

Email Address: _____



2-50 Existing Small Group Employee Addition Application

For adding new employees and their eligible dependents to existing coverage

Employee Application

Small Group Services
 Anthem Blue Cross
 P.O. Box 9062
 Oxnard, CA 93031-9062
 anthem.com/ca

Anthem Blue Cross offers: Premier PPO plans, PPO Copay plans, High Deductible EPO, Saver HMO, Classic HMO, HMO 100%, Select HMO, Saver HMO, Classic HMO, HMO 100%, Dental Net and Dental SelectHMO.

Anthem Blue Cross Life and Health Insurance Company offers: Basic PPO, Saver PPO, Solution plans, PPO Copay GenRx, Element Hospital plans, HIA plans, Lumenos HIA Plus 750, Lumenos HIA Plus 500, Lumenos HSA (80/50) plans, Lumenos (100/70) plans, PPO 3500, PPO 2400, Advantage PPO; all dental products except Dental Net and Dental SelectHMO; Life and AD&D plans.

INSTRUCTIONS

- You, the employee, must complete this application. You are solely responsible for its accuracy and completeness.
- All questions must be answered in full; all signatures and dates must be included where noted; otherwise, the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
- Type or print clearly using blue or black ink. Requested Effective Date (MM/DD/YY): _____ Group no. _____

1 COVERAGE - Please verify with your employer which plans are available.

A. MEDICAL COVERAGE SELECTION - Check only one Medical Plan:

MemberID
 | | | | | | | | | |

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Basic PPO | <input type="checkbox"/> Lumenos HSA 2000 (100/70) | <input type="checkbox"/> Premier PPO \$10 Copay | <input type="checkbox"/> Solution 5000 PPO | <input type="checkbox"/> Saver HMO |
| <input type="checkbox"/> Saver PPO | <input type="checkbox"/> Lumenos HSA 3000 (100/70) | <input type="checkbox"/> Premier PPO \$20 Copay | <input type="checkbox"/> High Deductible EPO | <input type="checkbox"/> Saver \$20 HMO |
| <input type="checkbox"/> PPO \$25 Copay GenRx | <input type="checkbox"/> Lumenos HSA 1500 (80/50) | <input type="checkbox"/> Premier PPO \$30 Copay | <input type="checkbox"/> HMO 100% | <input type="checkbox"/> Saver \$30 HMO |
| <input type="checkbox"/> PPO \$35 Copay GenRx | <input type="checkbox"/> Lumenos HSA 2500 (80/50) | <input type="checkbox"/> Power HealthFund 500 | <input type="checkbox"/> HMO \$10 100% | <input type="checkbox"/> Saver \$40 HMO |
| <input type="checkbox"/> PPO \$45 Copay GenRx | <input type="checkbox"/> Lumenos HSA 3500 (80/50) | <input type="checkbox"/> Power HealthFund 750 | <input type="checkbox"/> HMO \$25 100% | <input type="checkbox"/> Select HMO |
| <input type="checkbox"/> PPO \$20 Copay | <input type="checkbox"/> Lumenos HIA 500 | <input type="checkbox"/> PPO 2400 (HSA-Compatible) | <input type="checkbox"/> Classic HMO | <input type="checkbox"/> Select \$25 HMO |
| <input type="checkbox"/> PPO \$30 Copay | <input type="checkbox"/> Lumenos HIA 750 | <input type="checkbox"/> PPO 3500 (HSA-Compatible) | <input type="checkbox"/> Classic \$20 HMO | <input type="checkbox"/> Select \$35 HMO |
| <input type="checkbox"/> PPO \$40 Copay | <input type="checkbox"/> Lumenos HIA Plus 3000 | <input type="checkbox"/> Solution 2500 PPO | <input type="checkbox"/> Classic \$30 HMO | <input type="checkbox"/> Elements Hospital Preferred |
| <input type="checkbox"/> Lumenos HSA 1500 (100/70) | <input type="checkbox"/> Advantage PPO \$25 Copay | <input type="checkbox"/> Solution 3500 PPO | <input type="checkbox"/> Classic \$40 HMO | <input type="checkbox"/> Elements Hospital Plus |
| | | | | <input type="checkbox"/> Elements Hospital |
| | | | | <input type="checkbox"/> Other: _____ |

If selecting an HMO, you must select a Primary Medical Group (PMG) or an Independent Practice Association (IPA).

If you are selecting an IPA, please select a Primary Care Physician for each enrolling family member and list by number below in Section 3A.
 HMO plan PMG or IPA Medical Office Number: _____ Are you currently a patient of this facility? Yes No

B. DENTAL COVERAGE SELECTION - (if group has elected Dental Coverage) - Check only one Dental Plan:

- | | | | |
|--|--------------------|---|---|
| <input type="checkbox"/> Dental Blue Silver | 100-80 100 200 300 | <input type="checkbox"/> Basic Option PPO* | You must select a dental office number for the following plans: _____ Dental Office No. <input type="checkbox"/> Dental Net <input type="checkbox"/> Dental SelectHMO |
| <input type="checkbox"/> Dental Blue Silver Plus | 100-80 100 200 300 | <input type="checkbox"/> Standard Option PPO* | |
| <input type="checkbox"/> Dental Blue Gold | 100-80 100 200 300 | <input type="checkbox"/> High Option PPO* | |
| <input type="checkbox"/> Dental Blue Gold Plus | 100-80 100 200 300 | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Dental Blue Platinum | 100-80 100 200 300 | | |
| <input type="checkbox"/> Dental Blue Platinum Plus | 100-80 100 200 300 | | |

*Fee-for-service dental coverage is substituted if the member is outside of PPO dental service area.

Voluntary Dental Coverage
 PPO Dental Plan**
 Dental Saver SelectHMO - You must select a dental office number

- C. VISION** Yes No Blue View Blue View Plus
- D. OPTIONAL DEPENDENT LIFE INSURANCE - (Available only if offered by employer.)** Yes No
- E. SUPPLEMENTAL LIFE INSURANCE - (Available only if offered by employer.)** Yes No Amount: \$15,000 \$25,000 \$50,000 \$100,000

2 EMPLOYEE INFORMATION - Must be completed by employee.

- | | | | |
|--|-----------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Family addition | <input type="checkbox"/> New hire | <input type="checkbox"/> COBRA | COBRA/Cal-COBRA Effective Date: _____ |
| <input type="checkbox"/> Late enrollment | <input type="checkbox"/> Other | <input type="checkbox"/> Cal-COBRA* | |

*Cal-COBRA applicants must submit first month's premium.

| | | | | |
|--|--|---|--|---|
| Last name | First name | M.I. | Marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic partner (DP) | Social Security or ID no. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
| Home address (P.O. box not acceptable unless rural P.O.) | | Apt no. | # of dependents including spouse* | Spouse/DP Social Security or ID no. _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ |
| City | | State | ZIP code | Home phone no. () |
| Hire/Join Date (MMDDYY) | Employer name | Occupation/Job title | <input type="checkbox"/> Part time <input checked="" type="checkbox"/> Full time | # of Hours Worked per week (W2 Empls Only) |
| Business phone no. () | Salary (required) \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly | Life insurance beneficiary - last name, first, M.I. | | Relationship |

Language choice (optional) English Spanish Chinese Korean

*Spouse includes domestic partner ONLY if your employer has elected that coverage. If coverage is available, domestic partner enrollment requires submission of a signed and notarized Domestic Partner Affidavit or, if applicable, a copy of a valid Declaration of Domestic Partnership filed with and stamped by the Secretary of State of California.



3 EMPLOYEE / DEPENDENT INFORMATION – List yourself and only those eligible dependents who are enrolling.

An eligible “dependent” is an employee’s lawful spouse or domestic partner (if employer has elected to cover domestic partners); a child (except a newborn) of an employee who is the permanent legal guardian of that child and for which a valid court order establishing guardianship has been submitted; the unmarried child(ren) of the employee or, of the employee’s spouse who are under age 19, or, the unmarried child(ren) of the employee or enrolled spouse from the nineteenth (19th) to the twenty-fourth (24th) birthday who qualify as dependents for federal income tax purposes and are full time students. Anthem Blue Cross requires written proof of student status annually.

If spouse’s last name is different from yours, is he/she a domestic partner? Yes No

FAMILY ADDITION: Date of marriage: _____ Date of Adoption: _____

Social Security or ID no.

Spouse/DP Social Security or ID no.

3A. HMO only - IPA
 If you select an IPA you must choose a primary care physician for each member of your family.

| Sex | Last Name | First Name | MI | Height | Weight | Disabled? | Birthdate Mo. Day Year | Primary Care Physician No. |
|---|------------|------------|----|--------|--------|--|---------------------------|----------------------------|
| <input type="checkbox"/> Male <input type="checkbox"/> Female | Employee | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | Spouse/DP* | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |
| <input type="checkbox"/> Son <input type="checkbox"/> Daughter | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ | _____ |

4 COVERAGE DECLINATION – To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependents. Proof of coverage may be required.

- A. Health Plan coverage declined for:**
 Myself Spouse/DP*
 Child(ren)
- B. Dental coverage declined for:**
 Myself Spouse/DP*
 Child(ren)
- C. Vision coverage declined for:**
 Myself Spouse/DP*
 Child(ren)
- D. Life Insurance declined for:**
 Myself Spouse/DP*
 Child(ren)

- Reason for declining coverage: (Check one)**
- Covered by spouse’s group coverage -
Carrier name and ID number: _____
 - Covered by Anthem Blue Cross Individual Policy
 - Spouse covered by employer’s group medical coverage -
Carrier name: _____
 - Covered by Tricare
 - 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. PRE-EXISTING CONDITIONS, WHEN ENROLLED IN THIS GROUP MEDICAL PLAN, MAY NOT BE COVERED FOR SIX (6) MONTHS.**

X _____ Date (Month/Day/Year)

Signature if declining coverage for employee/dependent(s)

*Spouse includes domestic partner ONLY if your employer has elected that coverage. If coverage is available, domestic partner enrollment requires submission of a signed and notarized Domestic Partner Affidavit or, if applicable, a copy of a valid Declaration of Domestic Partnership filed with and stamped by the Secretary of State of California.

| |
|---------------------------|
| Social Security or ID no. |
| |

5 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 name(s): _____
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
Type of continuous coverage: Group Individual Other: _____
If Yes, Applicant/family member name(s): _____
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.

SUBMIT PROOF OF COVERAGE – To comply with federal and state laws, proof of this coverage must accompany this application.

Acceptable forms of proof are:

1. Certificate of coverage from prior carrier, *or*
2. Copy of ID card *and* copy of payroll stub showing medical coverage deduction, *or*
3. Copy of most recent medical premium bill or certificate of coverage from prior carrier.

Failure to advise and provide proof of coverage may subject you or a family member to a six month pre-existing conditions clause.

6 AUTHORIZATION – The following Authorization is to be signed by ALL EMPLOYEES applying for coverage.

I AGREE: To the best of my knowledge and belief, all information on this form is correct and true. I understand that this application and any information Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company obtains prior to the effective date of coverage is the basis on which coverage may be issued under the plan. I authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at my employer's place of business in permanent employment.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and any application made by my employer have been accepted and approved by ANTHEM BLUE CROSS and/or ANTHEM BLUE CROSS LIFE and HEALTH INSURANCE COMPANY.

I AM APPLYING FOR PPO COVERAGE: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider. If a PPO Plan is selected and a non-participating provider is used, medical payments will be based upon the lesser percentage of the negotiated fee rate and I will be responsible for any amount over that payment.

I AM APPLYING FOR HMO COVERAGE: I understand that I am responsible for paying for services rendered that are not authorized by my primary medical group.

I AM APPLYING FOR a Health Savings Account (HSA) compatible EPO PLAN: I understand that the High Deductible plans are designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. I understand that having this coverage does not establish an HSA. To do so, I must contact a qualified financial institution. Also, I understand that I should consult my tax advisor.

Continued on next page



| | | | | | | | | | |
|---------------------------|--|--|--|--|--|--|--|--|--|
| Social Security or ID no. | | | | | | | | | |
| | | | | | | | | | |

6 AUTHORIZATION – Continued

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.

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.

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

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. *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 provided by California law, 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 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.

All signatures and dates below are required if applying for coverage.

| | |
|---------------------------------------|-----------------|
| Signature of employee X | Date (MM/DD/YY) |
|---------------------------------------|-----------------|

see above

After completion, sign Authorization and submit application to your employer. Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.





Application Checklist

- Remember to **answer** all questions and **sign** the application(s) for the plan(s) you are choosing.
- Enclose initial month's premium payment (**even if you are selecting the Automatic Premium Payment option**). Include premiums for all applicable insurance plans (medical, dental, vision, and life insurance). If you are enrolling with Anthem Blue Cross, you may be required to **send two months of premium with your application**. After your initial payment you will pay a single monthly premium. Please check with your agent, or call RealCare, to confirm the minimum payment due with your application.
- Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- If you are choosing the Automatic Premium Payment method, enclose a **voided check** and complete the form below and return to RealCare with your initial premium check. **The initial premium must be submitted even if you select the Automatic Premium Payment option.**
- Include **proof of eligibility** if you are a new C.A.R. member or W-2 employee of a C.A.R. member. If you are enrolling outside of open enrollment, you must have a qualifying event. Please refer to the General Guidelines "Special Enrollment Provision" section to review a list of qualifying events.
- Have questions or need assistance? Call 1-800-939-8088 Ext. 202

Mail Applications to:
RealCare Insurance Marketing, Inc.
19310 Sonoma Hwy. Ste. A
Sonoma, CA 95476

MONTHLY CHECKING/SAVINGS ACCOUNT AUTOMATIC PREMIUM PAYMENT AUTHORIZATION

As a convenience to me, I request and authorize RealCare Insurance Marketing, Inc. to pay and charge to my account indicated below checks drawn on that account by and payable to the order of RealCare Insurance Trust Account (RITA) provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize RealCare Insurance Marketing, Inc. to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my health care dues and/or insurance premiums, adjustments and administration fees due. This authority is to remain in effect until revoked by me by providing RealCare Insurance Marketing, Inc. a 10-day advance written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, RealCare Insurance Marketing, Inc. shall be under no liability whatsoever even though such dishonor results in forfeiture of health care or insurance coverage.

If I am enrolled in an Anthem Blue Cross plan, payments will be debited from my account on the first of the month following the due date. If I am enrolled in a Kaiser plan or only enrolled in a dental, vision, and/or life insurance plan, payments will be debited from my account on the fifth of the month following the due date. If any such debits are dishonored, I agree to make payment to RealCare Insurance Trust Account (RITA) by cashier's check or money order before the end of the 30-day grace period in order to keep my health care and/or insurance coverage in force. I authorize any changes in premium and administration fees to be debited unless I notify RealCare Insurance Marketing, Inc. to terminate my health care and/or insurance coverage.

| | |
|--|----------------------|
| <i>Policyholder Information</i> | |
| Policyholder name: _____ | Phone: _____ |
| Social Security Number: _____ | Email Address: _____ |

**PLEASE
ATTACH A
COPY OF
YOUR VOIDED
CHECK AND
SUBMIT WITH
YOUR
ENROLLMENT
APPLICATION.**

| | |
|--|--|
| <i>Banking Information</i> | |
| Name of bank or financial institution: _____ | |
| Bank Account Name: _____ | |
| <input type="checkbox"/> Checking Account | <input type="checkbox"/> Savings Account |
| Account Number: _____ | |
| Bank Routing Number: _____ | |

| | |
|--|-------------|
| <i>Authorized Signature</i> | |
| _____ | Date: _____ |
| Authorized Signature <i>(As it appears in the financial institution's records)</i> | |



C.A.R. ENROLLMENT & PAYMENT INSTRUCTIONS

For Assistance, Call RealCare Insurance Marketing at (800) 939-8088

Step 1: Calculate Rates

Medical Plans

Medical rates are based on a Medical Rating Region for each carrier. The region is determined by the county and zip code for the address stated on the subscriber's Anthem Blue Cross application form. This address is used to determine the rating area, and for mailing all correspondence from Anthem Blue Cross including your ID cards, the Explanation of Coverage (EOC), and Explanation of Benefits (EOB) forms generated when claims are submitted.

Follow the steps below to calculate your rate:

1. Look up your county and zip code on the Medical Rating Regions page. *(If your county is included in more than one rating region, check to find your zip code to determine what rating region to use.)*
2. Find the rate table that applies to your rating region.
3. To determine the rate, look up the subscriber's attained age as of the requested effective date. To determine the rate, look up the subscriber's age, the plan chosen and which dependents (if any) are to be enrolled. Rates are based on the subscriber's attained age as of the requested effective date; and will change effective the first day of the month following the subscriber's birthday when the attained age moves to another age category.
4. **Calculate the first two months of premium.** Because of enrollment and billing dates, Anthem Blue Cross enrollees are required to send the first two month's premium payment with the application.
5. Add \$20 monthly administration fee for each month of premium submitted.

Dental/Vision/Life

The dental rates are based on the MetLife dental rating region. The rating region is determined by the county and in some cases the zip code in which the subscriber lives. The vision rates are not based on region but are determined by which (if any) dependents are enrolled. The life rates are based on the C.A.R. member's attained age and the amount of coverage purchased.

Note: You do not have to enroll the same family members in every plan. Follow the steps below to calculate your rate.

1. For Dental: Look up your county on the Dental Plans rate page. Find the rate table that applies to your rating region. *(If your county is included in more than one rating region, check to find your zip code to determine what rating region to use.)* Look up the rate based on the plan chosen and whether the member wants to enroll any eligible dependents.
2. For Vision: Review the Vision Plan rate page. Find the rate based on who is enrolling on the plan.
3. For Life: Review the Life Plan rate page. Find the rate based on the C.A.R. member's attained age and the level of coverage desired. (Only available to new C.A.R. members or employees. Not available to affiliate C.A.R. members.)

Step 2: Complete Forms

Please note you may need to complete more than one application, depending upon the coverage you select.

All Applications

- **Do not** complete any shaded sections of the form.
- **Personal Data:** List yourself and all eligible dependents you wish to enroll. Make sure to include each person's date of birth and social security number.
- **Requested Effective Date:** Write in the day, month and year. If enrolling outside of Open Enrollment, please see "General Guidelines" section "Special Enrollment Provision" for information on qualifying events and effective dates.
- **Adding Dependents after you enroll:** If you initially waive coverage for your dependents, they will not be able to enroll until the next Open Enrollment period unless they experience a qualifying event (See section "Special Enrollment Provision" for more information.) If coverage is desired for newborns, they must be added **within 30 days** of the date of their birth (their effective date of coverage will be their actual date of birth.)
- **Signature/Date:** The C.A.R. member must sign and date the form.

Anthem Blue Cross "Employee Addition" Application Form

- **Anthem Blue Cross HMO:** If you are enrolling in the Saver HMO plan, you must select a Primary Care Physician (PCP) for each enrolling family member. You will find the Anthem Blue Cross PCP listing on the Anthem Blue Cross website at www.anthem.com/ca. Click on “Find a Doctor” and continue as a “Visitor.” Be sure to select the **Small Group** plan type, and an Anthem Blue Cross HMO (California Care) provider. You will need to complete a **PCP number** for each doctor selected. The provider number is available on the website. If you do not choose a PCP of your own, Anthem Blue Cross will assign one to you.
- **If you choose to waive coverage for your eligible dependents,** you must complete and sign Section 4 to decline coverage.

MetLife Dental/Life Applications

- Use this application to enroll in either of the dental plans, life insurance on a stand alone basis, or dental and life insurance together.
- **Life Insurance Beneficiary:** ONLY complete this section if you are enrolling in the life insurance program. This coverage is only available on a **guaranteed basis to new C.A.R. members and W2 employees of C.A.R. members or local C.A.R. chapters** (who enroll between their 60th and 120th day of membership; and who have not been hospitalized.) Affiliate C.A.R. members are not eligible to enroll for life insurance coverage. C.A.R. members who wish to enroll in the life insurance program outside of the new member enrollment period must contact RealCare for a separate enrollment application. Coverage for those members will not be guaranteed and will require medical history underwriting.

MES Vision Application

- Use this application if you are enrolling in the vision plan in combination with other coverages, or on a stand alone basis.

Step 3: Calculate Initial Payment

Use the worksheet below to calculate your initial payment:

| | |
|--|-----------|
| Medical Premium | \$ |
| Dental Premium | \$ |
| Vision Premium | \$ |
| Life Premium * | \$ |
| Monthly Administration Fee ** | \$ 20.00 |
| Total Due With Applications | \$ |
| <p>* Life Insurance is guaranteed only for new members who elect coverage between their 60th and 120th day of membership and who have not been hospitalized within the 90 days prior to making application. Eligible members who wish to enroll outside of the initial eligibility date, or who have been hospitalized in the 90 days prior to making application may apply for coverage and will be medically underwritten. Coverage will not be guaranteed for these applicants.</p> <p>** Administration fee is lower if subscriber does not enroll in medical insurance.</p> | |

Step 4: Select A Payment Method

After the initial payment, you can either be billed monthly or pay by Automatic Premium Payment Option. Monthly invoices are generated around the 10th of the month for the following month. Premiums are due the first of the month. If you elect to pay by Automatic Premium Payment Authorization, you will need to complete the Automatic Premium Payment Authorization form and submit it with a voided check along with your initial payment. The Automatic Premium Payment will debit for all dues, premiums and fees on the due date.

Step 5: Review & Mail Enrollment Materials & Payment

- ✓ Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- ✓ Check your enrollment forms to be sure they are complete and have been signed.
- ✓ Submit proof of eligibility (see Eligibility Guidelines for more information).
- ✓ Submit completed Automatic Premium Payment Authorization and voided check.

| |
|---|
| <p align="center">Mail Completed Application and Payment To:</p> <p align="center">REALCARE INSURANCE MARKETING, INC. 19310 Sonoma Highway, Ste. A Sonoma, CA 95476</p> |
|---|



ANTHEM BLUE CROSS – METLIFE – MES BILLING, CANCELLATION & REINSTATEMENT POLICIES

RealCare Insurance Marketing, Inc. Billing Department: (800) 939-8088, Ext. 201 • Fax: (707) 939-8450

If you are enrolled in an **Anthem Blue Cross** medical plan, (with or without MetLife dental/life or MES vision plan), premiums are billed based on the Anthem Blue Cross-MetLife-MES Billing Cancellation and Reinstatement Policies. If you are not enrolled in an Anthem Blue Cross medical plan, refer to the **Kaiser Permanente-MetLife-MES** Billing, Cancellation and Reinstatement Policies.

Initial Payment

Applicants are required to send the first two months of premium with their **initial enrollment application**. After the initial payment, a single monthly payment is required.

Monthly Billing

- Bills are sent to plan members around the 8th of each month. Premiums are due by the 25th of each month for coverage beginning the first of the second month following the due date. (For example, premiums for coverage for the month of June are due on April 25th.) If payment is not received by the 10th day following the premium due date, a late fee of \$15 will be applied. If payment is not received within 30 days of the due date, coverage will be terminated effective the last day of the month through which premiums have been paid.
- Anthem Blue Cross rates are based on the subscriber's attained age, zip code and dependent status. If a subscriber has a birthday that moves him/her into the next age bracket, the rate increase will become effective the first of the month following the birthday, and will be reflected on that month's billing statement. Eligible subscribers who turn 65 while enrolled in an Anthem Blue Cross medical plan will be charged the "Medicare Secondary" rate effective the first of the month in which the subscriber reaches age 65. If a subscriber provides written documentation that s/he is eligible for Medicare, whether enrolled in Medicare or not, RealCare will change the Anthem Blue Cross billed rate to the "Medicare Primary" rate retroactive to the first of the month in which the subscriber reaches age 65. However, if a subscriber is ineligible for Medicare, that subscriber will continue to be charged the "Medicare Secondary" rate.
- Checks should be made payable to RealCare Insurance Trust Account (RITA) and remitted to 19310 Sonoma Highway, Suite A, Sonoma, CA 95476.

Automatic Premium Payment Authorization (APPA)

Plan members electing APPA will have all applicable premiums, dues, fees and adjustments debited on the first of the month following the due date. If an automatic debit is dishonored, a \$25 fee will be assessed and the premium payment and applicable fees must be remitted to RITA by cashier's check or money order and received before the end of the 30-day grace period to avoid cancellation of your health care and/or insurance coverage.

Cancellation

Coverage may be cancelled for:

- ✓ Failing to pay premium and applicable administrative fees before the end of the grace period.
- ✓ Providing false information about eligibility.
- ✓ Providing false information about a qualifying event.
- ✓ Providing false information about membership in C.A.R.
- ✓ Failing to maintain active membership in C.A.R.

Voluntary Termination

A subscriber may voluntarily cancel coverage for himself or covered dependents. A subscriber who wishes to terminate coverage for any covered person must submit the completed termination form to RealCare Insurance Marketing - available on our member website, www.RealCareOnline.com. The effective date of termination will be the first of the month following receipt of the completed form.

Reinstatement/Re-Enrollment Policy

- Subject to approval from Anthem Blue Cross of California, a subscriber may be allowed to reinstate his/her coverage twice in a plan year (June 1 through May 31) if the subscriber submits an appeal letter to the Plan Administrator and a cashier's check or money order for all premiums, dues and administrative fees due, plus a \$25 fee for the first reinstatement and \$50 for the second reinstatement payable to RealCare Insurance Trust Account, (RITA). If a reinstatement request is approved by Anthem Blue Cross of California, coverage will be reinstated effective as of the cancellation date.
- If your **medical or vision** coverage is not reinstated, you may be eligible to re-enroll at the next Open Enrollment or within 30 days of a qualifying event. If your **life** coverage is not reinstated, you may be eligible to re-enroll; however medical underwriting will be required and coverage is not guaranteed. If your **dental** coverage is terminated for any reason, you may be eligible to re-enroll at the first Open Enrollment following a thirteen month waiting period or within 30 days of a qualifying event. You will be required to pay all unpaid premiums, dues and fees at the time of enrollment.
- No lapses in coverage between the cancellation date and the reinstatement date are allowed.
- If your coverage is not reinstated, please contact RealCare to review your health care coverage options.

Amendment or Termination of the Plan

The California Association of REALTORS® intends to continue the Plan described within this summary, but reserves the right to amend or terminate the Plan at any time and for any reason. In addition, the carrier reserves the right to terminate the Plan at the end of the policy year.