PHBP

FREELANCE EMPLOYEE ENROLLMENT AND CHANGE FORM (CALIFORNIA PARTICIPANTS)

Completed forms must be submitted to BeneSys Administrators only. Please mail this form to: **PHBP, c/o BeneSys, P.O. Box 2340, West Covina, CA 91793** or fax to **(925) 478-4839**. You can also submit the form via email to staff@PHBPBenefits.org. Please be careful to ensure that you transmit this information securely (*e.g.* avoid public internet connections or using someone else's computer to send the information).

WHO COMPLETES THIS FORM

- All Participants migrating to the California Classic HMO
- All Participants migrating to the Classic Premier PPO with changes to Dependents
- All Participants continuing with the Classic Premier PPO with changes to Dependents

WHO DOES NOT NEED TO COMPLETE THIS FORM

- All Participants migrating to the Classic Premier PPO with NO changes to dependents
- All Participants continuing with the Classic Premier PPO with NO changes to dependents

USE THIS FORM FOR:

- The January 2019 roll-over to tiered coverage for all Participants and their Dependents. **THIS IS DUE DECEMBER 15, 2018.**
- Changes to your selected Primary Care Physician (PCP) for HMO Participants and their Dependents. These changes can be made anytime.
- Tier changes upon the annual renewal for Participants and their Dependents.
- Changes, Additions, or Subtractions of Dependents that can only take place during the annual open enrollment which coincides with the Participant's annual renewal.
- Adding Dependents during non-enrollments periods within 30 days of a 'Qualifying Event' such as a marriage, birth, adoption, or cancellation of a spouse's prior coverage. Supporting documentation (marriage, birth, or adoption certificates or proof of prior coverage) must be submitted to BeneSys Administrators at staff@PHBPBenefits.org.
- Newly eligible participants.

EMPLOYEE INFORMATION

FIRST NAME	MIDDLE INITIAL	LAST NAME	MAIDEN NAME (IF APPLICABLE)

ADDRESS	CITY	STATE	ZIP CODE

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED	EMAIL ADDRESS

HOME PHONE	BUSINESS PHONE	LANGUAGE PREFERENCE

Medical Plans (Select One)

Income tiers determine your coverage tier.

Income Tiers

- Under $75,000: PHBP California Classic HMO
- $75,000-$109,999.99: PHBP California Classic HMO with option to buy up
- $110,000+: PHBP Classic Premier PPO

Select a Coverage Tier

☐ PHBP California Classic HMO
☐ PHBP Classic Premier PPO

Life Insurance Beneficiaries

Please select a beneficiary or beneficiaries for your life insurance benefits. You must list what percentage of the life insurance benefit (e.g. 50%) you wish each beneficiary to receive.

BENEFICIARY			
☐ ADD ☐ DELETE	FIRST NAME	LAST NAME	MI
SOCIAL SECURITY NUMBER	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH	PERCENTAGE OF BENEFIT

BENEFICIARY			
☐ ADD ☐ DELETE	FIRST NAME	LAST NAME	MI
SOCIAL SECURITY NUMBER	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH	PERCENTAGE OF BENEFIT

BENEFICIARY			
☐ ADD ☐ DELETE	FIRST NAME	LAST NAME	MI
SOCIAL SECURITY NUMBER	GENDER ☐ MALE ☐ FEMALE	DATE OF BIRTH	PERCENTAGE OF BENEFIT

Enrollment Information

HMO Participants can go to **phbp.org/downloads/2019_California_Find_a_Doctor_PPO.pdf** for information on how to select a Primary Care Physician (PCP). If enrolling a spouse or child, please provide a copy of your marriage certificate and/or your child's birth certificate. If you are going to be covered under the California Classic HMO, you must provide the Anthem Blue Cross Primary Care Physician (PCP) Number for your primary care doctor for each eligible person.

MEMBER				
☐ ADD ☐ DELETE ☐ DECLINE	FIRST NAME	LAST NAME	MI	GENDER ☐ MALE ☐ FEMALE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	MEDICARE ELIGIBLE ☐ YES ☐ NO	ANTHEM IPA/PCP NUMBER (HMO ONLY)	

ENROLLMENT INFORMATION (CONTINUED)

SPOUSE					
☐ ADD ☐ DELETE ☐ DECLINE	FIRST NAME	LAST NAME		MI	GENDER ☐ MALE ☐ FEMALE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	MEDICARE ELIGIBLE ☐ YES ☐ NO	ANTHEM IPA/PCP NUMBER (HMO ONLY)		

CHILD 1					
☐ ADD ☐ DELETE ☐ DECLINE	FIRST NAME	LAST NAME		MI	GENDER ☐ MALE ☐ FEMALE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	MEDICARE ELIGIBLE ☐ YES ☐ NO	ANTHEM IPA/PCP NUMBER (HMO ONLY)		

CHILD 2					
☐ ADD ☐ DELETE ☐ DECLINE	FIRST NAME	LAST NAME		MI	GENDER ☐ MALE ☐ FEMALE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	MEDICARE ELIGIBLE ☐ YES ☐ NO	ANTHEM IPA/PCP NUMBER (HMO ONLY)		

CHILD 3					
☐ ADD ☐ DELETE ☐ DECLINE	FIRST NAME	LAST NAME		MI	GENDER ☐ MALE ☐ FEMALE
SOCIAL SECURITY NUMBER	DATE OF BIRTH	MEDICARE ELIGIBLE ☐ YES ☐ NO	ANTHEM IPA/PCP NUMBER (HMO ONLY)		

OTHER COVERAGE INFORMATION

Do you or your dependents currently have health insurance coverage or have you had other coverage during the last six (6) months (please provide a separate sheet, if necessary)?

☐ YES ☐ NO NAME OF PERSON(S) COVERED _____

TYPE OF COVERAGE: ☐ GROUP ☐ INDIVIDUAL ☐ OTHER _____

INSURANCE COMPANY _____

DATE COVERAGE BEGAN: _____ DATE COVERAGE ENDED: _____

Do you or your dependents intend to continue other group health coverage if this application is accepted?

☐ YES ☐ NO NAME OF PERSON(S) COVERED _____

INSURANCE COMPANY _____

Do you or your dependents currently have dental coverage?

☐ YES ☐ NO NAME OF PERSON(S) COVERED _____

TYPE OF COVERAGE: ☐ GROUP ☐ INDIVIDUAL ☐ OTHER _____

INSURANCE COMPANY _____

DATE COVERAGE BEGAN: _____ DATE COVERAGE ENDED: _____

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 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.

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage)
ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY (ANTHEM), 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, 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. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: 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 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. 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 providing your "handwritten or electronic" signature below, you acknowledge that such signature is valid and binding.

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

EMPLOYEE SIGNATURE	DATE
X	