Anthem Blue Cross

# Blue View Vision Enrollment Form

Blue View Vision offered by Anthem Blue Cross Life and Health Insurance Company

Effective Date | Group No. | Dept. No.

## I. PERSONAL INFORMATION

| Last Name (Print) | First Name (Print) | M.I. | ☐ Male ☐ Female |
|---|---|---|---|
| Street Address | City | State | ZIP |
| Home Telephone No. / Business Telephone No. | Association | Date of Hire | |
| Job Title | Class / Dept. No. / E-mail Address | | |

## II. SELECTED COVERAGE

**Type of Coverage:** ☐ New Enrollment ☐ Re-Hire ☐ Part Time to Full Time ☐ Open Enrollment ☐ COBRA

You must select one of the plan choices below:

- ☐ Blue View Vision – Full Service Plan
- ☐ Blue View Vision – Materials Only Plan
- ☐ Blue View Vision – Exam Only Plan

## III. LANGUAGE PREFERENCE

When information is sent to you, we may be able to send it in a language other than English.

What language would you prefer? (Optional)

☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Japanese
☐ Tagalog ☐ Vietnamese ☐ Khmer ☐ Hmong ☐ Farsi
☐ Arabic ☐ Armenian ☐ Russian ☐ Other _____

## IV. ASSOCIATION MEMBER AND DEPENDENT INFORMATION

| | Last Name | First Name | M.I. | Social Security No. | Birthdate | Age | If children are age 19 or over, you must check the appropriate boxes below | | Totally Disabled | Sex |
|---|---|---|---|---|---|---|---|---|---|---|
| Self | | | | | | | | | ☐Y ☐N | ☐M ☐F |
| ☐ Spouse ☐ Domestic Partner | | | | | | | Full-Time Student | IRS No. Dependent | ☐Y ☐N | ☐M ☐F |
| Child | | | | | | | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N | ☐M ☐F |
| Child | | | | | | | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N | ☐M ☐F |
| Child | | | | | | | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N | ☐M ☐F |
| Child | | | | | | | ☐Y ☐N | ☐Y ☐N | ☐Y ☐N | ☐M ☐F |

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

## V. COBRA INFORMATION – To be completed by employer

Company Name _____

Check correct box indicating "Qualifying Event" causing loss of coverage

**Association Member**

- ☐ Termination of Association Member
- ☐ Reduction of Association Member's work hours
- ☐ Benefits terminated or reduced within one year before or after retired Association Member's employer filing for bankruptcy under Chapter 11, if plan provides benefits for retirees

**Family Member:**

- ☐ Death of the Association Member
- ☐ Divorce or legal separation from Association Member
- ☐ Loss of dependent child eligibility
- ☐ Association Member's entitlement to Medicare
- ☐ Other: If enrolling in COBRA coverage, please indicate the qualifying event date and coverage date below
- ☐ Benefits terminated or reduced within one year before or after retired Association Member's filing for bankruptcy, if the plan provides benefit for retirees

| Date of Qualifying Event | Date of Loss of Coverage | Date When Continued Coverage Ends | Date Notice Given | Applicant's Initials |
|---|---|---|---|---|
| Group Policyholder Representative's Signature | | | | Telephone No. |

## VI.-VIII. 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.

VI. **DEDUCTION AUTHORIZATION:** If applicable, I authorize my employer to deduct from my wages the required dues.

VII. **NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my vision cost when I use a non-participating provider.

VIII. **ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employment 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 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 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 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.

X _____

Association Member Signature — Date

DISTRIBUTION: WHITE - Blue Cross Membership; CANARY - Blue Cross Marketing; PINK - Association Member