For HR Use Only - select one

Bay Area Builders ☐
Marin Builders ☐
North Coast Builders ☐

2022-2023 EMPLOYEE ENROLLMENT APPLICATION

Reason for Enrollment:

☐ New Enrollment ☐ Open Enrollment ☐ Other Qualifying Event _____

☐ Requested Effective Date:_____ ☐ Hire Date:_____ ☐ Rehire Date:_____ ☐ Part-Time to Full-Time Employment Date:_____

SECTION 1: EMPLOYEE INFORMATION

Name of Company:		Employee Job Title:	
Employee Last Name:	Employee First Name: M.I.	☐ Male ☐ Female	Home Phone ( ) —
Employee Social Security Number:	Date of Birth (mm/dd/yyyy)	E-Mail	Are you disabled? ☐ Yes ☐ No

Residence Address (Physical address required - no PO Boxes) Apt # City State Zip Code

Mailing Address (if different) Apt # City State Zip Code

Marital Status
☐ Single ☐ Married
☐ Domestic Partner (Affidavit Required)

Are you currently enrolled in Medicare? ☐ Yes ☐ No
If Yes; Part A Effective Date _____ Part B Effective Date _____
Reason for disability if under age 65: _____ Medicare Claim # _____

SECTION 2: HEALTH CARE BENEFITS

Anthem Blue Cross Medical

☐ **Gold Full PPO 30/500/20% 6BP1**
☐ Employee only ☐ Employee +Spouse ☐ Employee +Child(ren) ☐ Family

☐ **Gold Select PPO 5/1500/30% 6BLL**
☐ Employee only ☐ Employee +Spouse ☐ Employee +Child(ren) ☐ Family

☐ **Gold Select PPO 35/1000/20% 6BQ5**
☐ Employee only ☐ Employee +Spouse ☐ Employee +Child(ren) ☐ Family

☐ **Gold EPO 35/500/20%**
☐ Employee only ☐ Employee +Spouse ☐ Employee +Child(ren) ☐ Family

☐ **Silver Full PPO 2600/35% HSA 6BJE**
☐ Employee only ☐ Employee +Spouse ☐ Employee +Child(ren) ☐ Family

For Anthem Medical plans, please also complete an Anthem Employee Medical Enrollment Form.

Kaiser Permanente

☐ **Platinum HMO 0/20**
Employee only ☐ Employee +Spouse ☐ Employee +Child(ren) ☐ Family

☐ **Gold HMO 250/35**
Employee only ☐ Employee +Spouse ☐ Employee +Child(ren) ☐ Family

☐ **Gold HMO 1000/40**
Employee only ☐ Employee +Spouse ☐ Employee +Child(ren) ☐ Family

☐ **Silver HMO 1650/55**
Employee only ☐ Employee +Spouse ☐ Employee +Child(ren) ☐ Family

☐ **Bronze HMO 6300/65**
Employee only ☐ Employee +Spouse ☐ Employee +Child(ren) ☐ Family

☐ **Bronze HSA7000**
Employee only ☐ Employee +Spouse ☐ Employee +Child(ren) ☐ Family

Have you had a Kaiser HMO, DHMO or DHMO with HRA/HSA in the past? ☐ Yes ☐ No

If yes, what is your medical record number? _____

Kaiser Office Use: PID _____ Enrollment Unit: _____

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Anthem Dental Plan

□ **Value (2000)** □ **Standard (3000)** □ **Premier (4001)** □ **Voluntary 1000**

□ Employee only □ Employee + Spouse □ Employee + Child(ren) □ Family

Vision Plans

□ **Anthem Vision** □ **Vision Service Plan**

□ Employee only □ Employee + Spouse □ Employee + Child(ren) □ Family

SECTION 3: DEPENDENT INFORMATION

	□ Spouse □ Domestic Partner	Child # 1	Child # 2	Child # 3
Last Name:				
First Name:				
Middle Initial:				
Social Security Number:	— —	— —	— —	— —
Date of Birth:	/ /	/ /	/ /	/ /
Full-Time Student:	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
Gender:	□ Male □ Female	□ Male □ Female	□ Male □ Female	□ Male □ Female
Disabled:	□ Yes □ No	□ Yes □ No	□ Yes □ No	□ Yes □ No
Enrolling dependent in *(only check plans offered)*:	□ Medical □ Dental □ Vision	□ Medical □ Dental □ Vision	□ Medical □ Dental □ Vision	□ Medical □ Dental □ Vision
If child is age 26+, is he/she an IRS-qualified dependent?				
Do you or your dependents have other health care coverage? □ Yes □ No *(If yes, complete Section 5.)*				

For disabled dependents, please submit an *Over Age Dependent Certification of Disabled Dependent Certification* in addition to this form.

If Last Name of spouse or dependent is different from employee's Last Name, please explain:

If Address of spouse/domestic partner or dependent is different from Employee's Address, please list here:

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SECTION 4: LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Anthem Life/AD&D Plan (if offered by your employer)

□ Yes □ No

If yes, select the offered plan to the right and complete beneficiary information below.

□ **100% Employer Paid Benefit Amount**

□ Class 3: $ 5,000 (0001/0002) □ Class 2: $10,000 (0009/0013)
□ Class 3: $25,000 (0010/0014) □ Class 4: $50,000 (0011/0015)
□ Class 5: (Circle One) $10,000 / $25,000 / $50,000 (0012/0016)

□ **Supplemental (100% Employee Paid) Benefit**

Primary Beneficiary

Full Name: _____

Address: _____

_____

Birth Date: _____

Relationship: _____

Social Security Number: _____

Percent of Benefit: _____

Secondary Beneficiary

Full Name: _____

Address: _____

_____

Birth Date: _____

Relationship: _____

Social Security Number: _____

Percent of Benefit: _____

Other Beneficiary

□ Estate of Insured □ Revocable or Irrevocable Trust □ Trustee Under Insured's Will

Note: Supplemental Life Insurance requires a separate enrollment form to be filled out.

SECTION 5: OTHER HEALTH INSURANCE & PRIOR COVERAGE INFORMATION FOR PPO MEMBERS (This section is required.)

Are you or have you and/or any of the eligible family members been covered by other medical coverage within the last six months? Please list all current or prior medical coverage. Attach additional sheets if necessary.

Name	Primary *(check one)*	Policy Holder Name(s) *(i.e., Company Name)*	Insurance Company	Type of Coverage *(i.e., Medical, Dental, Vision)*	Policy / Group #	Effective Date	Termination Date	Reason for Termination
	□ Yes □ No							
	□ Yes □ No							
	□ Yes □ No							
	□ Yes □ No							
	□ Yes □ No							

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SECTION 6: YOUR LEGAL ACKNOWLEDGMENTS — REQUIRED

Deduction Authorization

I request coverage under my employer group insurance plan as noted and also verify the accuracy of the employee section. Furthermore, I authorize my employer to deduct from my earnings any payment, if applicable, for this coverage.

_____	_____	_____
Employee Signature to Enroll in Coverage	Print Name	Date

The following information is Anthem-specific language that must be read and acknowledged by signing and dating at the end of the section.

IF ENROLLING IN AN ANTHEM BLUE CROSS MEDICAL PLAN: PLEASE READ CAREFULLY — SIGNATURE REQUIRED

I attest by signing on the next page 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 Blue Cross approval.

COBRA/CAL-COBRA CONTINUATION COVERAGE

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end.

If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1. The date eligibility for COBRA Continuation Coverage ends, or
2. The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3. The date your employer discontinues coverage with Anthem Blue Cross, or
4. The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5. The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

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The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

W-9 Certification Language
I certify each Social Security number listed on this application is correct.

Anthem Blue Cross Legal Language

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 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. 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 permitted and as 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 or 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 AND PARTICIPATION IN A CLASS ACTION 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.

_____ _____

Employee Signature Required for Anthem Enrollees Date

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, or the ERISA claims procedure regulation, and 11 any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

_____ _____

Employee Signature Required for Kaiser Permanente Enrollees Date