



## HIPAA Plans

Health Insurance Portability and Accountability Act of 1996

Effective January 1, 2009  
[anthem.com/ca](http://anthem.com/ca)

# HIPAA APPLICATION CHECKLIST

The following is a checklist to assist you when submitting a HIPAA application. This form lists various situations and the necessary documentation we require. Please feel free to submit this form along with any additional information with your application.

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**The applicant needs to have completed a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored group health plan. Any of the following will meet this requirement:**

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- Certificate of Creditable Coverage – This must reflect the applicant's last 18 months of continuous coverage and have an end date.
- A letter from the prior employer or insurance carrier reflecting their last 18 months of continuous coverage. This letter needs to have a start and end date.

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**Has elected and exhausted continuation of coverage under COBRA or Cal-COBRA, if available.**

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***If COBRA was exhausted, we will need one of the following:***

- COBRA Expiration / Termination Letter - This document is usually sent 30-90 days prior to the applicant's COBRA expiration and simply explains that their COBRA will be coming to an end on a specific date.
- A letter from the prior employer or insurance carrier indicating COBRA was exhausted. This letter also needs to list the specific end date.

***If Cal-COBRA was offered, we will need:***

- A letter from the applicant's prior employer or insurance carrier indicating Cal-COBRA was exhausted. This letter needs to list the specific end date.

***If Cal-COBRA was not offered, we will need one of the following:***

- A letter from the applicant's prior employer or insurance carrier indicating they are self-insured.
- A letter from the applicant's prior employer or insurance carrier indicating they do not have a contract in the state of California.
- A copy of an Anthem Blue Cross ID card.

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**Miscellaneous Scenarios:**

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***If the applicant's prior group coverage ended and COBRA/Cal-COBRA was not offered, we will need:***

- A letter from the employer indicating the reason they are no longer offering group health benefits.

***If the applicant's COBRA/Cal-COBRA ended and was not exhausted, we will need:***

- A letter from the prior employer indicating the reason why COBRA/Cal-COBRA could not be exhausted.

# KEEPING CALIFORNIANS COVERED

Anthem Blue Cross HIPAA plans can keep you covered when coverage through an employer-sponsored plan ends. Coverage is guaranteed under one of our HIPAA plans for anyone who qualifies.

## Are you eligible?

To qualify for a HIPAA plan, you must:

- have completed a minimum of 18 months of continuous health coverage, most recently under an employer-sponsored group health plan;
- have elected and exhausted continuation of coverage under COBRA or Cal-COBRA, if available;
- have lost coverage within the last 63 days;\* and
- not be eligible for Medi-Cal or Medicare, or have any other medical coverage.

\* For reasons other than fraud or non-payment of premiums.

## Do you meet enrollment requirements?

To enroll, you must be a permanent legal resident of California and one of the following:

- the applicant's spouse or qualified Domestic Partner who is not Medicare-eligible;
- the applicant's children (under 19 years of age), or the children (under 19 years of age) of the enrolling applicant's spouse or qualified Domestic Partner;
- the applicant's spouse's or qualified Domestic Partner's unmarried dependent child ages 19 through 22 ("dependent" as defined by the Internal Revenue Service).
- the applicant's child (of any age) who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and chiefly dependent upon the applicant for support and maintenance.

## What are your HIPAA plan choices?

- **HIPAA PPO Share 1500 (DL97)**  
Featuring a \$1,500 annual deductible
- **HIPAA PPO Share 2500 (DL98)**  
Featuring a \$2,500 annual deductible
- **HIPAA PPO Share 5000 (DZ30)**  
Featuring a \$5,000 annual deductible
- **HIPAA Basic PPO 1000 (DL99)**  
A limited plan featuring a \$1,000 annual deductible

# HIPAA PLANS: OVERVIEW OF COVERAGE

... and your share of costs (after deductible)

Your Plan Features	HIPAA PPO Share 1500 (DL97)		HIPAA PPO Share 2500 (DL98)	
	Participating Provider	Non-Participating Provider	Participating Provider	Non-Participating Provider
<b>Lifetime Maximum</b>	\$5,000,000		\$5,000,000	
<b>Annual Out-of-Pocket Maximum<sup>1</sup></b> Participating and non-participating provider covered services combined	\$6,000 per member (Once 2 members each reach the maximum, the maximum is satisfied for the entire family.)		\$7,500 per member (Once 2 members each reach the maximum, the maximum is satisfied for the entire family.)	
<b>Annual Deductible</b> (applies to above Out-of-Pocket Maximum)	\$1,500 per member (Once 2 members each reach the deductible, the deductible is satisfied for the entire family.)		\$2,500 per member (Once 2 members each reach the deductible, the deductible is satisfied for the entire family.)	
<b>Doctors' Office Visits</b>	30% of negotiated fee (deductible waived)	50% of negotiated fee plus all excess charges (deductible waived)	\$35 copay (deductible waived)	50% of negotiated fee plus excess charges (deductible waived)
<b>Professional Services</b> (X-ray, lab, anesthesia, surgeon, etc.)	30% of negotiated fee	50% of negotiated fee plus all excess charges	30% of negotiated fee	50% of negotiated fee plus excess charges
<b>Hospital Inpatient/Outpatient</b>	30% of negotiated fee <sup>2</sup>	All charges except \$650/day inpatient, \$380/day outpatient	30% of negotiated fee <sup>2</sup>	All charges except \$650/day inpatient, \$380/day outpatient
<b>Emergency Room Services<sup>3</sup></b>	30% of negotiated fee	30% of customary & reasonable fees plus all excess charges	30% of negotiated fee	30% of customary & reasonable fee plus all excess charges
<b>Maternity</b>	30% of negotiated fee	50% of negotiated fee plus all excess charges	30% of negotiated fee	50% of negotiated fee plus all excess charges
<b>Preventive Care</b>	Annual physical exam(s): 30% of negotiated fee <sup>6</sup> (deductible waived) OR HealthyCheck <sup>SM</sup> Centers: \$25/\$75 copay for basic/premium screening (deductible waived) Routine mammogram, Pap and PSA tests <sup>4</sup> : 30% of negotiated fee Well Baby and Well Child (through age 6): 40% of negotiated fee (deductible waived)	Annual physical exam(s): 50% of negotiated fee <sup>6</sup> plus all excess charges (deductible waived) Routine mammogram, Pap and PSA tests <sup>4</sup> : 50% of negotiated fee plus all excess charges Well Baby and Well Child (through age 6): 50% of negotiated fee plus all excess charges (deductible waived)	Annual physical exam(s): 30% of negotiated fee <sup>6</sup> (deductible waived) OR HealthyCheck <sup>SM</sup> Centers: \$25/\$75 copay for basic/premium screening (deductible waived) Routine mammogram, Pap and PSA tests <sup>4</sup> : 30% of negotiated fee Well Baby and Well Child (through age 6): 40% of negotiated fee (deductible waived)	Annual physical exam(s): 50% of negotiated fee <sup>6</sup> plus all excess charges (deductible waived) Routine mammogram, Pap and PSA tests <sup>4</sup> : 50% of negotiated fee plus all excess charges Well Baby and Well Child (through age 6): 50% of negotiated fee plus all excess charges (deductible waived)
<b>Prescription Drugs (Anthem Blue Cross Formulary)<sup>5</sup></b> Amounts shown are for each 30-day retail or in-network mail order supply	\$10 copay generic; \$30 copay brand-name <sup>4</sup> after \$250 brand-name prescription drug deductible (2-member maximum); 30% of negotiated fee for self-administered injectables, except insulin	50% of drug limited fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits; subject to the annual \$250 brand-name prescription drug deductible	\$10 copay generic; \$30 copay brand-name <sup>4</sup> after \$500 brand-name prescription drug deductible (2-member maximum); 30% of negotiated fee for self-administered injectables, except insulin	50% of drug limited-fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits; subject to the annual \$500 brand-name prescription drug deductible

BC Life HIPAA PPO Share 5000 (DZ30)		BC Life HIPAA Basic PPO 1000 (DL99)	
Participating Provider	Non-Participating Provider	Participating Provider	Non-Participating Provider
\$5,000,000		\$5,000,000	
\$7,500 per member (Once 2 members each reach the maximum, the maximum is satisfied for the entire family.)		\$3,500 per member (Once 2 members each reach the maximum, the maximum is satisfied for the entire family.)	
\$5,000 per member (Once 2 members each reach the deductible, the deductible is satisfied for the entire family.)		\$1,000 per member (Once 2 members each reach the deductible, the deductible is satisfied for the entire family.)	
\$40 copay (deductible waived)	50% of negotiated fee plus all excess charges (deductible waived)	No office visit benefit until out-of-pocket maximum is met, then covered at 100% of negotiated fee	No office visit benefit until out-of- pocket maximum is met, then you pay 50% of negotiated fee plus all excess charges
30% of negotiated fee	50% of negotiated fee plus all excess charges	20% of negotiated fee, inpatient or surgical procedures only. No office visit benefits until out-of-pocket maximum is met, then plan pays 100% of negotiated fee	50% of negotiated fee plus all excess charges for covered inpatient or surgical procedures only
30% of negotiated fee <sup>2</sup>	All charges except \$650/day inpatient, \$380/day outpatient	20% of negotiated fee <sup>2</sup>	All charges except \$650/day inpatient, \$380/day outpatient
30% of negotiated fee	30% of customary & reasonable fees plus all excess charges	20% of negotiated fee	20% of customary & reasonable fees plus all excess charges
30% of negotiated fee	50% of negotiated fee plus all excess charges	Not Covered	Not Covered
Annual physical exam(s): 30% of negotiated fee <sup>6</sup> (deductible waived) OR HealthyCheck <sup>SM</sup> Centers: \$25/\$75 copay for basic/premium screening (deductible waived) Routine mammogram, Pap and PSA tests <sup>6</sup> : 30% of negotiated fee (deductible waived) Well Baby and Well Child (through age 6): 40% of negotiated fee	Annual physical exam(s): 50% of negotiated fee, plus all excess charges (deductible waived) Routine mammogram, Pap and PSA tests: 50% of negotiated fee plus all excess charges (deductible waived) Well Baby and Well Child (through age 6): 50% of negotiated fee plus all excess charges	Routine mammogram, Pap, and PSA tests <sup>6</sup> : 20% of negotiated fee (deductible waived) HealthyCheck <sup>SM</sup> Centers': \$25/\$75 copay for basic/premium screening (deductible waived)	Routine mammogram, Pap, and PSA tests <sup>6</sup> : 50% of negotiated fee plus all excess charges (deductible waived)
\$10 copay generic; \$35 copay brand-name <sup>4</sup> after \$750 deductible brand-name prescription drug deductible (2-member maximum); 30% of negotiated fee for self-administered injectables, except insulin	50% of drug limited-fee schedule and all excess charges plus the copay/coinsurance as stated for in-network benefits; subject to the annual \$750 brand-name prescription drug deductible	Not Covered	Not Covered

<sup>1</sup> Excludes non-participating charges in excess of the Anthem Blue Cross negotiated fee and non-participating charges in excess of customary and reasonable fees for emergency care. Copays/coinsurance to participating and non-participating providers apply to out-of-pocket maximum except where specifically noted in the policy.

<sup>2</sup> Additional \$500 admission charge at Participating Hospitals (no additional charge for Preferred Participating Hospitals) is for inpatient stays or outpatient surgery or infusion therapy. This charge is not required for Ambulatory Surgical Centers or medical emergencies.

<sup>3</sup> Additional \$100 copay applies for each emergency room visit (waived if admitted as inpatient).

<sup>4</sup> If a member selects a brand-name drug when a generic equivalent is available, then he or she will pay the generic copay plus the cost difference between the brand-name and available generic equivalent drug, even if the physician writes "dispense as written" or "do not substitute" on the prescription. The amount paid does not apply to the member's brand-name deductible.

<sup>5</sup> Non-Formulary Drugs: You pay 50% for generic; 100% for brand-name up to brand-name deductible amount. After that you pay 50% for brand if no generic is available or generic copay plus the difference between the brand name and available generic equivalent drug.

<sup>6</sup> Maximum annual physical exam benefit is \$200 for members covered more than 6 months; \$100 for members covered less than 6 months.

<sup>7</sup> One HealthyCheck visit at a HealthyCheck Center only allowed for each 12-month period. HealthyCheck applies only to adults and children age 7 and above.

<sup>8</sup> Tests ordered by a physician are covered, including appropriate screening for breast, cervical and ovarian cancer.

# WHAT THE MEDICAL PLANS DO NOT COVER

Every health plan has exclusions and limitations that describe what the plans do not cover. General exclusions and limitations are listed below for the health plans described in this brochure. Please take a few moments to review these listings. We want you to understand what your coverage does not include before you enroll. These listings are an overview only. Plan-specific Evidence of Coverage and Disclosure Form/Certificate booklets contain a comprehensive list of each plan's exclusions and limitations. For a sample copy of an Evidence of Coverage and Disclosure Form/Certificate booklet, ask your agent or contact us.

## Exclusions and Limitations

- Conditions covered by workers' compensation or similar law
- Experimental or investigative services
- Services provided by a local, state, federal or foreign government, unless you have to pay for them
- Services or supplies not specifically listed as covered under the plan agreement
- Services received before your effective date
- Services received after coverage ends
- Services you wouldn't have to pay for without insurance
- Services from relatives
- Any services received by Medicare benefits without payment of additional premium
- Services or supplies that are not medically necessary
- Routine physical exams, except for preventive care services (e.g., physical exams for insurance, employment, licenses or school are not covered)
- Any amounts in excess of the maximum amounts listed in the Evidence of Coverage and Disclosure Form/Certificate
- Sex changes
- Cosmetic surgery
- Services primarily for weight reduction except medically necessary treatment of morbid obesity
- Dental care, dental implants or treatment to the teeth, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Hearing aids
- Contraceptive drugs and/or certain contraceptive devices, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Infertility services
- Private duty nursing
- Eyeglasses or contact lenses, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Vision care including certain eye surgeries to replace glasses, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Mental and nervous disorders and substance abuse, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Certain orthopedic shoes or shoe inserts, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Outdoor treatment programs
- Telephone or facsimile machine consultations

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# Enrollment Form for Coverage under HIPAA



(Health Insurance Portability and Accountability Act)

HIPAA PPO Share 2500 and HIPAA PPO Share 1500 are offered by Anthem Blue Cross. 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 (DL99)
- HIPAA PPO Share 5000 (DZ30)
- HIPAA PPO Share 2500 (DL98)
- HIPAA PPO Share 1500 (DL97)

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 <input type="checkbox"/> Single <input type="checkbox"/> Married	Applicant/Spouse Maiden Name
E-mail Address	If possible, do you want e-mail notification? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has any person listed on this application resided outside the U.S. for the past three (3) consecutive months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Language Choice (Optional) <input type="checkbox"/> English <input type="checkbox"/> Korean <input type="checkbox"/> Spanish <input type="checkbox"/> 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 <input type="checkbox"/> Male 20 <input type="checkbox"/> Female	Yourself					
30 <input type="checkbox"/> Male 40 <input type="checkbox"/> Female	Spouse*					
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						
<input type="checkbox"/> Son <input type="checkbox"/> 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 <b>X</b>	Today's Date	Enrollee's Spouse <b>X</b>	Today's Date
Enrollee age 18 or over <b>X</b>	Today's Date	Enrollee age 18 or over <b>X</b>	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)	Date	Authorized Signature (As it appears on the credit card)	Date
X		X	

**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)	Date
X	

**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) <b>X</b>	Date
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**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) Health Coverage Insurance Services, Inc	Agent's Street Address Po Box 9417	Suite No.
Agent I.D. No. D   L   N   F   J   H   J   R   M   Y   _   _   _   _   _   _	City / State / ZIP Code Santa Rosa, CA 95405	
Phone No. ( 800 ) 569-1156	Fax No. ( 800 ) 376-4703	Signature of Agent (Required) <b>X</b>
		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**

Health care plans provided by Anthem Blue Cross. Insurance plans provided by Anthem Blue Cross Life and Health Insurance Company. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensees of the Blue Cross Association. ANTHEM is a registered trademark. The Blue Cross name and symbol are registered marks of the Blue Cross Association.



# WHAT THE MEDICAL PLANS DO NOT COVER

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- Educational services except as specifically provided or arranged by Anthem Blue Cross
- Nutritional counseling
- Food or dietary supplements, except for formulas and special food products to prevent complications of phenylketonuria (PKU)
- Care or treatment furnished in a non-contracting hospital, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Personal comfort items
- Custodial care
- Certain genetic testing
- Outpatient speech therapy, except as specifically stated in the Evidence of Coverage and Disclosure Form/Certificate
- Any amounts in excess of maximums stated in the Combined Evidence of Coverage and Disclosure Form/Certificate
- Services or supplies supplied to any person not covered under the Agreement in connection with a surrogate pregnancy
- Outpatient drugs, medications or other substances dispensed or administered in any outpatient setting

## **Additional Exclusions and Limitations for the HIPAA Basic PPO 1000 Only**

- Maternity or pregnancy care
- Preventive benefits, except for Pap and PSA tests, and mammograms, not specifically listed in the Certificate
- Outpatient prescription drugs
- Acupuncture/Acupressure
- Physician office visits and associated costs, except as specifically described in the Certificate
- Physical or occupational medicine or chiropractic services, except those provided during an inpatient hospital confinement
- Eye glasses and eye examinations

# RIGHTS AND OBLIGATIONS

## **No-Obligation Review Period**

After you enroll in an Anthem Blue Cross health plan, you will receive an Evidence of Coverage/Certificate booklet that explains the exact terms and conditions of coverage, including the plan's exclusions and limitations. You have 10 full days to examine your plan's features. During that time, if you are not fully satisfied, you may decline by returning your Evidence of Coverage/Certificate booklet along with a letter notifying us that you wish to discontinue coverage.

Evidence of Coverage/Certificate booklets are available for you to examine prior to enrolling. Ask your agent or Anthem Blue Cross. Once you enroll in an Anthem Blue Cross HIPAA plan, you will have 30 days from the date of enrollment to change to a different HIPAA plan. Your effective date will be the same as the date of your original enrollment. No further changes will be allowed after you have been enrolled for 30 days.

## **Incurred Medical Care Ratio**

As required by law, we are advising you that Anthem Blue Cross' incurred medical care loss ratio for 2007 was 80.43 percent. This loss ratio was calculated after provider discounts were applied.

# MONTHLY RATES

Rates for the Anthem Blue Cross HIPAA Plans are based upon the county in which you reside, and your family status and age. For Subscriber & Spouse and Family, rates are based on the age of the younger spouse. To determine your rate, find your county in the Rating Areas chart below and the rate for your area and category on the rate tables. Rates are recalculated at each billing period based on age and the residence address.

## Rating Areas

**Area 1:** Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba

**Area 2:** Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus

**Area 3:** Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara

**Area 4:** Orange, Santa Barbara, Ventura

**Area 5:** Los Angeles

**Area 6:** Riverside, San Bernardino, San Diego

## Payment Methods

You may choose one of the following payment methods:

- Monthly billing – available with Monthly Checking Account Automatic Premium Payment Authorization only
- Bimonthly (2-month) billing
- Quarterly (3-month) billing

See the application for instructions regarding your first premium payment.

# MONTHLY RATES

Effective 1/1/09

		HIPAA PPO Share 2500 (DL98)					
Age Range		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
<b>Single</b>	<15	\$250	\$238	\$240	\$231	\$232	\$219
	15-29	\$371	\$330	\$328	\$333	\$330	\$311
	30-34	\$478	\$413	\$411	\$413	\$410	\$389
	35-39	\$526	\$452	\$447	\$444	\$441	\$429
	40-44	\$594	\$507	\$502	\$502	\$500	\$481
	45-49	\$618	\$537	\$529	\$532	\$530	\$515
	50-54	\$747	\$644	\$638	\$644	\$611	\$592
	55-59	\$901	\$766	\$756	\$767	\$725	\$698
	60-64	\$901	\$766	\$756	\$767	\$725	\$698
<b>Subscriber &amp; Spouse</b>	15-29	\$750	\$679	\$674	\$664	\$659	\$631
	30-34	\$843	\$765	\$763	\$750	\$748	\$713
	35-39	\$905	\$827	\$825	\$814	\$814	\$778
	40-44	\$988	\$907	\$904	\$883	\$874	\$847
	45-49	\$1,060	\$965	\$964	\$952	\$942	\$899
	50-54	\$1,264	\$1,151	\$1,146	\$1,136	\$1,106	\$1,064
	55-59	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214
	60-64	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214
<b>Subscriber &amp; Child</b>	15-29	\$750	\$679	\$674	\$664	\$659	\$631
	30-34	\$843	\$765	\$763	\$750	\$748	\$713
	35-39	\$905	\$827	\$825	\$814	\$814	\$778
	40-44	\$988	\$907	\$904	\$883	\$874	\$847
	45-49	\$1,060	\$965	\$964	\$952	\$942	\$899
	50-54	\$1,264	\$1,151	\$1,146	\$1,136	\$1,106	\$1,064
	55-59	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214
	60-64	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214
<b>Family</b>	15-29	\$1,108	\$1,042	\$1,043	\$1,023	\$1,034	\$998
	30-34	\$1,243	\$1,200	\$1,201	\$1,155	\$1,154	\$1,107
	35-39	\$1,322	\$1,247	\$1,245	\$1,179	\$1,194	\$1,142
	40-44	\$1,429	\$1,319	\$1,319	\$1,252	\$1,249	\$1,205
	45-49	\$1,515	\$1,367	\$1,365	\$1,317	\$1,307	\$1,260
	50-54	\$1,702	\$1,532	\$1,525	\$1,499	\$1,481	\$1,389
	55-59	\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501
	60-64	\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501
	<b>Subscriber &amp; Children</b>	15-29	\$1,108	\$1,042	\$1,043	\$1,023	\$1,034
30-34		\$1,243	\$1,200	\$1,201	\$1,155	\$1,154	\$1,107
35-39		\$1,322	\$1,247	\$1,245	\$1,179	\$1,194	\$1,142
40-44		\$1,429	\$1,319	\$1,319	\$1,252	\$1,249	\$1,205
45-49		\$1,515	\$1,367	\$1,365	\$1,317	\$1,307	\$1,260
50-54		\$1,702	\$1,532	\$1,525	\$1,499	\$1,481	\$1,389
55-59		\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501
60-64		\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501

		HIPAA PPO Share 1500 (DL97)					
Age Range		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
<b>Single</b>	<15	\$250	\$238	\$240	\$231	\$232	\$219
	15-29	\$371	\$330	\$328	\$333	\$330	\$311
	30-34	\$478	\$413	\$411	\$413	\$410	\$389
	35-39	\$526	\$452	\$447	\$444	\$441	\$429
	40-44	\$594	\$507	\$502	\$502	\$500	\$481
	45-49	\$618	\$537	\$529	\$532	\$530	\$515
	50-54	\$747	\$644	\$638	\$644	\$611	\$592
	55-59	\$901	\$766	\$756	\$767	\$725	\$698
	60-64	\$901	\$766	\$756	\$767	\$725	\$698
<b>Subscriber &amp; Spouse</b>	15-29	\$750	\$679	\$674	\$664	\$659	\$631
	30-34	\$843	\$765	\$763	\$750	\$748	\$713
	35-39	\$905	\$827	\$825	\$814	\$814	\$778
	40-44	\$988	\$907	\$904	\$883	\$874	\$847
	45-49	\$1,060	\$965	\$964	\$952	\$942	\$899
	50-54	\$1,264	\$1,151	\$1,146	\$1,136	\$1,106	\$1,064
	55-59	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214
	60-64	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214
<b>Subscriber &amp; Child</b>	15-29	\$750	\$679	\$674	\$664	\$659	\$631
	30-34	\$843	\$765	\$763	\$750	\$748	\$713
	35-39	\$905	\$827	\$825	\$814	\$814	\$778
	40-44	\$988	\$907	\$904	\$883	\$874	\$847
	45-49	\$1,060	\$965	\$964	\$952	\$942	\$899
	50-54	\$1,264	\$1,151	\$1,146	\$1,136	\$1,106	\$1,064
	55-59	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214
	60-64	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214
<b>Family</b>	15-29	\$1,108	\$1,042	\$1,043	\$1,023	\$1,034	\$998
	30-34	\$1,243	\$1,200	\$1,201	\$1,155	\$1,154	\$1,107
	35-39	\$1,322	\$1,247	\$1,245	\$1,179	\$1,194	\$1,142
	40-44	\$1,429	\$1,319	\$1,319	\$1,252	\$1,249	\$1,205
	45-49	\$1,515	\$1,367	\$1,365	\$1,317	\$1,307	\$1,260
	50-54	\$1,702	\$1,532	\$1,525	\$1,499	\$1,481	\$1,389
	55-59	\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501
	60-64	\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501
	<b>Subscriber &amp; Children</b>	15-29	\$1,108	\$1,042	\$1,043	\$1,023	\$1,034
30-34		\$1,243	\$1,200	\$1,201	\$1,155	\$1,154	\$1,107
35-39		\$1,322	\$1,247	\$1,245	\$1,179	\$1,194	\$1,142
40-44		\$1,429	\$1,319	\$1,319	\$1,252	\$1,249	\$1,205
45-49		\$1,515	\$1,367	\$1,365	\$1,317	\$1,307	\$1,260
50-54		\$1,702	\$1,532	\$1,525	\$1,499	\$1,481	\$1,389
55-59		\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501
60-64		\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501

The HIPAA PPO Share 2500 and HIPAA PPO Share 1500 are offered by Anthem Blue Cross.

**Notes:**

For Subscriber & Spouse and Family, rates are based on the age of the younger spouse.

For more information, call your agent or Anthem Blue Cross at 800-333-0912.

# MONTHLY RATES

Effective 1/1/09

Age Range		HIPAA PPO Share 5000 (DZ30)					
		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
<b>Single</b>	<15	\$223	\$207	\$206	\$221	\$219	\$200
	15-29	\$296	\$281	\$279	\$283	\$284	\$260
	30-34	\$390	\$360	\$360	\$363	\$368	\$333
	35-39	\$433	\$396	\$391	\$403	\$411	\$371
	40-44	\$513	\$457	\$457	\$468	\$474	\$422
	45-49	\$580	\$514	\$512	\$529	\$530	\$471
	50-54	\$714	\$621	\$621	\$639	\$611	\$574
	55-59	\$869	\$746	\$740	\$767	\$725	\$689
	60-64	\$901	\$766	\$756	\$767	\$725	\$698
<b>Subscriber &amp; Spouse</b>	15-29	\$750	\$679	\$674	\$664	\$659	\$622
	30-34	\$843	\$765	\$763	\$750	\$748	\$713
	35-39	\$905	\$827	\$825	\$814	\$814	\$778
	40-44	\$988	\$907	\$904	\$883	\$874	\$847
	45-49	\$1,060	\$965	\$964	\$952	\$942	\$899
	50-54	\$1,264	\$1,151	\$1,146	\$1,136	\$1,106	\$1,064
	55-59	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214
60-64	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214	
<b>Subscriber &amp; Child</b>	15-29	\$750	\$679	\$674	\$664	\$659	\$622
	30-34	\$843	\$765	\$763	\$750	\$748	\$713
	35-39	\$905	\$827	\$825	\$814	\$814	\$778
	40-44	\$988	\$907	\$904	\$883	\$874	\$847
	45-49	\$1,060	\$965	\$964	\$952	\$942	\$899
	50-54	\$1,264	\$1,151	\$1,146	\$1,136	\$1,106	\$1,064
	55-59	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214
60-64	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214	
<b>Family</b>	15-29	\$1,088	\$1,012	\$1,005	\$1,023	\$1,034	\$992
	30-34	\$1,243	\$1,194	\$1,188	\$1,155	\$1,154	\$1,107
	35-39	\$1,322	\$1,247	\$1,245	\$1,179	\$1,194	\$1,142
	40-44	\$1,429	\$1,319	\$1,319	\$1,252	\$1,249	\$1,205
	45-49	\$1,515	\$1,367	\$1,365	\$1,317	\$1,307	\$1,260
	50-54	\$1,702	\$1,532	\$1,525	\$1,499	\$1,481	\$1,389
	55-59	\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501
	60-64	\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501
<b>Subscriber &amp; Children</b>	15-29	\$1,088	\$1,012	\$1,005	\$1,023	\$1,034	\$992
	30-34	\$1,243	\$1,194	\$1,188	\$1,155	\$1,154	\$1,107
	35-39	\$1,322	\$1,247	\$1,245	\$1,179	\$1,194	\$1,142
	40-44	\$1,429	\$1,319	\$1,319	\$1,252	\$1,249	\$1,205
	45-49	\$1,515	\$1,367	\$1,365	\$1,317	\$1,307	\$1,260
	50-54	\$1,702	\$1,532	\$1,525	\$1,499	\$1,481	\$1,389
	55-59	\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501
	60-64	\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501

Age Range		HIPAA Basic PPO 1000 (DL99)					
		Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
<b>Single</b>	<15	\$223	\$207	\$206	\$221	\$219	\$200
	15-29	\$296	\$281	\$279	\$283	\$284	\$260
	30-34	\$390	\$360	\$360	\$363	\$368	\$333
	35-39	\$433	\$396	\$391	\$403	\$411	\$371
	40-44	\$513	\$457	\$457	\$468	\$474	\$422
	45-49	\$580	\$514	\$512	\$529	\$530	\$471
	50-54	\$714	\$621	\$621	\$639	\$611	\$574
	55-59	\$869	\$746	\$740	\$767	\$725	\$689
	60-64	\$901	\$766	\$756	\$767	\$725	\$698
<b>Subscriber &amp; Spouse</b>	15-29	\$750	\$679	\$674	\$664	\$659	\$622
	30-34	\$843	\$765	\$763	\$750	\$748	\$713
	35-39	\$905	\$827	\$825	\$814	\$814	\$778
	40-44	\$988	\$907	\$904	\$883	\$874	\$847
	45-49	\$1,060	\$965	\$964	\$952	\$942	\$899
	50-54	\$1,264	\$1,151	\$1,146	\$1,136	\$1,106	\$1,064
	55-59	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214
60-64	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214	
<b>Subscriber &amp; Child</b>	15-29	\$750	\$679	\$674	\$664	\$659	\$622
	30-34	\$843	\$765	\$763	\$750	\$748	\$713
	35-39	\$905	\$827	\$825	\$814	\$814	\$778
	40-44	\$988	\$907	\$904	\$883	\$874	\$847
	45-49	\$1,060	\$965	\$964	\$952	\$942	\$899
	50-54	\$1,264	\$1,151	\$1,146	\$1,136	\$1,106	\$1,064
	55-59	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214
60-64	\$1,481	\$1,326	\$1,319	\$1,313	\$1,272	\$1,214	
<b>Family</b>	15-29	\$1,088	\$1,012	\$1,005	\$1,023	\$1,034	\$992
	30-34	\$1,243	\$1,194	\$1,188	\$1,155	\$1,154	\$1,107
	35-39	\$1,322	\$1,247	\$1,245	\$1,179	\$1,194	\$1,142
	40-44	\$1,429	\$1,319	\$1,319	\$1,252	\$1,249	\$1,205
	45-49	\$1,515	\$1,367	\$1,365	\$1,317	\$1,307	\$1,260
	50-54	\$1,702	\$1,532	\$1,525	\$1,499	\$1,481	\$1,389
	55-59	\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501
	60-64	\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501
<b>Subscriber &amp; Children</b>	15-29	\$1,088	\$1,012	\$1,005	\$1,023	\$1,034	\$992
	30-34	\$1,243	\$1,194	\$1,188	\$1,155	\$1,154	\$1,107
	35-39	\$1,322	\$1,247	\$1,245	\$1,179	\$1,194	\$1,142
	40-44	\$1,429	\$1,319	\$1,319	\$1,252	\$1,249	\$1,205
	45-49	\$1,515	\$1,367	\$1,365	\$1,317	\$1,307	\$1,260
	50-54	\$1,702	\$1,532	\$1,525	\$1,499	\$1,481	\$1,389
	55-59	\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501
	60-64	\$1,911	\$1,660	\$1,642	\$1,656	\$1,617	\$1,501

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

Notes:  
For Subscriber & Spouse and Family, rates are based on the age of the younger spouse.  
For more information, call your agent or Anthem Blue Cross at 800-333-0912.



The HIPAA PPO Share 2500 and HIPAA PPO Share 1500 Plans are offered by Anthem Blue Cross. The HIPAA Basic PPO 1000 and the HIPAA PPO 5000 Share Plans are offered by Anthem Blue Cross Life and Health Insurance Company.

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**Rates and benefits effective 1/1/09**



# Why another questionnaire?

This questionnaire asks you to provide information about your health. This is completely voluntary and your responses will be protected along with your other protected health information as described in the Notice of Privacy Practices that was previously provided to you by Anthem Blue Cross. This information will help us recommend Anthem Blue Cross programs designed to help you improve your health.

1. In general, my health is:

- Excellent     Very Good     Good     Fair     Poor

2. My current height and weight. \_\_\_\_\_' - \_\_\_\_\_" Height (feet'/inches") \_\_\_\_\_ Weight (pounds)

3. I have been told by my health care provider that I have the following health conditions.

Please check only the responses that apply to you.

	Yes, diagnosed within a year	Yes, diagnosed more than a year ago
<input type="checkbox"/> Hypertension (High Blood Pressure) [HTN]	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coronary Artery Disease (Heart Disease) [CAD]	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kidney Disease [KD]	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Congestive Heart Failure [CHF]	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Asthma or Chronic Obstructive Pulmonary Disease [COPD]	<input type="checkbox"/>	<input type="checkbox"/>

4. I visit my doctor regularly for any health conditions I may have

- Yes     No

Physician's name: \_\_\_\_\_

Physician's phone number: \_\_\_\_\_

5. I have instructions from my health care provider and know when to call my doctor if my health is worsening.

- Yes     No

6. I take medications as prescribed.

- Always     Sometimes     Never

7. Right now I am confident that I can follow all my doctor's instructions.

- I am very confident     I am somewhat confident     I am not confident

8. I am:

- Not a smoker     A current smoker     A former smoker

9. I would like assistance with the following:

- Quitting smoking
- Following a healthy diet
- Beginning an exercise plan (or modifying an existing one) to help me reach my goals
- Building a support system to help manage my health
- Working better together with my health care provider/physician
- None of the above

10. Having a chronic condition can be very taxing. As part of our care management programs, we want to help you identify possible signs of depression. Please remember that only a doctor can diagnose depression, and this questionnaire may help you seek advice from your physician and may help us identify additional resources Anthem Blue Cross can offer you.

- Over the past two weeks, I have found myself crying often and/or feeling down or hopeless.
- I have felt little interest or pleasure doing things I usually enjoy.

In order to work with you managing your health, please complete all of the information below.

Name \_\_\_\_\_ Health Care ID or SSN \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Email \_\_\_\_\_

I am currently enrolled in an Anthem Blue Cross plan.

- Yes    No

I am currently enrolled in Case Management or a Health Improvement Plan.

- Yes    No

Please chose your preferred contact method:

- Email    Phone    Mail

Thank you for your time. We look forward to serving you better with your health needs.

Please remit your completed questionnaire to:

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

All information you provide will remain confidential.

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association.



## Language Assistance Services

### English

Can you read the attached document? If not, we can have somebody help you read it. You may also be able to get this written in your language. For free help, please contact your agent.

### Spanish

Puede usted leer este documento anexo? Si no, podemos asignarle alguien que le ayude. También puede recibir esto escrito en su idioma. Para asistencia gratuita, por favor contacte a su agente.

### Chinese (Traditional)

您能讀懂所附文件嗎？如果不懂，我們可以請人幫您。也許您還可以收到中文版本。請聯絡您的代理人要求免費的協助。

### Korean

첨부 서류를 읽으실 수 있습니까? 읽지 못하신다면 읽어드릴 사람을 구해드릴 수 있습니다. 한국어 번역본도 받으실 수 있습니다. 도움은 무료이며 담당 에이전트에게 연락하십시오.

### Vietnamese

Quý vị đọc được tài liệu đính kèm không? Nếu không, chúng tôi sẽ cho người đọc giúp quý vị. Ngoài ra, quý vị cũng có thể được cấp tài liệu này bằng ngôn ngữ của quý vị. Vui lòng liên lạc với nhân viên đại diện của quý vị để được giúp đỡ miễn phí.

### Tagalog

Kaya mo bang basahin ang nakakabit na dokumento? Kung hindi naman, maaaring patulungan ka namin sa ibang tao sa pagbasa nito. Maaari mo ring makuha ito na nasusulat sa iyong lengguwahe. Para sa libreng pagtulong, paki-kontakin ang iyong ahente.

**No Cost Language Services.** You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-249-4844. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

**Servicios de idiomas sin costo.** Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-249-4844. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

**免費語言服務。** 您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打1-866-249-4844 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

**Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí.** Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-249-4844 .Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

**Walang Gastos na mga Serbisyo sa Wika.** Makakakuha ka ng interpreter o tagasalin. Maaari mong ipabasa sa iyo ang mga dokumento at maaari mong hingin na ipadala ang ilang mga dokumento sa iyo sa Tagalog. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-249-4844. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

**무료 통역 서비스.** 귀하는 통역 서비스를 받으실 수 있습니다. 한국어로 서류를 낭독해주는 서비스 받으실 수 있으며 한국어로 번역된 서류를 받아보실 수도 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-249-4844번으로 문의해 주십시오. 보다 자세한 문의 사항은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

**Անվճար Լեզվական Օտարություններ:** Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել սալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-249-4844 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆոռնիայի Ապահովագրության Բաժանմունք: Armenian

**Бесплатные услуги перевода.** Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-249-4844. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

**無料の言語サービス** 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-249-4844までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。Japanese

**خدمات مجاني مربوط به زبان.** میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگویند مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسایی شما قید شده است و یا این شماره 1-866-249-4844 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

**ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ:** ਤੁਸੀ ਦੁਬਾਰੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵੀਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵੀਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-249-4844 'ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫੋਨ ਕਰੋ। Punjabi

**សេវាកម្មភាសាឥតគិតថ្លៃ ។** អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នក ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទ មក យើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-249-4844 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងការពារប្រទេសកម្ពុជា តាមលេខ 1-800-927-4357 Khmer

**خدمات ترجمة بدون تكلفة.** يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-866-249-4844. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357. Arabic

**Cov Kev Pab Txhais Lus Tsis Them Nqi.** Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntwaw ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntwaw tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-249-4844. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntwaw 1-800-927-4357. Hmong

## Addendum to Individual Applications

A new law became effective January 1, 2009 (AB 2569) which requires all agents/brokers to include an attestation with each application submitted if that agent/broker assisted that applicant in completing the application.

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\_\_\_\_\_  
Applicant's Social Security or ID No.

\_\_\_\_\_  
Type or Print Name

Fax: (805) 713-8829

Mail: Individual Services  
P.O. Box 9041  
Oxnard, CA 93031-9041

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As the agent/broker, please check one of the following:

- I have not had any interactions whatsoever with this applicant either by phone, email or in person and did not provide any information, advice or assist the applicant in any manner in providing answers or responses to any questions in the application.
- I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

**NOTICE:** If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars (\$10,000), as authorized under California Health and Safety Code Section 1389.8(c)/ Insurance Code Section 10119.3.

\_\_\_\_\_  
Signature of Agent (*required*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or Print Name

\_\_\_\_\_  
Agent Number

CAINDATT 3/09 MCAFR6059C 3/09