Employee Enrollment Application
EmployeeElect for 1–50 Employee Small Groups
California

Anthem BlueCross

Health care plans offered by Anthem Blue Cross. Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company.

You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, answer all questions and be sure to sign and date your application.

Note: Social Security Numbers are required under Centers for Medicare & Medicaid (CMS) regulations.

Submit application to: Small Group Services
Anthem Blue Cross
PO Box 9062
Oxnard, CA 93031-9062
anthem.com/ca

Group no. (if known) 341267

Please complete in blue or black ink only.

Section A: Employee Information

Last name	First name	M.I.	Social Security no.* (required)

Home address – Street and PO Box if applicable

City	State	ZIP code

Marital status	Primary phone no.	Number of dependents
☐ Single ☐ Married ☐ Domestic Partner		

Employee email address

Employer name: RIVERSIDE PERSONNEL SERV

Employer street address: 3590 CENTAL AVENUE #200

City	State	ZIP code
RIVERSIDE	CA	92506

Employment status	Occupation	Hire date (MM/DD/YYYY)	No. of hours worked per week
☑ Full time ☐ Part time ☐ Disabled			

Language choice (optional): ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese ☐ Tagalog ☐ Other – please specify: _____

Do you read and write English?
☑ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability

Section B: Application Type

Select one

☑ New enrollment
☐ Open enrollment
☐ Family addition Event date:
☐ COBRA
☐ Cal-COBRA
Cal-COBRA applicants must submit first month's premium.

Select qualifying event
☐ Left employment
☐ Loss of dependent child status
☐ Covered employee's Medicare entitlement
☐ Reduction in hours
☐ Divorce or legal separation
☐ Death

Note: For Cal-COBRA/COBRA applicants: Effective date of qualifying event:

*Anthem Blue Cross is required by the Internal Revenue Service to collect this information.

Social Security no.

Section E: Other Group Coverage

Are you or anyone applying for coverage currently eligible for Medicare? ☐ Yes ☐ No

If yes, give name: _____

Medicare ID no.	Part A effective date	Part B effective date	Medicare eligibility reason (check all that apply)
			☐ Age ☐ Disability ☐ ESRD: Onset date _____

Medicare Part D ID no.	Medicare Part D Carrier	Part D effective date

Is anyone applying for coverage covered by other health, dental, or vision coverage? ☐ Yes ☐ No

If yes to any of these questions, please provide the following:

Name of person covered (Last name, first, M.I.)	Type (check one)	Coverage (check all that apply)	Carrier name	Carrier phone no.	Policy ID no.	Dates (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision				Start: / / End: / /
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Vision				Start: / / End: / /

Section F: Waiver/Declining Coverage – Proof of coverage will be required

Medical coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Dental coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

Vision coverage declined for – check all that apply: ☐ Myself ☐ Spouse/Domestic Partner ☐ Dependent(s)

*Life coverage declined for: ☐ Myself

Reason for declining coverage – check all that apply:

- ☐ Covered by Spouse's/Domestic Partner's group coverage
- ☐ Enrolled in other insurance –
  Please provide company name and plan: _____
- ☐ Enrolled in Individual coverage
- ☐ Spouse/Domestic Partner covered by employer's group medical Coverage
- ☐ Medicare/Medicaid/VA
- ☐ Other – please explain: _____
- ☐ No coverage

List names of dependents to be waived: _____

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 waive coverage. BY WAIVING 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 UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT.

Special Open Enrollment

If you declined enrollment for yourself or your dependent(s) (including a spouse/domestic partner), you may be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of certain triggering events, including: (1) you or your dependant loses minimum essential coverage; (2) you gain or become a dependent; (3) you are mandated to be covered as a dependent pursuant to a valid state or federal court order; (4) you have been released from incarceration; (5) your health coverage issuer substantially violated a material provision of the health coverage contract; (6) you gain access to new health benefit plans as a result of a permanent move; (7) you were receiving services from a contracting provider under another health benefit plan, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan; (8) you are a member of the reserve forces of the United States military or a member of the California National Guard, and returning from active duty service; or (9) you demonstrate to the department that you did not enroll in a health benefit plan during the immediately preceding enrollment period because you were misinformed that you were covered under minimum essential coverage. You must request special enrollment within 60 days from the date of the triggering event to be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of a qualifying triggering event.

*I hereby certify that I have been given the opportunity to apply for the available group life benefits offered by my employer, the benefits have been explained to me, and I and/or my dependent(s) decline to participate. Neither I nor my dependent(s) were induced or pressured by my employer, agent, or life carrier, into declining this coverage, but elected of my (our) own accord to decline coverage. I understand that if I wish to apply for such coverage in the future, I may be required to provide evidence of insurability at my expense. Please examine your options carefully before waiving this coverage.

Sign here only if you are declining coverage.

Signature of applicant	Printed name	Date (MM/DD/YYYY)
X		/ /