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Enrollment Form for Coverage under HIPAA

(Health Insurance Portability and Accountability Act)

HIPAA Basic PPO 1000 and HIPAA PPO Share 5000 are offered by Anthem Blue Cross Life and Health Insurance Company.

1. Enrollee Information

Please print in blue or black ink

Enrollee's Last Name	First Name	M.I.
Home Address (Must be complete: P.O. Box not acceptable)		
City	State	ZIP Code

2. Choice of Anthem Individual Coverage

Choose one plan per enrollment form.

- ☐ HIPAA Basic PPO 1000
- ☐ HIPAA PPO Share 5000

Billing Address (If different than above.) or P.O. Box	Personal Mail Box (PMB) No.	Daytime Phone No. ( )	Fax Phone No. ( )
City / State / ZIP Code	County *(Required)*	Marital Status ☐ Single ☐ Married	Applicant/Spouse Maiden Name
E-mail Address	If possible, do you want e-mail notification? ☐ Yes ☐ No	Has any person listed on this application resided outside the U.S. for the past three (3) consecutive months? ☐ Yes ☐ No	

Language Choice *(Optional)* ☐ English ☐ Korean ☐ Spanish ☐ Chinese

3. Family Members Enrolling

Please list ALL eligible family members enrolling.

If a listed family member's last name is different from your own, please explain on a separate sheet of paper.

Relation	Last Name	First Name	M.I.	Social Security or ID No.	Date of Birth	Age
10 ☐ Male 20 ☐ Female	Yourself					
30 ☐ Male 40 ☐ Female	Spouse*					
☐ Son ☐ Daughter						
☐ Son ☐ Daughter						
☐ Son ☐ Daughter						
☐ Son ☐ Daughter						

Dependent Information: Do you claim any child listed above who is between the ages of 19 through 22 as a dependent on your Federal Income Tax? ☐ Yes ☐ No

If "No," any child between the ages of 19 through 22 who is not claimed on your Federal Income Tax is NOT eligible as a dependent but may apply individually.

**Spouse includes domestic partner (when applicable).*

1. Have all enrollees had a minimum of 18 months of continuous health coverage most recently under an employer-sponsored group health plan that ended within the last 63 days for a reason other than fraud or non-payment of premium? .... ☐ Yes ☐ No

   If yes, please attach the Certificate of Creditable Coverage provided by your former employer or carrier OR letter from the employer giving us the start and end date of coverage.

   Name of insurance carrier: ______________________ Phone No. (_____) ______________

   If no for any enrollee, then he or she is not eligible for this guarantee issue plan.

2. Were all enrollees eligible for COBRA or Cal-COBRA? .... ☐ Yes ☐ No

   If yes, date coverage started (Mo/Day/Yr) ______________ Date coverage ended (Mo/Day/Yr) ______________

   If no, please explain: ______________________________

   If all available COBRA or Cal-COBRA is not exhausted for any enrollee, then he or she is not eligible for this coverage.

3. Is any enrollee currently covered by or eligible for Medicaid, Medicare or any other employer-sponsored health insurance benefits or does any enrollee have other health coverage? .... ☐ Yes ☐ No

   If yes for any enrollee, then he or she is not eligible for this coverage.

4. Conditions of Enrollment – IMPORTANT: It is important that you carefully read and fully understand the following:

Effective Date

☐ I request that Anthem Blue Cross assign an effective date if this enrollment form is processed. The effective date will be assigned as either the 1st or the 15th of the month following the approval date of this enrollment form.

☐ If Anthem Blue Cross processes this enrollment form, please assign an effective date of ___________________________.

Requested effective date must be within 63 days of prior coverage termination date. Anthem Blue Cross will allow a retroactive effective date to coincide with the prior coverage termination date.

For HIPAA enrollees, coverage is based upon section 1399.805(b) and payment of premium.

Please allow a minimum of 30 days from the date of this enrollment form for processing.

REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE PROCESSING TO BE COMPLETED BEFORE THE DATE REQUESTED.

Agreement

By requesting coverage, I, the undersigned, agree to the following:

1. Anthem Blue Cross may decline my enrollment form if I do not qualify, and if so, I will not have any coverage. No coverage comes into effect unless and until Anthem Blue Cross processes this enrollment form and notifies me in writing.
2. Even if I pay money with this enrollment form, that money is only a deposit against future premium if this enrollment form is accepted. Cashing my check does not mean my enrollment form is processed. If this enrollment form is declined, neither Anthem Blue Cross nor any affiliated company shall have any liability to me, except for the obligation to return the money submitted with this enrollment form. If this enrollment form is not accepted, I will not be entitled to benefits or coverage from Anthem Blue Cross.
3. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross underwriting policy or the terms of any Anthem Blue Cross coverage.

Requirements for Binding Arbitration

If you are applying for coverage, please note that Anthem Blue Cross requires binding arbitration to settle all disputes against Anthem Blue Cross, including claims of medical malpractice. 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 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."** Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL

Signatures (Required) **– IMPORTANT: All applicants over age 18 must sign and date.**

Enrollee / Parent or Legal Guardian **X**	Today's Date	Enrollee's Spouse **X**	Today's Date
Enrollee age 18 or over **X**	Today's Date	Enrollee age 18 or over **X**	Today's Date

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.

■ **IMPORTANT: All signatures MUST include today's date** ■

ATTACH BLANK, VOIDED CHECK FOR BANK DRAFT AUTHORIZATION, IF APPLICABLE, HERE. DO NOT TAPE.

Applicant's Social Security or ID No.

5. *Payment Method* **Premium payment required. First payment will be credited to approved applicants only.** By sending your check to us, you authorize Anthem Blue Cross to convert your check into an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

5A. Credit Card

Fax to: (800) 327-9255

☐ **Initial premium (For new member's Medical and Dental fees only)**
☐ **Monthly premiums**

Monthly Credit Card Authorization — As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums approximately 10 days prior to each due date. I understand that the amount may vary as a result of changes I make, such as, but not limited to, adding and deleting dependents, or moving to a new location. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage.

Credit Card: ☐ VISA ☐ MasterCard ☐ Discover

Card No.: | | | | | | | | | | | | | | | | Exp. Date: ____________________

Cardholder's Name PRINT *(As it appears on the credit card)* X	Date	Authorized Signature *(As it appears on the credit card)* X	Date

5B. Checking Account Automatic Premium Payment

☐ **Monthly checking account deduction premium payments**

Name of Bank or Financial Institution:

____

Account No.: | | | | | | | | | | Bank Routing No.: | | | | | | | | | |

Submit a blank check marked "VOID" above where indicated (DEPOSIT SLIPS NOT ACCEPTABLE). If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account. Premiums may be prorated in order to adjust the initial paid to date or in the event of membership changes.

Monthly Checking Account Automatic Premium Payment Authorization – As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of ANTHEM BLUE CROSS 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 Anthem Blue Cross to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross premiums. This authority is to remain in effect until revoked by me by providing you a 30-day 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, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed bi-monthly. You will incur a $25 service charge for any withdrawal not honored.

Cardholder's Name PRINT *(As it appears in the financial institution's records)* X	Date

5C. Billing (To be used if an automatic payment option is NOT selected from 5A or 5B above.)

☐ **Bi-monthly** (Submit 2 months premium) ☐ **Quarterly** (Submit 3 months premium)

6. *Statement of Accountability* – Complete when the enrollee cannot fill out the enrollment form for coverage under HIPAA.

I, ____, personally read and completed this enrollment form for the enrollee named below because:

☐ Enrollee does not read English ☐ Enrollee does not speak English ☐ Enrollee does not write English

☐ Other (explain): ____

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: ____

I also translated and fully explained the "Conditions of Enrollment."

Signature of Translator *(Required)* X	Date

7. *To the Anthem Blue Cross-Appointed Agent or Representative*

1. **Your client must personally read and complete this enrollment form. If your client does not read or write English, the Statement of Accountability must be completed.**
2. Did you see the proposed subscriber at the time this enrollment form was executed? .... ☐ Yes ☐ No

   If no, please explain: ____

Name of Agent *(Print name)* DAVID J. FLUKER	Agent's Street Address 767 MARIA WAY	Suite No.
Agent I.D. No. F K D F Q P R Q V Z	City / State / ZIP Code GILROY, CA 95020	
Phone No. (408) 847-6139 / Fax No. (408) 762-4450	Signature of Agent *(Required)* X	Date *(Required)*

Mail Service Agreement to: ☐ Broker/Agent ☒ Subscriber

PLEASE NOTE: If neither box is checked, the Service Agreement will be mailed directly to the subscriber.

Mailing Address

Enrollee:

Please return this enrollment form to the agent.

Agent:

Please mail to:

Anthem Blue Cross
P.O. Box 9041
Oxnard, CA 93031-9041

DO NOT WRITE IN THIS AREA

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