Anthem Blue Cross Enrollment Form

Please return the completed enrollment form to your employer.

Effective date (MMDDYY)	Group no.

Section 1: Applicant's personal information

Last name	First name	M.I.	Marital status ☐ Single ☐ Married ☐ Domestic Partner (DP)	Social Security or TIN no.[1] (required)
Mailing address		Apt. no.	No. of dependents including spouse	Spouse/DP Social Security or TIN no.[1] (required)
City		State	ZIP code	Home phone no.

Hire date/Rehire date Part-time to Full-time date (MMDDYY)	Employer name	Job title	Class	Dept. no.	Email address

Language choice (optional) ☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Other – please specify: _____

SIMNSA Eligibility[2]: (Complete only if SIMNSA is selected as the medical group for you or any dependent.)
Are you a Mexican National? ☐ Yes ☐ No Do you work in San Diego county or Imperial county? ☐ Yes ☐ No

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

1 TIN refers to Taxpayer Identification Number.

2 Member must meet both criteria above.

Section 2: Reason for application – Select one

- ☐ New enrollment
- ☐ Annual open enrollment (not applicable to life and disability)
- ☐ New hire
- ☐ Rehire – Rehire date: (MMDDYY)
- ☐ Marriage – Date of marriage: (MMDDYY)
- ☐ Domestic Partnership – Date of commencement: (MMDDYY)
- ☐ Birth of child
- ☐ Add dependent (Fill in section 4)
- ☐ Loss of eligibility for other coverage – Date previous coverage ended: (MMDDYY) (not applicable to life and disability)
- ☐ COBRA – Select qualifying event (not applicable to life and disability)
  - ☐ Left employment ☐ Reduction in hours ☐ Death ☐ Medicare
  - ☐ Loss of dependent child status ☐ Divorce or legal separation ☐ Covered employee's Medicare entitlement
  - Qualifying event date: (MMDDYY)
- ☐ Waiver (To decline ALL coverage skip to section 5.)

Social Security or TIN no.[1] (required)

Section 3: Type of coverage – Select from only the coverages offered by your employer.

Medical

Anthem Blue Cross plans:

- ☐ HMO[2]
- ☐ Priority Select HMO[2]
- ☐ Select HMO[2]
- ☐ Vivity HMO[2]
- ☐ Elements Choice HMO[2]
- ☐ POS (Blue Cross Plus)[2]
- ☐ EPO (Prudent Buyer Exclusive)
- ☐ Blue Connection EPO
- ☐ Anthem High Performance EPO
- ☐ Anthem High Performance EPO HSA

Anthem Blue Cross Life and Health Insurance Company plans:

- ☐ PPO (Prudent Buyer)
- ☐ Select PPO
- ☐ Elements Choice PPO
- ☐ Elements Choice HSA (non-California resident)
- ☐ BC PPO (non-California resident)
- ☐ BC Exclusive (non-California resident)
- ☐ Consumer Driven Health Plans: (select one of the following)
  - ☐ H.S.A.[3] ☐ H.R.A.
  - ☐ H.I.A. Plus
- ☐ Medicare

☐ Other: _____

☐ Add HRA Wrap (Administered by Anthem)

2 Indicate Medical Group/IPA no. in the ***Employee and family information*** section 4.

3 Anthem will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

Flexible Spending Account (FSA) – More than one plan may be selected, depending on employer offerings.

☐ Healthcare FSA ☐ Limited-Purpose FSA (for members enrolled in HSA plans) ☐ Dependent Care FSA ☐ Commuter Transit ☐ Commuter Parking

Dental

Anthem Blue Cross plans:

- ☐ Dental Net HMO[4]
- ☐ Choice Dental (select one of the following)
  - ☐ Dental Net HMO[4]
  - ☐ PPO Dental

Anthem Blue Cross Life and Health Insurance Company plans:

- ☐ Dental Consumer Choice
- ☐ Dental Essential Choice
- ☐ Dental Prime
- ☐ Dental Complete
- ☐ Dental Prime Voluntary
- ☐ Dental Complete Voluntary
- ☐ Dental Consumer Choice Voluntary
- ☐ Dental Essential Choice Voluntary
- ☐ Voluntary PPO Dental
- ☐ Dental Blue Complete Incentive
- ☐ Dental Choice EPO
- ☐ Dental Choice EPO Voluntary
- ☐ Dental Blue PPO
- ☐ PPO Dental
- ☐ National Dental Blue PPO
- ☐ National PPO Dental
- ☐ National Voluntary PPO Dental

☐ Other: _____

4 Indicate Dental Office no. in ***Employee and family information*** section 4.

Vision

☐ Blue View Vision (offered by Anthem Blue Cross Life and Health Insurance Company)

Life and Disability insurance

All the coverages listed may not be offered by your employer. To elect dependent coverage, the corresponding employee coverage must be selected. List all life insurance beneficiaries in the ***Life insurance beneficiary designation information*** section. If you select life and/or disability coverage over the guaranteed issue amount or are a late entrant an ***Evidence of Insurability*** form may be sent to you to complete.

Annual salary
$

Elected benefit	Benefit amount	Elected benefit	Benefit amount	Elected benefit	Benefit amount
☐ Basic Life (AD&D)	$_____	☐ Supplemental/Voluntary Life - Employee	$_____	☐ Voluntary AD&D - Employee	$_____
☐ Dependent Life - Spouse	$_____	☐ Supplemental/Voluntary Dependent Life - Spouse	$_____	☐ Voluntary AD&D - Spouse	$_____
☐ Dependent Life - Child	$_____	☐ Supplemental/Voluntary Dependent Life - Child	$_____	☐ Voluntary AD&D - Child	$_____
		☐ Short Term Disability	$_____	☐ Voluntary Short Term Disability	$_____
		☐ Long Term Disability	$_____	☐ Voluntary Long Term Disability	$_____

Group Accident, Critical Illness, and Hospital Indemnity Insurance

☐ **Group Accident Insurance** – Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Accident plan offered please select: ☐ Low Plan ☐ High Plan

☐ **Group Critical Illness Insurance** – Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Critical Illness plan offered please select: ☐ Low Plan ☐ High Plan
Have you smoked or used tobacco products in the last 12 months? ☐ No ☐ Yes, explain product used: _____

☐ **Group Hospital Indemnity Insurance** – Coverage option: ☐ Employee only ☐ Employee + Spouse ☐ Employee + Children ☐ Family
If more than one Hospital Indemnity plan offered please select: ☐ Low Plan ☐ High Plan

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

If any person to be covered by a Critical Illness or Hospital Indemnity plan is a resident of CA, GA, NY or CO, please answer the following question:

Will all applicants who reside in CA, GA, NY, or CO , when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy, an employer sponsored health plan, or an HMO that provides essential health benefits?

☐ Yes ☐ No Please note that if the response is No, such applicants are not eligible for coverage.

1 TIN refers to Taxpayer Identification Number.

Social Security or TIN no.[1] (required)

Group Accident, Critical Illness, and Hospital Indemnity Insurance beneficiary designation

Beneficiary designation — Attach a separate sheet if necessary.

	Name of beneficiary	Percentage	Social Security or TIN no.[1]	Relationship to applicant	Age
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

Note: Enrollment in the selected plan is dependent upon you residing or working within a plan's geographical service area, and the network, provider, and physician availability within the geographical service area. If at the time of your enrollment the network or physician/medical group is not available or you do not reside or work in the geographical service area of the plan, you may be assigned to or be required to choose a different provider, network, and/or plan.

Section 4: Employee and family information — Please list yourself and all eligible family members to be enrolled. Attach additional sheets if necessary.

Sex	Last Name	First Name	M.I.	Birthdate (MM/DD/YY)	Social Security or TIN no.[1] (required)	Full-time student (if applicable, for non-medical plans)	If children are age 26 or over you must check the appropriate boxes below	**HMO & POS ONLY** IPA/Primary Care Physician code	Current MD?	Dental Net **ONLY** Office no.
☐ M ☐ F	Employee					☐ Yes ☐ No	IRS Qualified Dependent		☐ Yes ☐ No	
☐ M ☐ F	Spouse/DP					☐ Yes ☐ No	IRS Qualified Dependent		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	
☐ M ☐ F						☐ Yes ☐ No	☐ Yes ☐ No		☐ Yes ☐ No	

1 TIN refers to Taxpayer Identification Number.

Social Security or TIN no.[1] (required)

Section 5: Declination — Please complete if any coverage is declined or refused by an eligible employee and/or their eligible dependents.

A. Medical coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

B. Dental coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

C. Vision coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

D. Life insurance coverage declined for:
☐ Myself ☐ Spouse/DP ☐ Child(ren)

E. Disability insurance coverage declined for:
☐ Myself

Reason for declining coverage – check one
☐ Covered by spouse's group coverage
Insurer name and ID no.: _____
☐ Covered by Anthem Individual policy
☐ Spouse covered by employer's group medical coverage
Insurer name: _____
☐ Enrolled in Tricare
☐ Enrolled in any other insurance plan
Insurer name: _____
☐ Medicare
☐ Other (Explain): _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT PERIOD TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN.**

Signature if declining coverage for employee/dependent(s)
X

Date (MMDDYY)

Section 6: COBRA/Cal-COBRA coverage information — Complete only if enrolling in COBRA/Cal-COBRA.

Reason for COBRA/Cal-COBRA coverage

Federal COBRA qualifying event date (MMDDYY)	Federal COBRA coverage begin date (MMDDYY)	Federal COBRA coverage end date (MMDDYY)
Cal-COBRA qualifying event date (MMDDYY)	Cal-COBRA coverage begin date (MMDDYY)	Cal-COBRA coverage end date (MMDDYY)

Section 7: Other coverage for all enrolling employees and dependents — All questions must be answered.

A. Do any persons on this application intend to continue other group coverage if this application is accepted? ☐ Yes ☐ No
If yes, name of person(s): _____
Insurance company: _____ Policy no. _____ Phone no. _____

B. Does any person applying for coverage currently have health insurance coverage? ☐ Yes ☐ No
Has any person applying for coverage had health insurance coverage at any time in the past six months? ☐ Yes ☐ No
If yes, applicant/family member name(s): _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____
Insurance company: _____ Policy no. _____ Phone no. _____
Date coverage began: _____ Date ended: _____ (MMDDYY)

C. Does any person applying for coverage currently have dental insurance coverage? ☐ Yes ☐ No
If yes, applicant/family member name(s): _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____ Includes orthodontia? ☐ Yes ☐ No
Insurance company: _____ Policy no. _____ Phone no. _____
Date coverage began: _____ Date ended: _____ (MMDDYY)

D. Does any person applying for coverage currently have vision insurance coverage? ☐ Yes ☐ No
If yes, applicant/family member name(s): _____
Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: _____
Insurance company: _____ Policy no. _____ Phone no. _____
Date coverage began: _____ Date ended: _____ (MMDDYY)

E. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits? ☐ Yes ☐ No
Note: If you are eligible for Medicare, Anthem may not duplicate Medicare benefits.

1 TIN refers to Taxpayer Identification Number.

Social Security or TIN no.[1] (required)

Section 9: Prior coverage for PPO and dental plans only — Attach additional sheets if necessary.

Please fill out the following information to receive proper credit for **previous coverage** (if immediately prior to becoming eligible for this plan, you have a dependent child(ren) over the age of 26 who cannot get a self-sustaining job due to a physical or mental condition and was covered under any public or private health care coverage, including MediCal or individual coverage). **Note**: If this section is left blank, there may be delays in the processing of claims for these dependents. If any coverage will remain in force once your dependent(s) enroll with Anthem, leave the end date blank.

Name (last, first, M.I.)	Type (check one)	Coverage (check all that apply)	Insurer name	Insurer phone no.	Policy ID no.	Date (if applicable) (MMDDYY)	Reason for ending coverage (if applicable)
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: End:	
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: End:	
	☐ Individual ☐ Group ☐ Medicare	☐ Health ☐ Dental ☐ Orthodontia				Start: End:	

Section 10: Life insurance beneficiary designation information

Beneficiary designation — Attach a separate sheet if necessary. **Note**: Dependent Life payments are always paid to the employee.
Primary Beneficiary – First to receive payment (required)

	Name of beneficiary	Percentage	Social Security or TIN no.[1]	Relationship to applicant	Age
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

Total percentages must add up to 100%. If the total percentages add up to less than 100%, the remaining percentage will be paid in equal shares to all named beneficiaries to total 100%. If the total percentages add up to more than 100%, each named beneficiary's share will be reduced equally to total 100%. If no percentages are indicated, the proceeds will be divided equally. If no primary beneficiary survives, the proceeds will be paid to the contingent beneficiary(ies) listed above. Beneficiaries may be changed by the insured's written notice to his or her employer.

Spousal Consent For Community Property States Only (Note: The insurance company is not responsible for the validity of a spouse consent for designation.)
If you live in a community property state (AZ, CA, ID, LA, NM, NV, TX, WA, and WI), your state may require you to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary for 50% or more of your benefit amount. Please have your spouse read and sign the following.
Authorization: I am aware that my spouse, the Employee/Retiree named above, has designated someone other than me to be the beneficiary of group life insurance under the above policy.
I hereby consent to such designation and waive any rights I may have to the proceeds of such insurance under applicable community property laws.
I understand that this consent and waiver supersedes any prior spousal consent or waiver under this plan.
In CA, NV, and WA, Spouse also includes your registered Domestic Partner.

Spouse/Domestic Partner signature	Spouse/Domestic Partner name	Date (MMDDYYYY)
X		

Section 11: Electronic notice — Signature required to opt-in to electronic delivery.

Member email address: _____

I (primary applicant) agree to receive my plan-related communications for myself and any dependents, either by email or electronically. This may include my certificate, evidence of coverage, explanation of benefits statements, required notices or helpful information to get the most out of my plan. I agree to provide and update Anthem with my current email address. I know that at any time I can change my mind and request a copy of these materials (or any specific materials) by mail, by contacting Anthem. I or my enrolled dependents will update our communication preferences by going to anthem.com/ca or calling Member Services at 877-242-5659.

Member signature	Date (MMDDYY)
X	

1 TIN refers to Taxpayer Identification Number.

Social Security or TIN no.[1] (required)

Section 12: 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 subscription charges/premiums.

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 approval.

COBRA/Cal-COBRA Continuation Coverage

You may continue your health care coverage by: 1) completing the remainder of this form; 2) signing your name in the blank space below; 3) paying your Total Monthly Continuation Payment; and 4) mailing this form to Anthem, no later than sixty (60) days after the date you receive this notice. If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your qualification for coverage will end. If you do choose COBRA Continuation Coverage, your current coverage will be continued until the earliest of the following dates:

1. The date eligibility for COBRA Continuation Coverage ends, or
2. The date you fail to make timely payments of your premium for COBRA Continuation Coverage, or
3. The date your employer discontinues coverage with Anthem, or
4. The date you become entitled to Medicare on the basis of age (65 years), or the date thirty (30) months after you become entitled to Medicare on the basis of end stage renal disease, or
5. The date you become covered under another group health plan as a result of employment, re-employment, remarriage, or otherwise.

If, at any time during the first sixty (60) days of your COBRA Continuation Coverage, you are determined under Title II or XVI of the United States Social Security Act to be disabled, you may be entitled to continue coverage while you are disabled for up to 29 months from the date you first qualified for Continuation Coverage under COBRA. Contact the Health Plan Administrator at your previous employer for full information.

The Monthly Continuation Payment is the cost of continued coverage for the month beginning on the date after the Date of Loss of Coverage. If you do not pay your initial monthly premium within 45 days after your election of COBRA Continuation Coverage, or if payment of succeeding premiums are not received within the 30-day grace period thereafter, your coverage will end.

Note: If you do not elect available COBRA Continuation of Medical Coverage, you will lose certain rights under federal law (HIPAA) to guaranteed issue individual coverage.

I certify each Social Security number listed on this application is correct.

Life and/or Disability Authorization Section – Read carefully before signing

1. Payment of proceeds shall be made in accordance with the terms of the group contract. Unless otherwise provided herein, if one or more life insurance beneficiaries are named, the proceeds due shall be paid in equal shares to the named beneficiaries surviving the insured. Beneficiaries may be changed by the insured employee's written notice to his or her employer.
2. These coverages will become effective on the date established by the provisions of the group contract and certificates issued thereunder.
3. This authorization, for purposes of processing this application form, is valid from the date signed for a period of 30 months unless revoked by me in writing, which I may do at any time by contacting Anthem. For the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization shall remain valid for the term of coverage of the policy for an accident and sickness insurance benefit and for the duration of the claim if the claim is not for an accident and sickness insurance benefit. A photocopy and/or electronic copy is as valid as the original. The Applicant or the Applicant's authorized representative is entitled to receive a copy of this Authorization.
4. I give this authorization for myself and on behalf of my eligible dependents if covered by the Plan, including my Spouse/Domestic Partner/Civil Union Partner. I am acting as their agent and representative.

REQUIREMENT FOR BINDING ARBITRATION (Not applicable to Life and Disability coverage)

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY (ANTHEM), 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. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require 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 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 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. 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 providing your "handwritten or electronic" signature below, you acknowledge that such signature is valid and binding.

Signature (Required)

Applicant **X**	Date (MMDDYY)

1 TIN refers to Taxpayer Identification Number.

Social Security or TIN no.[1] (required)

Important Accident Insurance eligibility information:

The following notice applies to all Accident and Voluntary Accident coverage presented on this form:

ACCIDENT INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Critical Illness Insurance eligibility information:

The following notice(s) apply to all Critical Illness and Voluntary Critical Illness coverage presented on this form:

CRITICAL ILLNESS INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Important Hospital Indemnity Insurance eligibility information:

The following notice applies to all Hospital Indemnity and Voluntary Hospital Indemnity coverage presented on this form:

HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT A QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

1 TIN refers to Taxpayer Identification Number.