Step by Step Guide to Switch from Anthem Blue Cross to Kaiser

For members of the California Association of REALTORS®

Step 1 - Complete RealCare Termination Request Form to Cancel Anthem Coverage

- Complete personal information
- Select the box(es) to indicate each type of coverage to terminate
- Select a box to indicate the reason for your request
- Sign and date the bottom of the form

Step 2 - Complete Anthem Employee Waiver Form Sections 1 and 2

- Fill in your personal information and the requested effective date of cancellation.
    - Retroactive cancellations are not allowed.
- **If you are a C.A.R. Member indicate the employer as "C.A.R." and provide your C.A.R. Join date in the space provided for Hire date.**
- If you are a W-2 employee of a C.A.R. member, enter the C.A.R. member's name or firm name.

Anthem Waiver Form Section 2

You must complete this section for all eligible family members who are cancelling coverage. By cancelling coverage you are waiving your eligibility for enrollment at this time.

- DO NOT check the boxes for Dental or Vision or Life, only Medical.
- Check a box in the first column to indicate who you are waiving/cancelling/declining coverage for.
- Check a box in the second section to indicate you are cancelling/declining medical coverage.
- Complete the section identifying the reason you're declining coverage.
- Sign and date the bottom of the page.

Step 3 – Complete and Sign Kaiser Enrollment Form

Submit Completed Application

- If enrolling in or changing Automatic Premium Payment Authorization, you must include a voided check

Email to:	Fax to:	Mail To:
RC-Enrollment@NFP.com	(707) 939-8450	548 Market St. PMB 91266 San Francisco, CA 94104

If you have questions, please contact us at (800) 939-8088

C.A.R. HEALTH & LIFE PLANS TERMINATION REQUEST FORM

This termination form is for use ONLY with C.A.R. health and life plans.
RealCare is not responsible for termination of coverage outside of the C.A.R. group plans.

Date: _____ Member ID or Policy #:_____

Subscriber Name: _____
Last First M.I.

Address: _____
Street Address

_____
City State Zip

Phone Number: _____ Email: _____

Please terminate the following coverage effective: _____ ***(Terminations must be effective as of the first of the month. Monthly premium payments are not prorated for terminations and retroactive terminations are usually not allowed.)***

☐ C.A.R. Group Kaiser Medical Plan

☐ C.A.R. Group Anthem Blue Cross Medical Plan *(Include completed/signed Anthem "Employee Waiver Form")*

☐ C.A.R. Group Dental Plan - If dental coverage is terminated, you will not be eligible to re-enroll until the next Open Enrollment following a thirteen-month waiting period.

☐ C.A.R. Group Vision Plan - If vision coverage is terminated, you will not be eligible to re-enroll until the next Open Enrollment following a thirteen-month waiting period.

☐ C.A.R. Group Life Insurance

I am terminating coverage because:

☐ I have obtained replacement coverage from another group

☐ I have obtained replacement coverage from an individual/family plan

☐ I have obtained replacement coverage from Covered California

☐ I don't want the coverage

☐ Other – Please Describe: _____

Subscriber Signature: _____ Date: _____

Fax your completed termination request form to RealCare Billing Department (707) 939-8450 or e-mail to rc-enrollment@nfp.com

RealCare Insurance Marketing, Inc. • 548 Market St., PMB 91266 • San Francisco, CA 94104
Phone: 800-939-8088 or 707-939-8088 • Fax 707-935-7142 • Website: www.RealCareCAR.com
California Insurance License #OB23546

Use this form to terminate Anthem coverage or drop dependents

California Employee Waiver Form For Small Groups

Anthem

Health care plans offered by Anthem Blue Cross and Insurance plans offered by Anthem Blue Cross Life and Health Insurance Company.

Instructions: Please complete and return to your Group Administrator. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, please answer all questions and be sure to sign and date your application.

Group/Case no. (if known)

Section 1: Employee Information

Last name	First name	M.I.	Social Security no.[1]

Home address — (P.O. Box not acceptable unless rural address)	City	State	ZIP code

Employment status (required) ☐ Full-time ☐ Part-time	Hire date (required) (MM/DD/YYYY)	Requested effective date

Employer name

Do you read and write English? ☐ Yes ☐ No If no, the translator must sign and submit a Statement of Accountability/Translator's Statement.

Section 2: Waiver/Declining coverage —

Complete only if any coverage is declined or refused by you and/or your eligible dependents. Proof of coverage may be required.

Type of coverage/Declined for: Select all that apply		**Reason for declining/refusing coverage:** Select all that apply
☐ Employee	☐ Medical ☐ ~~Dental~~ ☐ ~~Vision~~	☐ No coverage ☐ Covered by Spouse's/Domestic Partner's group coverage ☐ Spouse/Domestic Partner covered by their employer's group coverage ☐ Enrolled in individual coverage ☐ Medicare/Medi-Cal/VA ☐ Enrolled in other Insurance — Please provide company name and plan: _____ ☐ Other — please explain: _____
☐ Spouse/Domestic Partner	☐ Medical ☐ ~~Dental~~ ☐ ~~Vision~~	
☐ Dependent(s)	☐ Medical ☐ ~~Dental~~ ☐ ~~Vision~~ List name of dependents to be waived: _____	

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, including but not limited to my employer or agent, has tried to influence me or put any pressure on me to waive coverage. BY WAIVING THIS GROUP MEDICAL, DENTAL, AND VISION COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL, DENTAL, AND VISION COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UNTIL THE NEXT OPEN ENROLLMENT TO BE ENROLLED IN THIS GROUP'S MEDICAL, DENTAL, AND VISION INSURANCE PLAN UNLESS I QUALIFY FOR A SPECIAL OPEN ENROLLMENT. Please note Spouse/Domestic Partner and Dependent coverage will not be available if the Employee has waived/declined.

Special Open Enrollment

If you declined enrollment for yourself or your dependent(s) (including a spouse/domestic partner), you may be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of certain triggering events, including: (1) you or your dependent loses minimum essential coverage; (2) you gain or become a dependent; (3) you are mandated to be covered as a dependent pursuant to a valid state or federal court order; (4) you have been released from incarceration; (5) your health coverage issuer substantially violated a material provision of the health coverage contract; (6) you gain access to new health benefit plans as a result of a permanent move; (7) you were receiving services from a contracting provider under another health benefit plan, for one of the conditions described in Section 1373.96(c) of the Health and Safety Code and that provider is no longer participating in the health benefit plan; (8) you are a member of the reserve forces of the United States military or a member of the California National Guard, and returning from active duty service; or (9) you demonstrate to the department that you did not enroll in a health benefit plan during the immediately preceding enrollment period because you were misinformed that you were covered under minimum essential coverage. You must request special enrollment within 60 days from the date of the triggering event to be able to enroll yourself or your dependent(s) in this health benefit plan or change health benefit plans as a result of a qualifying triggering event.

Signature of applicant if declining coverage for yourself or dependents	Date (MM/DD/YYYY)
X	/ /

1 Anthem is required by the Internal Revenue Service and Centers for Medicare & Medicaid (CMS) regulations to collect this information.

Get help in your language

Language Assistance Services

Anthem.

Curious to know what all this says? We would be too. Here's the English version:
IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-888-254-2721. (TTY/TDD: 711)

Separate from our language assistance program, we make documents available in alternate formats for members with visual impairments. If you need a copy of this document in an alternate format, please call the customer service telephone number on the back of your ID card.

Spanish
IMPORTANTE: ¿Puede leer esta carta? De lo contrario, podemos hacer que alguien lo ayude a leerla. También puede recibir esta carta escrita en su idioma. Para obtener ayuda gratuita, llame de inmediato al 1-888-254-2721. (TTY/TDD: 711)

Arabic
مهم: هل يمكنك قراءة هذه الرسالة؟ إذا لم تستطع، فيمكننا الاستعانة بشخص ما ليساعدك على قراءتها. كما يمكنك أيضًا الحصول على هذا الخطاب مكتوبًا بلغتك. للحصول على المساعدة المجانية، يُرجى الاتصال فورًا بالرقم1-888-254-2721. (TTY/TDD: 711)

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Կարողանո՞ւմ եք ընթերցել այս նամակը: Եթե ոչ, մենք կարող ենք տրամադրել ինչ-որ մեկին, ով կօգնի Ձեզ՝ կարդալ այն: Կարող ենք նաև այս նամակը Ձեզ գրավոր տարբերակով տրամադրել: Անվճար օգնություն ստանալու համար կարող եք անհապաղ զանգահարել 1-888-254-2721 հեռախոսահամարով: (TTY/TDD: 711)

Chinese
重要事項：您能看懂這封信函嗎？如果您看不懂，我們能夠找人協助您。您有可能可以獲得以您的語言而寫的本信函。如需免費協助，請立即撥打1-888-254-2721。(TTY/TDD: 711)

Farsi
مهم: آیا می‌توانید این نامه را بخوانید؟ اگر نمی‌توانید، می‌توانیم شخصی را به شما معرفی کنیم تا در خواندن این نامه شما را کمک کند. همچنین می‌توانید این نامه را به صورت مکتوب به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، همین حالا با شماره 1-888-254-2721 تماس بگیرید. (TTY/TDD: 711)

Hindi
महत्वपूर्ण: क्या आप यह पत्र पढ़ सकते हैं? अगर नहीं, तो हम आपको इसे पढ़ने में मदद करने के लिए किसी को उपलब्ध करा सकते हैं। आप यह पत्र अपनी भाषा में लिखवाने में भी सक्षम हो सकते हैं। निःशुल्क मदद के लिए, कृपया 1-888-254-2721 पर तुरंत कॉल करें। (TTY/TDD: 711)

Hmong
TSEEM CEEB: Koj puas muaj peev xwm nyeem tau daim ntawv no? Yog hais tias koj nyeem tsis tau, peb muaj peev xwm cia lwm tus pab nyeem rau koj mloog. Tsis tas li ntawd tej zaum koj kuj tseem yuav tau txais daim ntawv no sau ua koj hom lus thiab. Txog rau kev pab dawb, thov hu tam sim no rau tus xov tooj 1-888-254-2721. (TTY/TDD: 711)

Japanese
重要：この書簡を読めますか？もし読めない場合には、内容を理解するための支援を受けることができます。また、この書簡を希望する言語で書いたものを入手することもできます。次の番号にいますぐ電話して、無料支援を受けてください。 1-888-254-2721 (TTY/TDD: 711)

107750CAMENABC 05/18 DMHC3 DMHCW #CA-DMHC-001#

Khmer
សំខាន់៖ តើអ្នកអាចអានលិខិតនេះទេ? បើមិនអាចទេ យើងអាចឲ្យនរណាម្នាក់អានវាជូនអ្នក។
អ្នកក៏អាចទទួលលិខិតនេះដោយសរសេរជាភាសារបស់អ្នកផងដែរ។ ដើម្បីទទួលជំនួយឥតគិតថ្លៃ
សូមហៅទូរស័ព្ទភ្លាមៗទៅលេខ 1-888-254-2721។ (TTY/TDD: 711)

Korean
중요: 이 서신을 읽으실 수 있으십니까? 읽으실 수 없을 경우 도움을 드릴 사람이 있습니다. 귀하가 사용하는
언어로 쓰여진 서신을 받으실 수도 있습니다. 무료 도움을 받으시려면 즉시 1-888-254-2721로 전화하십시오.
(TTY/TDD: 711)

Punjabi
ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਅਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਲਈ ਕਿਸੇ ਨੂੰ ਬੁਲਾ ਸਕਦਾ ਹਾਂ ਤੁਸੀਂ ਸ਼ਾਇਦ ਪੱਤਰ ਨੂੰ
ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਲਿਖਿਆ ਹੋਇਆ ਵਬੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਫੋਰਨ 1-888-254-2721 ਤੇ ਕਾਲ ਕਰੋ।
(TTY/TDD: 711)

Russian
ВАЖНО. Можете ли вы прочитать данное письмо? Если нет, наш специалист поможет вам в этом. Вы
также можете получить данное письмо на вашем языке. Для получения бесплатной помощи звоните по
номеру 1-888-254-2721. (TTY/TDD: 711)

Tagalog
MAHALAGA: Nababasa ba ninyo ang liham na ito? Kung hindi, may taong maaaring tumulong sa inyo sa
pagbasa nito. Maaari ninyo ring makuha ang liham na ito nang nakasulat sa ginagamit ninyong wika. Para sa
libreng tulong, mangyaring tumawag kaagad sa 1-888-254-2721. (TTY/TDD: 711)

Thai
หมายเหตุสำคัญ: ท่านสามารถอ่านจดหมายฉบับนี้หรือไม่ หากท่านไม่สามารถอ่านจดหมายฉบับนี้
เราสามารถจัดหาเจ้าหน้าที่มาอ่านให้ท่านฟังได้ ท่านยังอาจให้เจ้าหน้าที่ช่วยเขียนจดหมายในภาษาของท่านอีกด้วย
หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดโทรติดต่อที่หมายเลข 1-888-254-2721 (TTY/TDD: 711)

Vietnamese
QUAN TRỌNG: Quý vị có thể đọc thư này hay không? Nếu không, chúng tôi có thể bố trí người giúp quý vị đọc
thư này. Quý vị cũng có thể nhận thư này bằng ngôn ngữ của quý vị. Để được giúp đỡ miễn phí, vui lòng gọi
ngay số 1-888-254-2721. (TTY/TDD: 711)

It's important we treat you fairly
That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

MEDICAL APPLICATION

FOR KAISER PERMANENTE HEALTH CARE PLANS

Please print or type in black ink only. ***Fields with (*) are mandatory for enrollment.*** Retain a copy of this enrollment form and use as temporary ID after effective date

A. TO BE COMPLETED BY RealCare Insurance Marketing, Inc.
Company: California Association of REALTORS® Purchaser #: _____ (EU): _____
Purchaser Contact: **RealCare Insurance Marketing, Inc.** Phone: **(800) 939-8088**

Enrollment Reason - Check Only ONE:

☐ New C.A.R. Member – Join Date:_____ ☐ Open Enrollment ☐ New W-2 Hire – Hire Date:_____

☐ Qualifying Event:_____ Event Date:_____ ☐ Other: _____

B. PLAN SELECTION

☐ Bronze 60 HMO 5800/60	☐ Silver 70 HMO 2900/65	☐ Gold 80 HDHP-HMO 1750/15%
☐ Bronze 60 HDHP-HMO 6650/0% (HSA)	☐ Silver 70 HDHP-HMO 2850/25% (HSA)	☐ Gold 80 HRA-HMO 2250/35
☐ Silver 70 HMO 1900/65	☐ Gold 80 HMO 0/35	☐ Platinum 90 HMO 0/10
☐ Silver 70 HMO 2300/65	☐ Gold 80 HMO 250/35	☐ Platinum 90 HMO 0/20
☐ Silver 70 HMO 2500/55	☐ Gold 80 HMO 1000/40	☐ Platinum 90 HMO 250/30

C. SUBSCRIBER INFORMATION

Requested Effective Date of Coverage: _____/_____/_____ C.A.R. Join Date: _____/_____/_____ Hire Date: (If W2 Employee)_____/_____/_____

Are you now or have you ever been a Kaiser Permanente member? Yes: ☐ No: ☐ Don't Know: ☐

If so, what is/was your Medical Record Number? _____ *CA Real Estate License #: _____

*Last Name: _____ *First Name: _____ M.I.: _____

*Date of Birth: _____ *Gender: Male: ☐ Female: ☐ Marital Status: Single: ☐ Married: ☐

*Social Security Number: _____ Email Address: _____

*Home Address: _____ City: _____ State: _____ Zip: _____

*Mailing Address (if different than home): _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

D. LIST FAMILY MEMBERS TO BE ENROLLED (Attach additional sheets if necessary)

LIST FAMILY MEMBERS TO BE ENROLLED (attach additional sheet, if needed). Dependent children may be covered up to age 26 and may be married and not attending school full-time. A dependent child who has access to other employer-sponsored health coverage is not eligible under this plan.

Relationship	Last Name	First Name	MI	Social Security Number	Date of Birth MM/DD/YY	Gender	Medical Record Number if Known
☐ Spouse ☐ Domestic Partner						M ☐ F ☐	
☐ Child ☐ Other						M ☐ F ☐	
☐ Child ☐ Other						M ☐ F ☐	
☐ Child ☐ Other						M ☐ F ☐	

E. Kaiser Foundation Health Plan Arbitration Agreement:

To the best of my knowledge and belief, all information on this form is correct and true.

Kaiser Foundation Health Plan Arbitration Agreement:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that can't be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

Employee/Subscriber Signature Required _____ **Date** _____

_____
Print Employer/C.A.R. Member name (if subscriber is W-2 employee)