PHBP BENEFITS ENROLLMENT AND CHANGE FORM

COMPLETED FORMS MUST BE SUBMITTED TO BENESYS ONLY. DUE TO PHI LAW, FORMS MUST NEVER BE SENT VIA UNSECURE EMAIL BY MAIL/OVERNIGHT (PHBP, C/O BeneSys, P.O. Box 2340 West Covina, CA 91793) or BY SECURE FAX (925-478-4839)

Anthem Blue Cross Medical Plans: Anthem PHBP Group Number: **277596** Employer Name (if applicable):_____

❑ Classic PPO Dept Code (Staff CA): **M004** ❑ Classic PPO Dept Code (Freelance CA): **M001**

❑ Classic PPO Dept Code (Staff OOS): **M010** ❑ Classic PPO Dept Code (Freelance OOS): **M007**

❑ Anthem Dental PPO Complete (Staff & Freelance) **Group Number: 935803**

❑ Open Enrollment ❑ New Enrollee ❑ Other Change ❑ Family Addition ❑ Freelance ❑ Staff

Effective Date:_____ *Qualifying Event and Event Date: _____

EMPLOYEE INFORMATION (Please Print Clearly)

Last Name _____ First Name _____ MI _____ Maiden Name (if applicable) _____ Job Title _____

Residential Address _____ City _____ State _____ Zip Code _____ ❑ Single ❑ Married ❑ Divorced

❑ Domestic Partner (DP)**

Mailing Address *(if different from residential)* _____ City _____ State _____ Zip Code _____

(___) _____ Business Phone (___) _____ Home Phone _____ Employer-Provided E-mail *(Required)*

Language Preference ❑ English ❑ Other:_____

Date of Hire:_____ Re-Hire Date:_____ Part-Time to Full Time Employment Date:_____

*If you are adding you or dependent outside the annual open enrollment period, you must submit this form along with the necessary documents (birth cert, proof of prior coverage, marriage cert, etc) within 30 days of the date of the change or no approval can be granted. **To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships. ***If you are eligible for Medicare, Anthem Blue

IF ENROLLING A SPOUSE OR CHILD, PLEASE PROVIDE A COPY OF YOUR MARRIAGE CERTIFICATE AND/OR YOUR CHILD'S BIRTH CERTIFICATE.

ENROLLMENT INFORMATION

	First Name	Last Name	MI	Social Security #	Sex	Date of Birth	Age 26 & Over	Plans
SELF ❑Decline							Check appropriate boxes below	ANTHEM MEDICAL PPO AND ANTHEM DENTAL + VSP ENROLLED IN MEDICARE *** ❑
SPOUSE ❑ **DP**** ❑ ❑ Add ❑ Delete ❑Decline							IRS Qualified Dependent	ANTHEM MEDICAL PPO AND ANTHEM DENTAL + VSP ENROLLED IN MEDICARE *** ❑
CHILD ❑ Add ❑ Delete ❑Decline							❑ Yes ❑ No	ANTHEM MEDICAL PPO AND ANTHEM DENTAL + VSP VISON
CHILD ❑ Add ❑ Delete ❑Decline							❑ Yes ❑ No	ANTHEM MEDICAL PPO AND ANTHEM DENTAL + VSP VISION
CHILD ❑ Add ❑ Delete ❑Decline							❑ Yes ❑ No	ANTHEM MEDICAL PPO AND ANTHEM DENTAL + VSP VISION
CHILD ❑ Add ❑ Delete ❑Decline							❑ Yes ❑ No	ANTHEM MEDICAL PPO AND ANTHEM DENTAL + VSP VISION

Reason for Declining Coverage (Check One)

❑ Covered by spouse's Plan: *Carrier Name and ID#* _____ ❑ Medicare ❑ Covered by Individual Plan ❑ Enrolled in Tricare ❑ Spouse Covered by Employer

❑ Enrolled in any other plan: *Carrier*_____ ❑*Other*: _____

Check box if additional sheet is attached to this application ❑

ONLY SIGN IF YOU ARE REFUSING COVERAGE FOR YOURSELF OR YOUR ELIGIBLE DEPENDENTS - DECLINATION/REFUSAL OF INSURANCE

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 DENTAL GROUP LIFE INSURANCE PLAN. BY DECLINING THE GROUP VISION COVERAGE, I ALSO ACKNOWLEDGE THAT MY DEPENDENTS AND I WILL NOT HAVE ANY OPPORTUNITY IN THE FUTURE TO ENROLL IN THE PLAN UNLESS WE CAN SHOW PROOF OF LOSS OF OTHER VISION COVERAGE.

X _____ _____

Employee Signature (if REFUSING/DECLINING coverage for employee and/or dependents) **Date**

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(s): _____ Insurance Co: _____ ❑ Primary

B. Does any person or persons applying for coverage currently have health insurance coverage?
❑ Yes ❑ No Effective Date of Other Coverage:_____

C. Has any person or persons 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 continuous coverage: ❑ Group ❑ Individual ❑ Other: _____
Insurance company: _____
Date coverage began: _____ Date coverage ended: _____

D. Does any person applying for coverage currently have dental insurance coverage? ❑ Yes ❑ No
if yes, applicant/family member name(s): _____ ❑ Group ❑ Individual ❑ Other: _____
Insurance company: _____
Date coverage began: _____ Date coverage ended: _____

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

SIGNATURE

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 AUTHORI ZATION : 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 and VSP approval for Vision Plan Only.

REQUIREMENT FOR BINDING ARBITRATION

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUECROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDERTHE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICALMALPRACTI CE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITT ED TO BINDING ARBITR ATION 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, negligently 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 TRI AL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANYOTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTH ER ISSUES RELATED TO THE PLAN/POLICY.

I, the applicant, acknowledge that I have read and understood this application in its entirety and agree to the terms therin.

X _____ _____

Employee Signature (required for ALL Enrollees) **Date**