Anthem BlueCross

UCLA House Staff
Medical Insurance
Anthem Blue Cross Medical Insurance Group No. 1350JA

Enrollment/Change Form

anthem.com/ca

PLEASE PRINT

SECTION A: House staff information

Last name	First name	MI	Sex	Start date (MM/DD/YYYY)

Street address	Phone no. ( )	Date of birth (MM/DD/YYYY)

City	State	ZIP Code	Social security no.

SECTION B: Type of activity

☐ New coverage ☐ Name change ☐ Address change ☐ Reinstate coverage

☐ Add spouse or dependent If adding spouse, date of marriage: _____ ☐ Other _____

SECTION C: Dependent information for medical benefits. *No charge for insurance for spouse/eligible partner or children.*

Relationship	Last name	First name	MI	Social security no.	F/T student	Sex	Disabled	Date of birth MM DD YY
Spouse OR					☐ Yes ☐ No		☐ Yes ☐ No	
Eligible partner					☐ Yes ☐ No		☐ Yes ☐ No	
Child 1					☐ Yes ☐ No		☐ Yes ☐ No	
Child 2					☐ Yes ☐ No		☐ Yes ☐ No	
Child 3					☐ Yes ☐ No		☐ Yes ☐ No	

SECTION D: Type of coverage. *Please make plan selection and check the appropriate box.*

☐ Employee only ☐ Employee + one ☐ Employee + family

☐ I decline medical insurance coverages offered by UCLA. Reason: _____

☐ I decline medical insurance coverage for my spouse. Reason: _____

FOR OFFICE USE ONLY

New coverage effective: _____	Physician ID no.
Change from: _____ To: _____ Effective: _____	

PLEASE COMPLETE SIDE TWO

UCLA HOUSE STAFF
MEDICAL INSURANCE ENROLLMENT/CHANGE FORM

SECTION F: Do you or your dependents have other Health Care Coverage? If yes, complete Section F.

My family is not covered by any other insurance company. Check here ☐

Relationship	Name	Primary Coverage	Name and address of other insurance coverage	Effective date	Group no.
Self		☐ Yes ☐ No			
Spouse or eligible partner		☐ Yes ☐ No			
Child 1		☐ Yes ☐ No			
Child 2		☐ Yes ☐ No			
Child 3		☐ Yes ☐ No			

SECTION G: Please read Section G carefully. Signature required.

Please read the following carefully and provide signatures where indicated. Thank you.

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

II. 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.

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

REQUIREMENT FOR BINDING ARBITRATION

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES, 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, 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. ***It is understood that any dispute including disputes relating to the delivery of services under the plan/policy or any other issues related to the plan/policy, including 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 as 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.*** **THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL AND PARTICIPATION IN A CLASS ACTION FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY.**

Signature (Required)

Applicant	Date
X	

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