

5. 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 further 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 the 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.

Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded.

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 HSA compatible 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.

ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employee Retirement Income Security Act of 1974), certain disputes may not be subject to the following arbitration provisions:

I understand that any and all disputes between myself (and/or any enrolled family member) and Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company, including claims for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company are giving up the right to have any dispute decided in a court of law before a jury. Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Evidence of Coverage/Certificate. If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

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.

Signature of Employee X	Date (Mo/Day/Yr)	Signature of Employee's Spouse (If applying for coverage) X	Date (Mo/Day/Yr)
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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.

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.



Anthem Blue Cross Application Checklist

- J Remember to **answer** all questions and **sign** the application(s) for the plan(s) you are choosing.
- J 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). **Send two months of premium with your application.** After your initial payment you will pay a single monthly premium.
- J Make your check payable to RealCare Insurance Trust Account (R.I.T.A.).
- J 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.**
- J 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.
- J 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 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.

Automatic premium payments will be debited from my account on the date that dues/premiums are due. 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, dues 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: _____

<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>	

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

