



**REASON FOR ENROLLMENT:**  New Enrollment  Open Enrollment  Re-Hire  IRS Qualifying Event  
**GROUP NAME:** LOS ANGELES POLICE RELIEF ASSOCIATION, INC. **EFFECTIVE DATE:**

Office Use Only  
**FUND CODE:**  
**PART CODE:**



**PERSONAL INFORMATION**

|  |            |      |                     |  |   |   |                           |
|--|------------|------|---------------------|--|---|---|---------------------------|
| Last Name  | First Name | M.I. | Social Security No. | <input type="checkbox"/> M<br><input type="checkbox"/> F | Status<br><input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA | If Retired, Date of Retirement (mm/dd/yyyy) | Telephone No.<br>( ) -    |
| Street Address   |            |      | City                | State  | Zip Code  | Date of Birth (mm/dd/yyyy)                  | Date of Hire (mm/dd/yyyy) |
| Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Japanese <input type="checkbox"/> Tagalog <input type="checkbox"/> Vietnamese <input type="checkbox"/> Khmer <input type="checkbox"/> Hmong <input type="checkbox"/> Farsi <input type="checkbox"/> Arabic <input type="checkbox"/> Armenian <input type="checkbox"/> Russian <input type="checkbox"/> Other: _____ |            |      |                     |  |   |   |                           |

**COVERAGE SELECTION**

Plan Selection (Choose One):  PPO (Prudent Buyer)  HMO (CaliforniaCare)  BC PPO (Blue Card)  Fee-for-Service  Decline  
 Coverage (Choose One):  Member Only  Member and One Dependent  Member and Two or More Dependents

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 Association's next Open Enrollment, at which time I may re-apply for coverage. In addition, once 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 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.

**MEMBER AND FAMILY INFORMATION**

(Please list yourself and all eligible family members to be enrolled - attach additional sheets, if necessary)

|  | Last Name     | First Name    | M.I. | Social Security No. | Sex  | Birthdate (mm/dd/yyyy) | Age | Totally Disabled?   | If children are age 19 or over, you must check the appropriate boxes below |   | Medical Group/ IPA Number | Blue Cross HMO IPA Primary Care Physician Code | Is this your current MD?                                    |
|--|---------------|---------------|------|---------------------|--|------------------------|-----|---|--|---|---------------------------|--|---|
| Self   | Same as above | Same as above |      |                     |  |                        |     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |  |   |                           |  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| <input type="checkbox"/> Spouse<br><input type="checkbox"/> Domestic Partner |               |               |      |                     | <input type="checkbox"/> M<br><input type="checkbox"/> F |                        |     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | Qualifies as IRS Dependent   | Full-Time Student   |                           |  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Child  |               |               |      |                     | <input type="checkbox"/> M<br><input type="checkbox"/> F |                        |     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No                | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                           |  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Child  |               |               |      |                     | <input type="checkbox"/> M<br><input type="checkbox"/> F |                        |     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No                | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                           |  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Child  |               |               |      |                     | <input type="checkbox"/> M<br><input type="checkbox"/> F |                        |     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No                | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                           |  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Child  |               |               |      |                     | <input type="checkbox"/> M<br><input type="checkbox"/> F |                        |     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No                | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                           |  | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |

**DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE, INCLUDING MEDICARE? (If yes, please complete this section)**

|  | Name | Name and Address of Other Insurance Carrier | Effective Date (mm/dd/yyyy) | Group No. | Is this considered primary coverage?                        | Does it Cover?  |   | Medicare Coverage   | Part A Part A Eff. Dt.                                      | Part B Part B Eff. Dt.                                      | Medicare ID No. | ESRD?   |
|--|------|---|-----------------------------|-----------|---|---|---|---|---|---|-----------------|---|
|  |      |   |                             |           |   | Medical   | Mental Health   |   |   |   |                 |   |
| Self   |      |   |                             |           | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                 | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| <input type="checkbox"/> Spouse<br><input type="checkbox"/> Domestic Partner |      |   |                             |           | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                 | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Child  |      |   |                             |           | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                 | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Child  |      |   |                             |           | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                 | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Child  |      |   |                             |           | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                 | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |
| Child  |      |   |                             |           | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |                 | <input type="checkbox"/> Yes<br><input type="checkbox"/> No |

**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. **DEDUCTION AUTHORIZATION:** If applicable, I authorize my employer to deduct from my wages the required dues.  
**NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider. **HIV TESTING PROHIBITED:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance. **EFFECTIVE DATE:** The effective date of coverage is subject to Anthem Blue Cross approval. **REQUIREMENT FOR BINDING ARBITRATION:** I understand that I will be subject to the following binding arbitration provision: **I UNDERSTAND THAT ANTHEM BLUE CROSS REQUIRES BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO CLAIMS OF MEDICAL MALPRACTICE IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT.** This means that Anthem Blue Cross and I are waiving our rights to a jury trial for both specified disclosures in this regard, including the following notice: "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 incompletely rendered, will be determined by submission to arbitration as provided by California law, 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." Anthem Blue Cross and I are also giving up our right to pursue on a class basis any claim or controversy against each other.

**NOTICE: EXCEPT AS NOTED ABOVE, BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ALL DISPUTES AGAINST ANTHEM BLUE CROSS WHERE THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS AND ANY OTHER DISPUTES.**

Member Signature: X \_\_\_\_\_ Date: \_\_\_\_\_