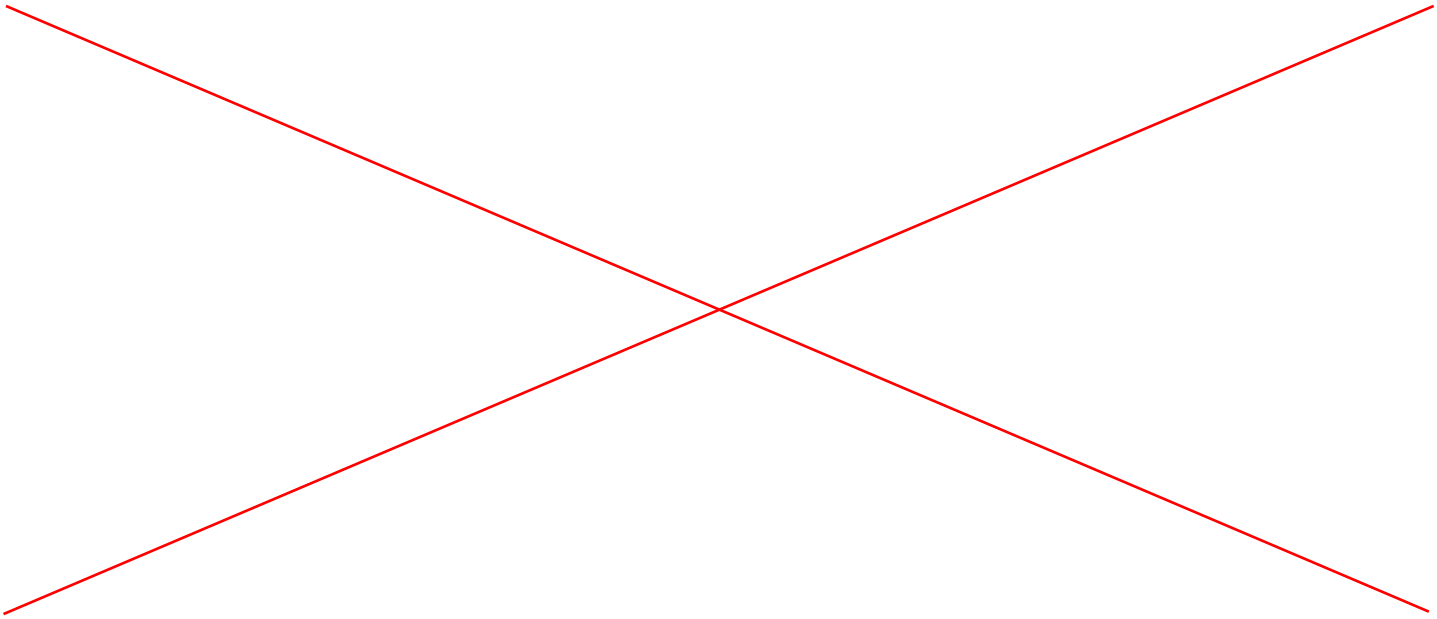

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*Anthem is required by the Internal Revenue Service to collect this information.

SECTION 9: LIFE INSURANCE BENEFICIARY DESIGNATION INFORMATION

Note: Dependent Life payments are always paid to the employee.

Primary Beneficiary — First to receive payment (required) If more than one beneficiary is named, enter a % for each. If no percentage is shown, e

Name	Birthdate	Social Security no.	Relationship	%
Street address		City	State	ZIP code
Name	Birthdate	Social Security no.	Relationship	%
Street address		City	State	ZIP code

SECTION 10: 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 be with no omissions or misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required subscription charges/premium

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a nor

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a co

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross 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 spa Total Monthly Continuation Payment; and 4) mailing this form to Anthem Blue Cross, no later than sixty (60) days after the date If you fail to choose COBRA Continuation Coverage within sixty (60) days after the date you receive this notice, your quali cation 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 Blue Cross, 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 en 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 c

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

*Anthem is required by the Internal Revenue Service to collect this information.