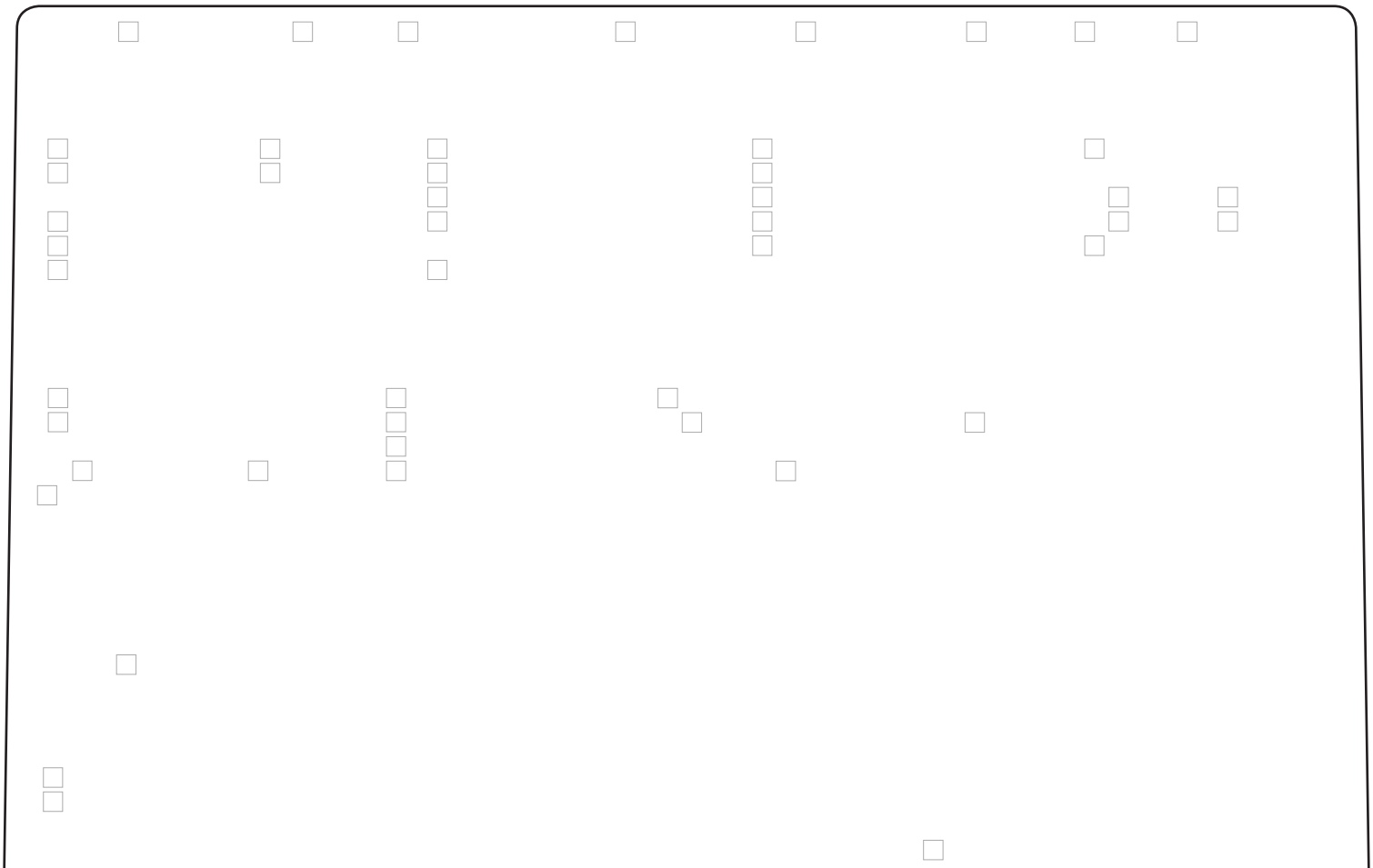
Anthem Blue Cross Enrollment Form



*Anthem is required by the Internal Revenue Service to collect this information.

Note: Dependent Life payments are always paid to the employee.
Primary Beneficiary – First to receive payment (required) If more than one beneficiary is named, enter a % for each. If no percentage is shown, equal shares are assumed.

Name	Birthdate	Social Security no.	Relationship	%
Street address		City	State	ZIP code
Name	Birthdate	Social Security no.	Relationship	%
Street address		City	State	ZIP code

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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.

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

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

: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

: The effective date of coverage is subject to Anthem Blue Cross approval.

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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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