Specialty Benefit Modification Form
For Dental and Vision

To add or change dental or vision coverage on an existing Anthem plan or alongside a new Anthem medical plan, complete this form and submit with a copy of the proposal. Any new enrollees or family additions must complete an Employee Application requesting coverage. Any current Anthem subscribers not wanting to enroll must submit a waiver. Please consult with your Anthem Representative before completing this form.

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

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Section 1: Company Information (Group size 2-100) * Minimum of 2 required

Select One: ☐ New Enrollment ☐ Coverage Change	Group/Case No.	SIC Code (4 digits)	Requested Effective Date	Employer Tax ID

Employer Name	Broker TIN	Agent Name	General Agent Name

Employer Address	Employer Zip Code	Group Contact Name

Section 2: Dental Coverage – Ineligible SIC Codes include Dental Offices #8021 and Miscellaneous #9999

Select One: ☐ Employer Sponsored ☐ Voluntary	Plan Name: _____ Contract Code: _____ Plan Name: _____ Contract Code: _____ NOTE: Orthodontia coverage is only available for groups with 5 or more enrolled.

☐ Base Rate ☐ Bundling Rate (New dental with one additional line of new Specialty (e.g. vision) are eligible to receive an additional 5% premium savings).

Section 3: Vision Coverage

Select One: ☐ Employer Sponsored ☐ Voluntary	Plan Name: _____ Contract Code: _____ Plan Name: _____ Contract Code: _____

☐ Base Rate ☐ Bundling Rate (New dental with one additional line of new Specialty (e.g. dental) are eligible to receive an additional 5% premium savings).

Section 4: Eligibility – Dental and Vision rates are based on total eligible, not enrolled

Number of eligible full-time employees working 30 hours per week: _____	Number of employees enrolling in: Dental: _____ Vision: _____

Section 5: Prior Coverage

Has this group had coverage within 12 months of this application's signature date? ☐ Yes ☐ No

Replacing Current Plan?	If yes, provider carrier name & plan type	Original Effective Date	Termination Date (MM/DD/YYYY)
Dental: ☐ Yes ☐ No			
Vision: ☐ Yes ☐ No			

Section 6: Employee Benefit Plan Changes

#	Employee Name	Contract Code	#	Employee Name	Contract Code
1			6		
2			7		
3			8		
4			9		
5			10		

Binding Arbitration

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, 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, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DESPITE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. For claims that exceed the jurisdiction of the small claims court that are subject to binding arbitration under this Agreement, California Health and Safety Code Section 1363.1 and Insurance Code section 10123.19 require specified disclosures in this regard. 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 permitted and 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 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. YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU. If your plan/policy is subject to 45 CFR 147.136, this agreement does not limit your rights to internal and external review of adverse benefit determinations as required by that law. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By signing, writing or typing your name below you agree to the terms of this agreement and acknowledge that your signed, written or typed name is a valid and binding signature.

Please send all Binding Arbitration demands in writing to:

Anthem Blue Cross
P.O. Box 9086
Oxnard, CA 93031-9086

Section 7: Employer Signature

By signing below, I agree to the above condition of enrollment in addition to all other terms, limitations and conditions of the Group Contract. X _____	Title	Date

For General Agent/Producer/Broker use only *Only needed if Agent/Broker is not on record for Group

General agent/producer/broker name*	Agent/producer/broker ID no.*		
Street Address*	City*	State*	ZIP Code*

I certify to the best of my knowledge, the responses herein are accurate.

☐ I have not had any interactions whatsoever with this applicant either by phone, e-mail or in person and did not provide any information, advise 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.

By signing below, I agree to the above condition of enrollment in addition to all other terms, limitations and conditions of the Group Contract and Application. X _____	Date

Anthem Use Only

Sales Representative and Account Manager

Sales Representative name	Sales Representative code no.
Account Manager Name	Account Manager code no.