



**PERSONAL INFORMATION**

Current Last Name	Current First Name	Member ID	New Last Name	New Last Name Applies to: <input type="checkbox"/> Member Only <input type="checkbox"/> All Family Members	New First Name	Name Change is Effective (mm/dd/yyyy)	Status <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA
New Address			City	State	Zip Code	New Telephone No. ( ) -	Address/Phone # Change is Effective (mm/dd/yyyy):

**MEDICAL AND DENTAL PLAN ELECTIONS**

Current: <b>MEDICAL</b> → <input type="checkbox"/> PPO (Prudent Buyer) <input type="checkbox"/> HMO (CaliforniaCare Plus) <input type="checkbox"/> Decline	New: <b>MEDICAL</b> → <input type="checkbox"/> PPO (Prudent Buyer) <input type="checkbox"/> HMO (CaliforniaCare Plus) <input type="checkbox"/> Decline
Current: <b>DENTAL</b> → <input type="checkbox"/> PPO (Complete) <input type="checkbox"/> HMO <input type="checkbox"/> Decline	New: <b>DENTAL</b> → <input type="checkbox"/> PPO (Complete) <input type="checkbox"/> HMO <input type="checkbox"/> Decline

**MEDICAL AND DENTAL COVERAGE TIERS**

Current: <b>MEDICAL</b> → <input type="checkbox"/> Member Only <input type="checkbox"/> Member & One Dependent <input type="checkbox"/> Member & Two or More Dependents	New: <b>MEDICAL</b> → <input type="checkbox"/> Member Only <input type="checkbox"/> Member & One Dependent <input type="checkbox"/> Member & Two or More Dependents
Current: <b>DENTAL</b> → <input type="checkbox"/> Member Only <input type="checkbox"/> Member & One Dependent <input type="checkbox"/> Member & Two or More Dependents	New: <b>DENTAL</b> → <input type="checkbox"/> Member Only <input type="checkbox"/> Member & One Dependent <input type="checkbox"/> Member & Two or More Dependents

**MEMBER AND FAMILY INFORMATION**

Complete the information below for all family and/or spouse/domestic partner additions. Check the disabled box only if the condition prohibits the person from working or performing daily activities. For Anthem Blue Cross HMO medical 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. For Anthem Blue Cross HMO dental plans only, each person listed must choose a dental provider. 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.

A=Add T=Term C=Change	Applies To	Last Name	First Name	M.I.	Social Security No.	Sex	Birthdate (mm/dd/yyyy)	Age	Totally Disabled?	If child is unmarried and age 19 or over, is he or she dependent on the Member for support and a full-time student?	Medical Coverage?	Medical Group/IPA Number	Blue Cross HMO IPA - Primary Care Physician Code	Is this your current MD?	Dental Coverage?	Dental Office Number (if enrolling in the HMO Dental Plan)	Current Patient?
	Self	Same as above	Same as above						<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.					<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child					<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child					<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child					<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child					<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

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

A=Add T=Term C=Change	Applies To	Name	Name & Address of Other Medical Insurance Carrier	Effective Date (mm/dd/yyyy)	Termination Date (mm/dd/yyyy)	Group No.	Is this considered primary coverage?	Does it Cover?		Medicare Coverage	Part A Eff. Dt.	Part B Eff. Dt.	Medicare ID No.	ESRD?	Name & Address of Other Dental Insurance Carrier	Effective Date (mm/dd/yyyy)	Termination Date (mm/dd/yyyy)	Group No.	Is this primary coverage?
								Medical	Mental Health										
	Self	Same as above					<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No						<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No						<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No						<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No						<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No						<input type="checkbox"/> Yes <input type="checkbox"/> No
	Child						<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No						<input type="checkbox"/> Yes <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 premiums. **NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of costs when I use a non-participating provider.

Member Signature: **X**

Date: