LOGO

CSAC EIA Health
(Client Name) Benefit Election Form

Group Name: _____

Effective Date: _____

MEMBER ENROLLMENT OR CHANGE – COMPLETE IN FULL				
Name (Last, First, MI):	Social Security #:	Birth Date (mm/dd/yy):	☐ Male ☐ Female	
Home Street Address: (No P.O. Box) City State Zip		Home Phone:	Work Phone:	
Mailing Address: (P.O. Box may be used) City State Zip ☐ Same as Home Address		E-mail Address:		
Occupation/Title:	Date of Hire (mm/dd/yy):	Employee Status: ☐ Full Time ☐ Early Retiree ☐ Part Time ☐ Medicare Retiree		
Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Legally Separated ☐ Divorced				

TYPE OF ACTION
☐ New Hire Enrollment (list below all dependents to be covered) ☐ Annual Open Enrollment ☐ Add or Drop Dependent due to Qualifying Event: QE Event: _____ ☐ Termination ☐ Other: _____ ☐ Name/Address Change

MEMBER ELECTION APPLICABLE PLANS ONLY		
Anthem PPO 90% ☐ EE Only ☐ EE + 1 ☐ EE + Family	**Anthem PPO 80%** ☐ EE Only ☐ EE + 1 ☐ EE + Family	**Anthem Medicare COB** ☐ Retiree Only ☐ Retiree + 1 ☐ Retiree + Family
Anthem HMO Select $15 ☐ EE Only ☐ EE + 1 ☐ EE + Family	**Anthem HMO Traditional $20** ☐ EE Only ☐ EE + 1 ☐ EE + Family	**Kaiser KPSA** ☐ Retiree Only ☐ Retiree + 1 ☐ Retiree + Family
Kaiser HMO $15 ☐ **EE Only** ☐ **EE + 1** ☐ **EE + Family**	**Kaiser HMO $20** ☐ **EE Only** ☐ **EE + 1** ☐ **EE + Family**	

DEPENDENT COVERAGE

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Spouse ☐ Domestic Partner ☐ Child

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child

☐ ADD ☐ TERM	Name (Last, First, MI):	Social Security #:	Birth Date:	☐ Male ☐ Female
Home Street Address: (if different than address above) City,State, Zip			Disabled? ☐ Yes ☐ No	Relation: ☐ Child

ANTHEM ARBITRATION 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.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premiums.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

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.

EFFECTIVE DATE: The effective date of coverage is subject to Anthem approval.

W–9 Certification Language

I certify each Social Security number listed on this application is correct.

ANTHEM ARBITRATION PLEASE READ CAREFULLY - SIGNATURE REQUIRED - continued

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY (ANTHEM), 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, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. 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 permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, 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.* YOU AND ANTHEM AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU.

Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "handwritten or electronic" signature below, you acknowledge that such signature is valid and binding.

Signature: ***(Signature required for Anthem Plan)***	Date:

DECLINATION OF COVERAGE – SIGNATURE REQUIRED- Complete only if declining medical coverage

I understand that I am eligible for medical coverage through my employer. I waive the right to enroll in the medical plan as offered by my employer for the following persons (please check all that apply below):

☐ Self ☐ Spouse ☐ Child(ren)

Reason for waiver:

☐ I have my own other group coverage
☐ We are covered through my spouse's employer
☐ My spouse and dependents have other group coverage

Retirees: *Once a plan is waived you will not longer be eligible to enroll*.

I understand and agree by signing this document that I am declining coverage and if I fail to show proof of other group coverage that I will be added to the lowest cost plan automatically. I understand by declining coverage, I will not be eligible for coverage until my employer's next Open Enrollment period unless I qualify for coverage due to a HIPAA qualifying event (including getting married, having a child, or involuntarily losing my other coverage). If a HIPPA qualifying event occurs and I want to enroll in other group coverage I know that I must submit proof of other group coverage or my request will not be processed.

Signature:	Date: