

3. Choice of Medical Coverage

- | | | | |
|-----------------------|--|--|--|
| CoreShare | <input type="checkbox"/> 750 - 50% (01CJ) | <input type="checkbox"/> 1500 - 50% (01CK) | <input type="checkbox"/> 2500 - 50% (01CL) |
| | <input type="checkbox"/> 3500 - 50% (01CM) | <input type="checkbox"/> 5000 - 50% (01CN) | <input type="checkbox"/> 7500 - 50% (01CP) |
| | <input type="checkbox"/> 10,000 - 100% (01CQ) | <input type="checkbox"/> 15,000 - 100% (01CR) | <input type="checkbox"/> 25,000 - 100% (01CS) |
| ClearProtection | <input type="checkbox"/> 1000 - 60% (01J4) | <input type="checkbox"/> 3300 - 60% (01J5) | <input type="checkbox"/> 5000 - 60% (01JN) |
| SmartSense Plus | <input type="checkbox"/> 1000 - 70% w Standard Rx (01HW) | <input type="checkbox"/> 2000 - 70% w Standard Rx (01HX) | <input type="checkbox"/> 3500 - 70% w Standard Rx (01HY) |
| | <input type="checkbox"/> 5500 - 70% w Standard Rx (01JW) | <input type="checkbox"/> 7000 - 70% w Standard Rx (01HZ) | |
| | <input type="checkbox"/> 1000 - 70% w Upgrade Rx (01J0) | <input type="checkbox"/> 2000 - 70% w Upgrade Rx (01J1) | <input type="checkbox"/> 3500 - 70% w Upgrade Rx (01J2) |
| | <input type="checkbox"/> 5500 - 70% w Upgrade Rx (01JX) | <input type="checkbox"/> 7000 - 70% w Upgrade Rx (01J3) | |
| Premier | <input type="checkbox"/> 1000 - 75% (01JD) | <input type="checkbox"/> 1500 - 75% (01JE) | <input type="checkbox"/> 2500 - 75% (01JF) |
| | <input type="checkbox"/> 3500 - 75% (01JG) | <input type="checkbox"/> 5000 - 75% (01JH) | <input type="checkbox"/> 6000 - 75% (01JJ) |

Lumenos HSA 5000/10,000 - 100% (061Q)

Lumenos HSA -

Individual Policy Plus 3000 - 100% (065J) 4500 - 100% (065K) 5950 - 100% (065L)

Lumenos HSA -

Family Policy Plus 3500 - 100% (065M) 5500 - 100% (065N) 7500 - 100% (065P)

11,900 - 100% (065Q)

Yes, I would like to establish a health savings account in conjunction with the HSA-compatible health plan I selected above.

Anthem will provide your information to Anthem's banking partner. (Please fill in your social security number in section 1.)

No, I DO NOT want to establish a health savings account in conjunction with the HSA-compatible health plan I selected above.

Other To apply for a plan/policy not listed, write in the name here:



5. Significant Terms, Conditions and Authorizations (TERMS)

Please read this section carefully before signing the application.

AGREEMENT

By applying for coverage, I, the undersigned, agree to the following:

1. Anthem Blue Cross and Blue Shield may decline my application. No coverage comes into effect until Anthem approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Anthem at its discretion.
2. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross and Blue Shield underwriting policy or the terms of any Anthem coverage.
3. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
4. I understand that my domestic partner, if applicable, is only eligible for coverage if: we have chosen to share one another's lives in an intimate and committed relationship of mutual caring; we desired by our own free will to enter into a domestic partnership; the NV Secretary of State has issued a Certificate of Registered Domestic Partnership to us; we share a common residence on at least a part time basis; he or she is mentally competent; he or she is at least 18 years old; is not related to me in any way (including by blood or adoption) that would prohibit us from being married under state law; and he or she is not married to or separated from anyone else.
5. If I am accepted, this application will become part of the contract between Anthem BCBS and me. I agree to abide by the terms of that contract.

Rescission of Membership

I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that it is mandatory that I immediately notify Anthem BCBS in writing if I (or any other person for whom coverage is sought) received medical treatment, advice, care or a diagnosis for any illness, injury or condition after the date I sign this application but before my coverage effective date.

I understand that if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered in this application, Anthem BCBS may revoke my coverage. This means Anthem may cancel membership as if it never existed. Also, after approval for membership, if any act, practice, or omission that constitutes fraud, or intentional misrepresentation of material fact is discovered by Anthem that was not provided to Anthem prior to the effective date of the policy, Anthem may revoke my coverage.

REQUIREMENT FOR BINDING ARBITRATION:

I UNDERSTAND AND AGREE THAT ANY AND ALL DISPUTES BETWEEN ANTHEM AND ME MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT. UNDER THIS BINDING ARBITRATION REQUIREMENT, ANTHEM AND I ARE GIVING UP THE CONSTITUTIONAL RIGHT TO HAVE THE DISPUTE DECIDED IN A COURT OF LAW BY A JURY.

BEFORE COMMENCING ARBITRATION, THE PARTY SEEKING ARBITRATION MUST HAVE EXHAUSTED ALL LEVELS OF APPEAL AND REVIEW SET FORTH IN THE CERTIFICATE. ANY SUCH ARBITRATION WILL BE GOVERNED BY THE PROCEDURES AND RULES ESTABLISHED BY THE AMERICAN ARBITRATION ASSOCIATION. THE LAW OF THE STATE IN WHICH THE POLICY WAS ISSUED AND DELIVERED TO THE POLICYHOLDER SHALL GOVERN THE DISPUTE. THE DECISION IN ARBITRATION IS BINDING UPON BOTH ANTHEM AND ME. THE AWARD GIVEN IN ARBITRATION MAY BE ENFORCED OR REVIEWED IN ANY COURT THAT HAS PROPER JURISDICTION. IN THE EVENT ANY PERSON SUBJECT TO THIS ARBITRATION CLAUSE INITIATES LEGAL ACTION OF ANY KIND, THE OTHER PARTY MAY APPLY FOR A COURT OF COMPETENT JURISDICTION TO ENJOIN, STAY OR DISMISS ANY SUCH ACTION AND DIRECT THE PARTIES TO ARBITRATE IN ACCORDANCE WITH THIS PROVISION. THE QUESTION OF WHAT DISPUTES ARE SUBJECT TO THIS ARBITRATION CLAUSE SHALL BE DETERMINED BY THE ARBITRATOR.



5. Significant Terms, Conditions and Authorizations (TERMS) (continued)

If an Applicant does not read English, the translator must sign and submit a Statement of Accountability for translating this entire application (see section 6).

NOTICE:
 By signing this contract you are agreeing to have ANY and ALL disputes against Anthem Blue Cross and Blue Shield decided by neutral arbitration and you are giving up your right to jury OR COURT trial for both medical malpractice claims and any other disputes. *Signatures Required.*

IMPORTANT: ALL APPLICANTS OVER AGE 18 MUST PERSONALLY READ, AGREE TO, SIGN AND DATE THIS APPLICATION.

SIGN HERE	Printed name of Applicant	Signature of Applicant* or Legal Representative X	Date of Birth / /	Date Signed / /
	Printed name of Spouse or Domestic Partner	Signature of Spouse or Domestic Partner or Legal Representative X	Date of Birth / /	Date Signed / /
	Printed name of Dependent Child over 18	Signature of Dependent Child over 18 X	Date of Birth / /	Date Signed / /
	Printed name of Dependent Child over 18	Signature of Dependent Child over 18 X	Date of Birth / /	Date Signed / /

**(or Custodial Parent's or Guardian's signature if applicant is under age 18)*

6. Statement of Accountability

APPLICANT DOES READ AND WRITE ENGLISH.

If an Applicant does not read or write English, the translator must complete and sign the Statement of accountability below.

To be completed when the applicant cannot complete the application.

NOTE: Translator must be 18 years or older to translate the application on behalf of the applicant.

I, _____, personally read and completed this Individual Enrollment Application for the applicant named below because:

Applicant does not read English Applicant does not speak English

Applicant 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 the: Applicant Or by _____

I also translated and fully explained the "Significant Terms, Conditions and Authorizations (TERMS)."

Translator Signature (Required): X	Date (Required)
---------------------------------------	-----------------

I confirm that the application was translated on my behalf.

Applicant Signature (Required): X	Date (Required)
--------------------------------------	-----------------

Please mail this application to the following address:

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

OR

Fax to: (800)327-9255

