credit for PREVIOUS COVERAGE (if immediately prior to becoming eligible for this plan, you have a dependent child(ren) over the age of 29 who cannot get a self-sustaining job due to a physical or mental condition and was covered under any public or private health care coverage, including MediCal or individual coverage). NOTE: If this section is left blank, there may be delays in the processing of claims for these dependents.

<table>
<thead>
<tr>
<th>Name</th>
<th>Coverage Begin Date</th>
<th>Coverage End Date</th>
<th>Carrier Name</th>
<th>Reason for Ending Coverage</th>
</tr>
</thead>
</table>

...
### SECTION 8: LIFE INSURANCE BENEFICIARY DESIGNATION INFORMATION

**Note:** Dependent Life payments are always paid to the employee.

**Primary Beneficiary—First to receive payment (required):** If more than one beneficiary is named, enter a % for each. If no percentage is shown, equal shares are assumed.

<table>
<thead>
<tr>
<th>Name</th>
<th>Birthdate</th>
<th>Social security no.</th>
<th>Relationship</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street address</td>
<td>City</td>
<td>State</td>
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<td></td>
</tr>
</tbody>
</table>

### SECTION 10: PLEASE READ CAREFULLY—Signature required

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

**DEDUCTION AUTHORIZATION:** If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

**NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

**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.

**EFFECTIVE DATE:** The effective date of coverage is subject to Anthem Blue Cross approval.

**COBRA/CAL-COBRA CONTINUATION COVERAGE**

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice.

If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end.

If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1. The date eligibility for COBRA Continuation Coverage ends, or
2. The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3. The date your employer discontinues coverage with Anthem Blue Cross, or
4. The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5. The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title I or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

**Note:** If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

### REQUIREMENT FOR BINDING ARBITRATION

**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 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. 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, NEGLECTFULLY OR INCOMPETENTLY RENDERED, WILL BE DETERMINED BY SUBMISSION TO ARBITRATION AS PERMITTED AND AS 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. 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 AND PARTICIPATION IN A CLASS ACTION 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 (Required)**

Applicant

X

Date