Anthem Blue Cross Life and Health Insurance Company
Notice of Language Assistance

IMPORTANT: An interpreter can be provided for you to communicate with your doctor or health plan at no cost. To get an interpreter or ask about written information in your language, please call the phone number listed on the back of your ID card or contact your group administrator.

IMPORTANTE: Se le puede brindar sin costo los servicios de un intérprete para que pueda comunicarse con su médico o plan de salud. Para obtener un intérprete o para solicitar información en su idioma, llame al número que figura en el reverso de su tarjeta de identificación o póngase en contacto con el administrador de su grupo. (Spanish)

重要提示： 您與您的醫生或保健計畫交談時，可獲得免費口譯服務。如欲請翻譯員提供口譯，或欲查詢中文書面資料，請撥打您識別證背面的電話號碼，或聯絡您的團體行政人員。(Chinese)

CHÚ Ý QUAN TRỌNG: Quý vị có thể được thông dịch viên giúp đỡ miễn phí khi quý vị cần tiếp xúc với bác sĩ hoặc nhân viên trong chương trình bảo hiểm sức khỏe của quý vị. Để được thông dịch viên giúp đỡ hoặc được cấp thông tin, văn bản chuyển ngữ sang ngôn ngữ của quý vị, xin quý vị vui lòng gọi số điện thoại ghi phía sau thẻ hội viên của quý vị hoặc liên lạc ban quản trị chương trình bảo hiểm. (Vietnamese)

MAHALAGA: Mai-alok ang tagapagsalin sa iyo nang libre upang makipag-usap ka sa iyong doktor o planong pangkalusugan. Upang kumuha ng tagapagsalin o magtanong tungkol sa nakasulat na impurmasyon sa iyong lengguahe,paki-tawagan ang numero ng telepono na nakalista sa likod ng iyong ID card o paki-usap ang tagapangasiwa ng iyong pangkat. (Tagalog)

중요: 의사 또는 건강보험사와의 의사소통을 위하여 통역사를 무료로 이용하실 수 있습니다. 통역이나 한국어로 번역된 정보를 원하시면 가입자님의 ID 카드 뒷면에 있는 전화번호로 연락하시거나 그룹 담당자에게 요청하시기 바랍니다. (Korean)

ԿԱՐԵՎՈՐ. Ձեր բժշկի կամ առողջապահական ծրագրի հետ հաղորդակցվելու համար՝ Ձեզ անվճար թարգմանիչ կարող է մատակարարվել: Թարգմանիչ ստանալու կամ Ձեր լեզվով գրավոր տեղեկությունների մասին հարցնելու համար՝ խնդրվում է զանգահարել Ձեր ինքնության քարտի ետ§ի մասում գրված հեռախոսի համարով կամ կապվեք Ձեր խմբային կառավարչի հետ: (Armenian)

ПОМНИТЕ: Для общения с вашим врачом или представителем плана медицинского страхования вам могут предоставить бесплатные услуги переводчика. Для того, чтобы получить услуги переводчика или попросить о предоставлении информации в письменном виде на вашем языке, пожалуйста, позвоните по номеру, который указан на оборотной стороне вашей идентификационной карты (ID card), или свяжитесь с администратором вашей медицинской группы. (Russian)

重要事項： 医師、および、ヘルスプラン担当者との意思疎通には、通訳者による通訳サービスを無料で受けることが出来ます。通訳者サービス、または、あなたが話す言語で書かれた文書による情報を要請するには、あなたのIDカードの裏側に記載された電話番号に電話をするか、または、あなたの属するグループのアドバイザーに連絡をとってください。(Japanese)

ਜ਼ਰੂਰੀ ਸੂਚਨਾ: ਤੁਹਾਡੇ ਡਾਕਟਰ ਨਾਲ ਜਾਂ ਹੈਲਥ ਪਲਾਨ ਬਾਰੇ ਗੱਲਬਾਤ ਕਰਨ ਲਈ ਤੁਹਾਨੂੰ ਦੁਭਾਸ਼ੀਏ (ਅਨੁਵਾਦਕ) ਦੀ ਸੇਵਾ ਮੁਫਤ ਦਿੱਤੀ ਜਾ ਸਕਦੀ ਹੈ। ਦੁਭਾਸ਼ੀਆ ਲੈਣ ਲਈ ਜਾਂ ਲਿਖਤ ਜਾਣਕਾਰੀ ਪੰਜਾਬੀ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੇ ਆਈ.ਡੀ. ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਨੰਬਰ ਤੇ ਫੋਨ ਕਰੋ ਜਾਂ ਆਪਣੇ ਗਰੁੱਪ ਪ੍ਰਬੰਧਕ ਨੂੰ ਸੰਪਰਕ ਕਰੋ। (Punjabi)

សារៈសំខាន់ : យើងអាចផ្តល់អ្នកបកប្រែជូនអ្នកដោយឥតគិតថ្លៃ សំរាប់ប្រាស្រ័យទាក់ទងជាមួយនឹងគ្រូពេទ្យ ឬគំរោងសុខភាពរបស់អ្នក ។ ដើម្បីទទួលអ្នកបកប្រែ ឬសាកសួរអំពីព័ត៌មានដែលសរសេរជាភាសាខ្មែរ សូមទូរស័ព្ទទៅលេខដែលមានកត់នៅលើខ្នងអត្តសញ្ញាណប័ណ្ណរបស់អ្នក ឬទាក់ទងអ្នកគ្រប់គ្រងក្រុមរបស់អ្នក ។ (Khmer)

هام: يمكننا توفير مترجم فوري لك للتواصل مع الطبيب الخاص بك أو بخصوص خطتك الصحية بدون مقابل. للحصول على مترجم فوري أو لطلب معلومات كتابية بلغتك، رجاء الاتصال على رقم الهاتف الموجود على ظهر بطاقة العضوية أو اتصل بمسؤول المجموعة. (Arabic)

TSEEM CEEB: Yeej nrhiav tau ib tug neeg pab txhais lus uas yuav pab koj nrog koj tus kws kho mob los sis pawg kho mob tham pub dawb rau koj. Yog xav tau ib tug neeg txhais lus los sis xav tau cov ntawv hauv koj yam lus, thov hu mus rau tus naj npawb xov tooj nram qab koj daim ID los sis hu mus rau tus neeg saib xyuas koj pawg hauj lwm. (Hmong)

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Group Change Form

Please read carefully and provide all applicable information.

Employee Last Name (Print)	First Name (Print)	Member ID No.	Group Medical No.	Group Dental No.	Life Group No.
			282537		

Type of Change: ☐ Name ☐ Address ☐ Dependent Status ☐ Medical/Dental Office ☐ Life Insurance ☐ Declining Coverage

NAME CHANGE

☐ Employee name only ☐ Entire family

New Name: ____________________

ADDRESS CHANGE

New Address

City | State | ZIP Code

New Phone No.

MEDICAL/DENTAL OFFICE CHANGE

☐ **Office Change***

Dental Office No.:

* For medical office changes, please indicate below under the Anthem Blue Cross HMO (CaliforniaCare) IPA Primary Care Physician Code section.

DEPENDENT STATUS CHANGE

☐ **Add Domestic Partner** – Date of registration: ____/____/____

☐ **Add Spouse** – Date of marriage: ____/____/____

☐ **Add Family Member** – Effective date: ____/____/____

Reason: ____________________

Is family member currently being added on Medicare? ☐ Yes ☐ No

If yes: ☐ Part A ☐ Part B ☐ Both

Name of Medicare dependent: ____________________

☐ **Remove Family Member(s)** – Effective date: ____/____/____

Name(s): ____________________ Reason: ____________

DECLINATION INFORMATION

I understand that if I terminate or decline coverage at this time, if I choose to apply for enrollment at a later date, I may be excluded from coverage until the employer's next open enrollment, or 12 months from date of application, at which time I may reapply for coverage.

In addition, once re-enrolled, I understand that my coverage may be subject to a six-month exclusion for pre-existing conditions. This exclusion also applies to any dependents on this declination. If you are declining coverage for yourself, your spouse, domestic partner or your dependents because of other health insurance coverage, you must tell us. You may enroll yourself or your dependents in this plan provided you request enrollment within 31 days after your coverage ends. You may also enroll following marriage (with your spouse), registration (with your domestic partner), childbirth or adoption (with your spouse and that child only) provided you request enrollment within 31 days after the marriage, registration, birth or adoption.

LIFE BENEFICIARY

Primary Name (first to receive payment)	%	Relationship	Birthdate	Social Security No.

Secondary Name (second to receive payment)	%	Relationship	Birthdate	Social Security No.

FAMILY ADDITIONS

Complete the information below for all family and/or spouse additions or medical office selections and/or changes. Check the disabled box only if the condition prohibits the member from working or performing daily activities. Please indicate if family member is covered by another health insurance plan by checking the Other Health coverage box. Complete the Prior Coverage section below, if applicable. For Anthem Blue Cross HMO and POS plans only, each person listed must choose a Medical Group or Independent Practice Association (IPA) within their enrollment area. IF YOU SELECT AN IPA, YOU MUST INDICATE A PRIMARY CARE PHYSICIAN FROM WITHIN THAT IPA. If you need assistance, contact Anthem Blue Cross at the number listed on your Membership ID Card or your health benefit officer.

To be eligible as a Domestic Partner, the Employee 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.

Relation	Last Name	First	M.I.	Sex	Birthdate Mo/Day/Yr	Age	Social Security No.
Self	Same as above	Same as above					
☐ Spouse ☐ Domestic Partner				☐ M ☐ F			
Child				☐ M ☐ F			
Child				☐ M ☐ F			
Child				☐ M ☐ F			
Child				☐ M ☐ F			

If children are age 19 or over, you must check the appropriate boxes below: Qualifies as IRS Dependent	Full-time Student	Totally Disabled	Coverage	Has other health coverage	Medical Group/ IPA Office No.	Anthem Blue Cross HMO IPA Primary Care Physician Code	Is this your current doctor
		☐ Y ☐ N	☐ Medical ☐ Dental ☐ Vision	☐ Y ☐ N			☐ Y ☐ N
		☐ Y ☐ N	☐ Medical ☐ Dental ☐ Vision	☐ Y ☐ N			☐ Y ☐ N
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Medical ☐ Dental ☐ Vision	☐ Y ☐ N			☐ Y ☐ N
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Medical ☐ Dental ☐ Vision	☐ Y ☐ N			☐ Y ☐ N
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Medical ☐ Dental ☐ Vision	☐ Y ☐ N			☐ Y ☐ N
☐ Y ☐ N	☐ Y ☐ N	☐ Y ☐ N	☐ Medical ☐ Dental ☐ Vision	☐ Y ☐ N			☐ Y ☐ N

PRIOR COVERAGE

If, immediately prior to becoming eligible for this plan, you or your eligible dependents were covered under any public or private health care coverage, please complete the section below to receive credit for that coverage.

According to Federal Law, your employer or former carrier must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

Name	Date Began	Date Ended	Prior Carrier Name	Reason for Ending Coverage

Name	Date Began	Date Ended	Prior Carrier Name	Reason for Ending Coverage

Employee Signature	Date
X	

FOR OFFICE USE ONLY

Effective Date:

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Vision and Life Insurance coverage provided by Anthem Blue Cross Life and Health Insurance Company.

anthem.com/ca

WHITE – Anthem Blue Cross Membership **YELLOW** – Employer **PINK** – Employee