Specialty Benefit Modification Form
For Dental, Vision, Life and Disability

To add or change dental, vision, life and/or disability coverage on an existing Anthem medical 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. No retroactive requests will be accepted. Any current Anthem subscribers not wanting to enroll must submit a wavier. Please complete section 8 for any current members wishing to enroll, more than 10 please complete full census. Please consult with your Anthem Representative before completing this form.

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	Broker Tin
Employer Name	Employer Tax ID	Agent Name	General Agent Name	
Employer Address	Employer Zip Code	Group Contact Name		
Group Contact Email address				

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

Select one:
☐ Employer Sponsored ☐ Voluntary

Choose your dental contribution(optional):
Employer to contribute_____% per employee_____% per dependent

Plan Name: _____ Contract Code: _____
Plan Name: _____ Contract Code: _____
NOTE: Orthodontia coverage is only available for groups with five or more enrolled.

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

Section 3: Vision Coverage

Select one:
☐ Employer Sponsored -minimum of two subscribers must enroll ; employer contribution between 50% and 100%
☐ Voluntary -minimum of five subscribers must enroll ; employer contribution between 0% and 49%

Choose your vision contribution(optional):
Employer to contribute_____% per employee_____% per dependent

Plan Name: _____Contract Code: _____
Plan Name: _____Contract Code: _____

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

Section 4: Life & Disability Coverage — Offered by Anthem Blue Cross Life and Health Insurance Company

LIFE PRODUCT CONTRIBUTION		DISABILITY PRODUCT CONTRIBUTION	
Product Choice (minimum of two employees must enroll)	**Percentage**	**Product Choice** (minimum of two employees must enroll)	**Percentage**
☐ None		☐ None	
☐ Basic Life & AD&D	_____%	☐ Short-Term Disability	_____%
☐ Basic Dependent Life	_____%	☐ Long-Term Disability	_____%
☐ Optional Supplemental/Voluntary Life and AD&D*	_____%	☐ Voluntary Short-Term Disability*	_____%
☐ Optional Supplemental/Voluntary Dependent Life*	_____%	☐ Voluntary Long-Term Disability*	_____%
*Available for Groups of 10+		*Available for Groups of 10+	

Life and/or Disability Eligibility Waiting Period — Waive eligibility waiting period for ALL existing employees at initial group enrollment? ☐ Yes ☐ No

Is the eligibility waiting period for new eligible employees enrolling in Life and/or Disability plans after the group's coverage effective date the same as the Anthem medical policy waiting period? ☐ Yes ☐ No If no, enter the Life and Disability eligibility waiting period below.

Class Number	**Coverage description** (e.g.: life, short-term disability, long-term disability, etc.)	**Description of eligibility waiting period** (e.g.: date of hire, first of month following 60 days of continuous employment, etc.)

Section 5: 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:_____ Life:_____ Disability: _____

Section 6: Prior Coverage

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

Replacing current plan?	If yes, provide carrier name & plan type	Original Effective Date:	Termination Date (MM/DD/YYYY):
Dental: ☐ Yes ☐ No			
Vision: ☐ Yes ☐ No			
Life: ☐ Yes ☐ No			
Disability: ☐ Yes ☐ No			

Section 7: 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

Section 8 – Employee Benefit Plan Changes

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

For General Agent/Producer/Broker use only

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:

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 DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE 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

X_____**DATE**_____

Anthem Use Only	
Sales Representative and Account Manager	
Sales Representative name	Sales Representative code no.
Account Manager Name	Account Manager code no.