Anthem Blue Cross

Individual Enrollment Application

The following plans are offered by Anthem Blue Cross: PPO Share, Select HMO, HMO Saver, Individual HMO, EPO and DentalSelect HMO plans. The following plans are offered by Anthem Blue Cross Life and Health Insurance Company: SmartSense, Lumenos, Basic PPO, PPO Saver, PPO Share, RightPlan PPO 40 plans, PPO 3500 (HSA-Compatible), 3500 Deductible PPO, Dental PPO and Term Life products. Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association.

1. Application must be completed by the applicant in blue or black ink.
2. Any family member currently pregnant (whether or not listed on the application) or in the process of adoption is not eligible.

Applicant's Social Security or ID No.

1. Applicant Information (Please print)

Primary Applicant's Last Name	First Name	M.I.
Home Address (Must be complete: P.O. Box not acceptable)		
City	State	ZIP Code

Reason for Application (Check one)

☐ New enrollment(s) ☐ Child only

☐ Add dependent(s) to ID No: ______

To change existing Anthem Blue Cross plan, please enter ID No: ______

For Summary Bill (existing), please enter ID No: ______

Primary Applicant's Social Security or ID No.	County Applicant Resides in *(Required)*		Home Phone No.
Mailing Address *(If different than above)* or P.O. Box	Personal Mail Box (PMB) No.	Daytime Phone No.	FAX No.
City	State ZIP Code	Marital Status ☐ Single ☐ Married	Spouse's Social Security or ID No.
E-mail Address	If possible, do you want e-mail notification? ☐ Yes ☐ No	Maiden Name of Applicant / Spouse	

Has any person listed on this application resided (not traveled) outside the U.S. for the past three (3) consecutive months? ☐ Yes ☐ No
If yes, please explain:

Language Choice *(Optional)* ☐ English ☐ Spanish ☐ Korean ☐ Chinese

2. Choice of Anthem Blue Cross Individual Coverage

Do you wish to choose FamilyElect℠ for medical coverage? ☐ **Yes** ☐ **No**

If yes, proceed to Section 3 on the following page. Refer to the 4-digit codes in parentheses below to indicate medical coverage choices in Section 3B for each family member. **(NOTE: If choosing FamilyElect℠, all family members will be assigned the same original effective date.)**

If no, select ONE medical plan choice below.

If you are choosing **Dental** coverage or **Term Life Insurance**, please complete the appropriate sections on page 2.

MEDICAL COVERAGE

PPO Coverage

Anthem Blue Cross Life and Health Products

- ☐ SmartSense 500 Generic Rx (Z153)
- ☐ SmartSense 1500 Generic Rx (Z155)
- ☐ SmartSense 2500 Generic Rx (Z157)
- ☐ SmartSense 5000 Generic Rx (Z159)
- ☐ SmartSense 500 Comprehensive Rx (Z161)
- ☐ SmartSense 1500 Comprehensive Rx (Z163)
- ☐ SmartSense 2500 Comprehensive Rx (Z165)
- ☐ SmartSense 5000 Comprehensive Rx (Z167)
- ☐ PPO 3500 (HSA Compatible) (T160)
- ☐ 3500 Deductible PPO (R420)
- ☐ PPO Share 5000 (H062)
- ☐ RightPlan PPO 40 Generic Rx (PE48)
- ☐ RightPlan PPO 40 Comprehensive Rx (PE49)
- ☐ Lumenos HSA 5000 (no maternity) (Z129)
- ☐ Lumenos HSA 5000 (with maternity) (DX44)
- ☐ Lumenos HSA 1500 (no maternity) (Z126)
- ☐ Lumenos HSA 1500 (with maternity) (DX26)
- ☐ Basic PPO 1000 (7900)
- ☐ Basic PPO 1000 without Life (PE25)

Anthem Blue Cross Products

- ☐ PPO Share 1500 (7889)
- ☐ PPO Share 2500 (7891)

To apply for a plan not listed, write in the plan name here:

☐ ______

______

Alternative HMO Coverage

☐ Select HMO* (PE43) ☐ HMO Saver * (7896) ☐ Individual HMO* (7898)

* **If you have chosen Select HMO, HMO Saver or Individual HMO medical coverage, please complete Section 3A on the following page.**

If you do not qualify for an HMO plan, would you like to be considered for enrollment in PPO coverage at a higher premium rate?

☐ **No, DO NOT enroll me** ☐ **Yes –** Specify any PPO coverage you wish to be enrolled: ______

HIPAA Enrollment

To determine eligibility for HIPAA guaranteed enrollment, please go to Section 5, questions D–D3.

If eligible, please enroll me in: ☐ HIPAA Basic PPO 1000 ☐ HIPAA PPO Share 2500 ☐ HIPAA PPO Share 5000 ☐ HIPAA PPO Share 1500

Applicant's Social Security or ID No.

DENTAL COVERAGE					
☐ Dental PPO (7874) ☐ Dental Saver SelectHMO* (ZE6N)		☐ Dental SelectHMO* (ZE7N) ☐ Dental Premier SelectHMO* (ZE8N)		Provider Number	
* For any of the Blue Cross Dental SelectHMO coverages, please indicate the Provider number: Please list applicants you wish to provide Dental coverage for:					
Applicant Name	**Birthdate**	**Applicant Name**	**Birthdate**	**Applicant Name**	**Birthdate**
Self		Dependent			
Spouse					

3. *Applicants for Medical Coverage*

Please list ALL applicants (youngest to oldest) applying for coverage.
For RightPlan PPO 40, each member will be enrolled on his/her own policy. Use FamilyElect section 3B. If a family member's last name is different than yours, please explain: ____________________

MUST BE ACCURATE

3A. For HMO Use Only Choose a physician for each family member from the Provider Directory.

3B. FamilyElect Medical Coverage Choose Medical Plan code number(s) from Section 2

Relation	Last Name First M.I.	Social Security or ID No.	Birthdate	Age	Height	Weight	PMG/ IPA	Primary Care Physician (PCP)	Current Patient	3B
10 ☐ Male 20 ☐ Female	Yourself		/ /						☐ Yes ☐ No	
30 ☐ Male 40 ☐ Female	Spouse*		/ /						☐ Yes ☐ No	
☐ Son ☐ Daughter			/ /						☐ Yes ☐ No	
☐ Son ☐ Daughter			/ /						☐ Yes ☐ No	
☐ Son ☐ Daughter			/ /						☐ Yes ☐ No	

3C. Dependent Information: Do you claim all children listed above who are between the ages of 19 through 22 as dependents on your Federal Income Tax? ☐ Yes ☐ No **If "NO", any child between the ages of 19 through 22 who is not claimed on your Federal Income Tax is not eligible as a dependent but may apply individually.** *Spouse includes domestic partner (when applicable). Domestic partner enrollment requires submission of a copy of a valid Declaration of Domestic Partnership filed with and stamped by the California Secretary of State.

4A. *Anthem Blue Cross Life and Health Term Life Insurance*

TERM LIFE COVERAGE

Applicants and/or any dependents that are approved will also qualify for Term Coverage at an additional charge. Applicants under the age of one year are not eligible for life insurance.
DO NOT SUBMIT PREMIUM FOR LIFE INSURANCE.

Family Member Name	✓ Amount of Coverage $15,000* (30)	$30,000* (31)	$50,000* (32)	Beneficiary Name	Relationship	Beneficiary Address City / State / ZIP Code

If you have selected term life coverage, you are submitting this application and providing the information on this application to the life insurance department of Anthem Blue Cross Life and Health Insurance Company – Initial: ____________

***NOTE:** The $50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to $30,000.

If beneficiary is not listed and policy is issued, death benefits will be paid in accordance with the Beneficiary Provision on page 3 of the Policy.

I have discussed Life Insurance with my agent and decline to apply – Initial: ____________

4B. If you have selected Basic PPO 1000 (7900) or PPO Saver (NM31), please provide the beneficiary name below:

Applicant's Social Security or ID No.

5. *Prior Insurance History and HIPAA Eligibility –*
Please answer ALL of the following questions.

Anthem Blue Cross credits prior coverage toward the preexisting period for those applicants who apply and are accepted for coverage and request an effective date within 63 days after termination of qualifying prior coverage as required by law. To obtain credit toward the preexisting period, please complete the following.

A. Has any applicant been a member of Anthem Blue Cross ☐ or any other health plan ☐ within the last 5 years? .... ☐ Yes ☐ No

B. Has any applicant had coverage in the last 63 days? .... ☐ Yes ☐ No

If you answered "Yes" to A or B above, please provide the following information for each applicant:

Applicant Name	Insurer Name	Certificate/Policyholder No.	
Plan Name	State	Most recent coverage start date	End Date
Applicant Name	Insurer Name	Certificate/Policyholder No.	
Plan Name	State	Most recent coverage start date	End Date
Applicant Name	Insurer Name	Certificate/Policyholder No.	
Plan Name	State	Most recent coverage start date	End Date

I certify that my coverage terminated/will terminate on (date):

Do you agree to discontinue your current coverage if this application is accepted? .... ☐ Yes ☐ No

If No, please explain:

C. Has any applicant ever been eligible for or received benefits from any of the following?
(Check all that apply): ☐ Medicaid ☐ Medi-Cal ☐ Medicare ☐ California State Disability Insurance ☐ Workers' Compensation ☐ Employer-sponsored health plan

If Yes, please explain:	Start Date *(Mo/Day/Yr)*	End Date *(Mo/Day/Yr)*

D. HIPAA Coverage – If I do not qualify for the Individual Plans, I would like to be considered for coverage under HIPAA. HIPAA does require eligibility. I understand that no underwriting is required and rates may be higher than for the Individual Plans. If I qualify, please offer the HIPAA coverage and send complete details regarding my options and rates. .... ☐ Yes ☐ No

If yes, please provide the following information:

Name of Applicant(s) requesting HIPAA Coverage

1. Are you currently covered by or eligible for Medicaid, Medicare, or any other employer-sponsored health insurance benefits, or do you have other health coverage? .... ☐ Yes ☐ No
   If yes, you are not eligible for HIPAA coverage.
2. Have you had a minimum of 18 months of continuous health coverage most recently under an employer-sponsored group health plan, ("employer" includes a governmental entity or church), that ended within the last 63 days for a reason other than fraud or non-payment of premium? ☐ Yes ☐ No
   If yes, you will be asked to provide documentation of such coverage, preferably the Certificate of Coverage from your former employer or carrier OR a letter from the employer giving us the following:

Name of Applicant	Start Date *(Mo/Day/Yr)*	End Date *(Mo/Day/Yr)*
Name of insurance carrier(s):	Phone No.	

   If no, you are not eligible for HIPAA coverage.
3. Were you eligible for COBRA or Cal-COBRA? .... ☐ Yes ☐ No
   If yes, please provide the following:

Start Date *(Mo/Day/Yr)*	End Date *(Mo/Day/Yr)*

   If no, please explain:

   If COBRA or Cal-COBRA is not exhausted, you are not eligible for HIPAA coverage.

6. *Health History* – Include information on ALL family members you wish to enroll.
HIPAA law guarantees coverage. Applicants for only HIPAA do not need to complete.

Applicant's Social Security or ID No.

6A. *Health History Questionnaire* – ALL QUESTIONS MUST BE ANSWERED OR THE APPLICATION WILL BE RETURNED.
Give COMPLETE details of any "Yes" answers in Section 6C on the following page.

Has any person listed on this application, in the last **10 years**, had any signs or symptoms, seen a health care provider, had treatment recommended including prescription medications, received treatment, or been hospitalized for any of the following conditions as stated in questions 1 through 14?

1. **Brain/Nervous –** such as: frequent and/or severe headaches, migraines, seizures, epilepsy, dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, sleep apnea, narcolepsy, used a sleep monitoring device. ☐ Yes ☐ No
2. **Heart/Circulatory –** such as: chest pain, angina, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, valve replacement, pacemaker, defibrillator; or blood clot, phlebitis, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever, Raynaud's. ☐ Yes ☐ No
3. **Lungs/Respiratory –** such as: allergies, infections, sinusitis, asthma, bronchitis, emphysema, pneumonia, tuberculosis, difficulty breathing, shortness of breath, chronic cough, spitting/coughing up blood. ☐ Yes ☐ No
4. **Digestive –** such as: tonsillitis, infections of the mouth/throat, jaw/chewing problems, gastric reflux, ulcers, hernia, colitis, intestinal problems, diarrhea, rectal problems/bleeding, polyps, hemorrhoids, gallbladder, pancreatitis, liver disease, cirrhosis, hepatitis, jaundice, unexplained weight loss. ☐ Yes ☐ No
5. **Urinary –** such as: kidney, bladder, urinary tract infections, stones, urinary incontinence, blood in urine. ☐ Yes ☐ No
6. **Male Reproductive System –**
   a) Such as: prostate, infertility, low sperm count, impotence, sexual dysfunction, penile or scrotal implant, sexually transmitted disease, herpes, genital warts, undescended testes. ☐ Yes ☐ No
   b) Is any male listed on this application expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not listed on this application? ☐ Yes ☐ No
7. **Female Reproductive –**
   a) Such as: breast disorder/cyst, lump, breast implants, fibroid tumors, endometriosis, pelvic pain, menstruation disorders, abnormal/absent menstrual bleeding, uterine fibroids, ovarian cysts, infertility, miscarriages, sexually transmitted disease, herpes, genital warts. ☐ Yes ☐ No
   b) Does any proposed female member menstruate? ☐ Yes ☐ No
   If yes, indicate if: ☐ Applicant/spouse ☐ Dependent(s)
   Dependent name(s): ______________________
   c) Has it been more than 40 days since her/their last menstrual period? ☐ Yes ☐ No
   Name(s): ______________ ☐ Applicant/spouse ☐ Dependent
   If yes, explain: ______________________
   d) Has any female applicant had a pelvic exam/Pap smear? ☐ Yes ☐ No
   If yes, complete 7e below.
   e) Date and result of last pelvic exam/Pap smear for each female over age 16.
   Name: __________ Mo/Day/Yr: ____ ☐ Normal ☐ Abnormal
   Name: __________ Mo/Day/Yr: ____ ☐ Normal ☐ Abnormal
   Name: __________ Mo/Day/Yr: ____ ☐ Normal ☐ Abnormal
   f) Is any female applicant pregnant, or in the process of adoption or surrogate pregnancy? ☐ Yes ☐ No
8. **Musculoskeletal –** such as: bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/joint, amputation, physical handicap, polio, arthritis, gout, sprain/strain, prosthesis, joint replacement, hardware, internal fixations (i.e., pins, plates, screws), fractures, TMJ. ☐ Yes ☐ No
9. **Endocrine/Metabolic –**
   a) Such as: diabetes, thyroid, anemia, adrenal disorders, pituitary disorders, lupus, AIDS/ARC, immune disorders not including the result for an HIV test, scleroderma, Epstein-Barr/chronic fatigue syndrome. ☐ Yes ☐ No
   b) Is any applicant a candidate for, or a recipient of an organ or bone marrow transplant? ☐ Yes ☐ No
   c) Is any applicant currently on the waiting list and/or registered to donate an organ or bone marrow **(excluding DMV donor card)?** ☐ Yes ☐ No
10. Has any applicant ever had cancer, tumor/growth, leukemia, cyst? ☐ Yes ☐ No
    If yes, specify: ☐ Cancer ☐ Tumor/growth ☐ Leukemia ☐ Cyst
11. **Skin Disorder/Problems –** such as: cancer, melanoma, pre-cancerous lesion, psoriasis, keratosis, warts, birthmarks, 2nd or 3rd degree burns, acne, fungal infections, eczema, dermatitis, herpes, scars/keloids, or revisions of cosmetic or reconstructive surgery, infections. ☐ Yes ☐ No
12. **Eyes, Ears, Nose and Throat –** Disorders such as: any infections, crossed eyes, glaucoma, cataracts, detached retina, polyps, deviated nasal septum, excessive snoring, problems with tonsils or adenoids, sleep apnea? ☐ Yes ☐ No
13. **Nervous, Mental, Emotional, Behavioral –** such as: eating disorder, anorexia/bulimia, depression, anxiety, alcohol or substance abuse/dependency, counseling, bi-polar, chemical imbalance, attention deficit disorder, schizophrenia, obsessive-compulsive or panic disorder. ☐ Yes ☐ No
14. **Congenital Abnormalities, Birth Defects –** such as: cleft lip/palate, club foot, webbed fingers or toes, mental retardation, developmental delay, Down's syndrome, heart/lung problems, skull/facial deformities, birthmark. ☐ Yes ☐ No
15. Has any applicant taken any prescribed medications in the **last 12 months?** ☐ Yes ☐ No
    If yes, complete 6E on page 6.
16. Has any applicant consulted a provider for any condition or symptom(s) in the **last 12 months**, for which a diagnosis has not been established? ☐ Yes ☐ No
17. Has any applicant been advised to see a dentist or oral surgeon in the **last 12 months (excluding normal checkups)?** ☐ Yes ☐ No
18. Has any applicant been a patient in a hospital, clinic, surgicenter, sanatorium, or other medical facility as an inpatient or outpatient (excluding childbirth) in the last 10 years? ☐ Yes ☐ No
    If yes, complete 6C on page 6.
19. In the last 10 years, has any applicant had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing, surgery or treatment? ☐ Yes ☐ No
20. In the last 10 years, has any applicant seen, received treatment from or consulted any doctor, or any other person providing health care services for any other condition or symptom(s) not listed on this application? ☐ Yes ☐ No
    If yes, complete 6C on page 6.

Applicant's Social Security or ID No.

6B. *Other Health Questions*

A. During the past 12 months, has any applicant smoked cigarettes, cigars, or pipes, or used chewing tobacco? ☐ Yes ☐ No

Applicant Name: ______________________

Applicant Name: ______________________

B. Has any applicant used marijuana, cocaine, heroin, methamphetamines, LSD, or any other illegal or controlled drugs, or substances in the last 10 years, or been diagnosed as chemically or alcohol dependent? ☐ Yes ☐ No

Applicant Name: ______________________

Substance: ______________ Date discontinued: ________

Applicant Name: ______________________

Substance: ______________ Date discontinued: ________

C. Has any applicant consumed any alcoholic beverages in the last 6 months? ☐ Yes ☐ No

(Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.)

Applicant Name:____________ Type: ____________

Amount: ____________ per: ☐ Day ☐ Week ☐ Month

Applicant Name:____________ Type: ____________

Amount: ____________ per: ☐ Day ☐ Week ☐ Month

D. Has any applicant been advised by a health care professional to reduce alcohol intake within the past 10 years? ☐ Yes ☐ No

Applicant Name:____________ Date discontinued:________

Applicant Name:____________ Date discontinued:________

6C. *Professional Services*

Give COMPLETE details in all sections below of any "Yes" answers to the questions in Section 6A.

Question #	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	Phone No. ( )
Date of Onset/Treatment *(Month/Year)*		Date Ended ☐ Still under treatment	Physician Specialty ☐ Pediatric ☐ Cardiac ☐ Internal Medicine ☐ Family ☐ Other ________	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* / **Results**			City / State / ZIP Code	FAX No. *(Optional)* ( )

Question #	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	Phone No. ( )
Date of Onset/Treatment *(Month/Year)*		Date Ended ☐ Still under treatment	Physician Specialty ☐ Pediatric ☐ Cardiac ☐ Internal Medicine ☐ Family ☐ Other ________	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* / **Results**			City / State / ZIP Code	FAX No. *(Optional)* ( )

Question #	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	Phone No. ( )
Date of Onset/Treatment *(Month/Year)*		Date Ended ☐ Still under treatment	Physician Specialty ☐ Pediatric ☐ Cardiac ☐ Internal Medicine ☐ Family ☐ Other ________	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* / **Results**			City / State / ZIP Code	FAX No. *(Optional)* ( )

Question #	Name of Family Member *(As identified on Physician's Record)*		Name of Hospital, Clinic and/or Person Providing Care	Phone No. ( )
Date of Onset/Treatment *(Month/Year)*		Date Ended ☐ Still under treatment	Physician Specialty ☐ Pediatric ☐ Cardiac ☐ Internal Medicine ☐ Family ☐ Other ________	
Name of Condition/Illness			Address	Suite No.
Treatment Rendered *(i.e., X-ray, lab, surgical procedure, etc.)* / **Results**			City / State / ZIP Code	FAX No. *(Optional)* ( )

Applicant's Social Security No. or ID No.

6D. *Last Doctor Visit (for any reason including checkup)* – **Provide information for ALL family members you wish to cover.**

Family Member	Date of Visit	Reason for Visit	Results		Name, Phone No. & FAX No. *(FAX # optional)* of Physician or Hospital Complete Address / City / State / Zip Code
			Normal ✓	Abnormal Findings *(Explain)*	
					Name: ____ Phone: ____ FAX: ____ Address: ____ City____ State ____ Zip ____
					Name: ____ Phone: ____ FAX: ____ Address: ____ City____ State ____ Zip ____
					Name: ____ Phone: ____ FAX: ____ Address: ____ City____ State ____ Zip ____
					Name: ____ Phone: ____ FAX: ____ Address: ____ City____ State ____ Zip ____

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant. ☐ **No. of sheets attached**

6E. *Prescription Medications* – **List all medications taken within the last 12 months by any family member listed on this application.**

Family Member	Medication/Dosage/Frequency (i.e., Lopressor/100mg/daily)	Illness for which Medication is Prescribed	Date Prescribed (Mo/Day/Yr)	Date Discontinued (Mo/Day/Yr)	Name, Phone No. of Physician or Hospital
					Name: ____ Phone: ____
					Name: ____ Phone: ____
					Name: ____ Phone: ____
					Name: ____ Phone: ____

Statement of Accountability – **To be completed when the applicant cannot complete the application.**

I, ________________________, personally read and completed this Individual Enrollment Application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other (explain): ________________________

I translated the contents of this form and to the best of my knowledge obtained and listed all the requested personal and medical history disclosed by: ________________________

I also translated and fully explained the "Application Conditions and Agreement."

________________________ Signature of Translator *(Required)*

________________________ Today's Date *(Required)*

7. *Application Understandings, Conditions and Agreement*

IMPORTANT: It is important that you carefully read and fully understand the following.
All Applicants age 18 and over must personally read, agree to and sign the following. If an Applicant does not read English, the translator must sign and submit a Statement of Accountability for translating this entire application (see above).

7. *Application Understandings, Conditions and Agreement* (Continued)

Applicant's Social Security or ID No.

PPO Plan Applicants only

I, the undersigned, understand that under the Anthem Blue Cross plan in which I am enrolling, I will be entitled to lesser benefits if I use an out-of-network hospital or physician than if I use a network hospital or physician.

Effective Date (PPO Applicants only)

REQUESTING AN EFFECTIVE DATE DOES NOT GUARANTEE UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED.

☐ If Anthem Blue Cross approves my application, please assign an effective date of ______________________.

The effective date must be after the signature date but not greater than 75 days from the signature date on this application.

☐ If Anthem Blue Cross approves my application, please assign an effective date of the first day after Anthem Blue Cross approval.

Please note: If you are adding a dependent or changing coverage, your effective date will always be the first of the **month following approval.**

HMO Applicants only: I understand I will only receive benefits for services by, or authorized by, the HMO facility I selected on this application.

☐ If Anthem Blue Cross approves my application, please assign an effective date of the first day after Anthem Blue Cross approval.

☐ If Anthem Blue Cross approves my application, please assign an effective date of ______________________.

If you have simultaneously applied for a Anthem Blue Cross Life and Health Short Term Plan, the effective date of this coverage will begin the day of termination of that Short Term Plan.

High Deductible EPO for Health Savings Account Applicants only

I understand that the High Deductible Plans are designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. I understand that having this coverage does not establish an MSA. To do so, I must contact a qualified financial institution. Also, I understand that I should contact my tax advisor.

HIPAA enrollees only: Your effective date is determined by the delivery or postmark date of your premium to Anthem Blue Cross. If your payment is delivered or postmarked in the first fifteen days of the month, your effective date is the first of that month. If your payment is delivered or postmarked after the fifteenth day of the month, coverage is effective the first day of the following month.

Eligible/Ineligible Applicants: Anthem Blue Cross will enroll all eligible family members unless otherwise instructed.

☐ I, the Applicant, request that Anthem Blue Cross not enroll any eligible applicants unless ALL family members qualify.

All Applicants

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.

CURRENT HEALTH COVERAGE: If you currently have health coverage, we strongly recommend that you maintain your current coverage and request an effective date of 60 to 75 days from the date of application. This will help ensure that your application is processed before you surrender your present insurance.

Agreement **(all applicants)**

By applying for coverage, I, the undersigned, agree to the following:

1. Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") may decline my application. No coverage comes into effect until Anthem Blue Cross approves this application and informs me in writing. The effective date of my coverage, if this application is accepted, will be assigned by Anthem at its discretion (except for HIPAA).
2. Even if I pay money with this application, that money is only a deposit against future premiums if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Anthem Blue Cross nor any affiliated company shall have any liability to me or anyone else listed on it, except for the obligation to return the money submitted with this application. If this application is not accepted, neither I nor anyone listed on it will be entitled to benefits or coverage from Anthem Blue Cross.
3. The selling agent has no authority to promise me coverage or to modify Anthem Blue Cross underwriting policy or the terms of any Anthem Blue Cross coverage.
4. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)
5. In no event shall Anthem or any affiliated company have any liability to the applicant if the application is not approved, except for the obligation to return the money submitted with this application if this application is not approved, and neither shall any coverage exist nor shall the applicant be entitled to any benefits unless and until this application is approved by the Medical Underwriting Department of Anthem.
6. I understand Anthem may use any information prior to the effective date of coverage in considering my application, including medical conditions which occur after the signature and before the original effective date.

Rescission of Membership

I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if I intentionally provided incomplete or false material information Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") may revoke my coverage. This means Anthem will cancel membership as if it never existed. Also, after approval for membership, if material information is discovered by Anthem that was not provided to the Plan prior to the effective date of the policy, Anthem may deny coverage.

All of my dependents listed on this application who are over the age of 18 years have read this application and have provided complete and accurate information for this application. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about any children under the age of 18 listed on this application is true and complete. I understand and agree that I alone am responsible for the accuracy and completeness of this application. I understand and agree that no one listed on this application will be eligible for coverage if they provide false or incomplete information and that Anthem may revoke coverage if it discovers that in applying for coverage I intentionally provided incomplete or false material information to Anthem.

I understand that if my coverage is revoked I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for enrollment. I also understand that I will be required to pay for any services that were covered while a member and that Anthem will refund all amounts paid by me except amounts owed to Anthem.

I have personally read and completed this application. If I am accepted, this application will become part of the contract between Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company ("Anthem") and me. I and any enrolled family members agree to abide by the terms of that contract.

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 ("Anthem") require binding arbitration to settle all disputes against Anthem, including claims of medical malpractice. 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 provided by California law, 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."** Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. ***Signatures (Required)*** **– IMPORTANT: All applicants over age 18 must sign and date.**

Applicant/Parent or Legal Guardian	Today's Date	Applicant's Spouse	Today's Date
Applicant's Dependent age 18 or over	Today's Date	Applicant's Dependent age 18 or over	Today's Date

ATTACH BLANK, VOIDED CHECK FOR BANK DRAFT AUTHORIZATION, IF APPLICABLE, HERE. DO NOT TAPE.

Applicant's Social Security or ID No.

8. *Payment Method* Premium payment required. First payment will be credited to approved applicants only. By sending your check to us, you authorize Anthem Blue Cross to convert your check into an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

8A. Checking Account Automatic Premium Payment

☐ **Monthly checking account deduction premium payments**

Name of Bank or Financial Institution: ______

Account No.: ______ Bank Routing No.: ______

Submit a blank check marked "VOID" above where indicated (DEPOSIT SLIPS NOT ACCEPTABLE). If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account. Premiums may be prorated in order to adjust the initial paid to date or in the event of membership changes.

Monthly Checking Account Automatic Premium Payment Authorization – As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of ANTHEM BLUE CROSS provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check signed personally by me. I authorize Anthem Blue Cross to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Anthem Blue Cross premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed bi-monthly. **You will incur a $25 service charge for any withdrawal not honored.**

Authorized Signature *(As it appears in the financial institution's records)*	Date
X	

8B. Credit Card **FAX to: (800) 327-9255**

☐ **Initial premium (For new member's Medical and Dental fees only)** ☐ **Monthly premiums**

Monthly Credit Card Authorization - As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the amount may vary as a result of changes I make, such as, but not limited to, adding and deleting dependents, or moving to a new location. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. Credit Card: ☐ VISA ☐ MasterCard ☐ Discover

Card No.: ______ Exp.: ____ Cardholder's Zip Code ______

Cardholder's Name *(As it appears on the credit card)* PRINT	Authorized Signature *(As it appears on the credit card)*	Date
X	X	

8C. Billing (To be used if an automatic payment option is NOT selected from 8A or 8B above.)

☐ **Bi-monthly** (Submit 2 months premium) ☐ **Quarterly** (Submit 3 months premium)

TO BE COMPLETED BY YOUR ANTHEM BLUE CROSS-APPOINTED AGENT

1. Are you aware of any information not disclosed on this application relating to the health, habits or reputation of any person listed on this application which might have a bearing on the risk? ☐ Yes ☐ No
   If yes, please attach explanation.
2. Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed? ☐ Yes ☐ No
   If no, please explain: ______
3. I verify that this application was completed by the applicant unless the Statement of Accountability was completed.

Signature of Agent *(Required)*	Date *(Required)*
X H Tonk	

4. **Breakdown of funds collected:**
   Total Medical funds $ ______
   Total Dental funds $ ______
   Total funds collected $ ______
5. Was the Term Life Insurance option selected? *(If yes, first Term Life Insurance payment will be billed.)* ☐ Yes ☐ No

Name of Agent (Print Name)		Agent's Street Address Suite No./Personal Mail Box (PMB) No.	
HARMINDER TONK		2175 De La Cruz Blvd. Suite 9	
Agent ID No.	Sub-Agent ID No.	City/State/ZIP Code	Location No.
HLKMMTSSZ	NONE →	Santa Clara, CA, 95050	—
Phone No.	FAX No.	E-mail Address	
(408) 748-1701	(408) 748-1401	htonkins@yahoo.com	

Mail Service Agreement to: ☐ Agent ☒ Primary Applicant

PLEASE NOTE: If neither box is checked, the Service Agreement will be mailed directly to the primary applicant.

Mailing address:

Agent: Please mail this application to the following address:

Anthem Blue Cross • P.O. Box 9041 • Oxnard, CA 93031-9041

Language Assistance Services

English

Can you read the attached document? If not, we can have somebody help you read it. You may also be able to get this written in your language. For free help, please contact your agent.

Spanish

Puede usted leer este documento anexo? Si no, podemos asignarle alguien que le ayude. También puede recibir esto escrito en su idioma. Para asistencia gratuita, por favor contacte a su agente.

Chinese (Traditional)

您能讀懂所附文件嗎？如果不懂，我們可以請人幫您。也許您還可以收到中文版本。請聯絡您的代理人要求免費的協助。

Korean

첨부 서류를 읽으실 수 있습니까? 읽지 못하신다면 읽어드릴 사람을 구해드릴 수 있습니다. 한국어 번역본도 받으실 수 있습니다. 도움은 무료이며 담당 에이전트에게 연락하십시오.

Vietnamese

Quý vị đọc được tài liệu đính kèm không? Nếu không, chúng tôi sẽ cho người đọc giúp quý vị. Ngoài ra, quý vị cũng có thể được cấp tài liệu này bằng ngôn ngữ của quý vị. Vui lòng liên lạc với nhân viên đại diện của quý vị để được giúp đỡ miễn phí.

Tagalog

Kaya mo bang basahin ang nakakabit na dokumento? Kung hindi naman, maaaring patulungan ka namin sa ibang tao sa pagbasa nito. Maaari mo ring makuha ito na nasusulat sa iyong lengguwahe. Para sa libreng pagtulong, paki-kontakin ang iyong ahente.

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MCASH6334CML 01/09

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-249-4844. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-249-4844. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打1-866-249-4844 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-249-4844 .Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin. Maaari mong ipabasa sa iyo ang mga dokumento at maaari mong hingin na ipadala ang ilang mga dokumento sa iyo sa Tagalog. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-249-4844. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357. Tagalog

무료 통역 서비스. 귀하는 통역 서비스를 받으실 수 있습니다. 한국어로 서류를 낭독해주는 서비스 받으실 수 있으며 한국어로 번역된 서류를 받아보실 수도 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-249-4844번으로 문의해 주십시오. 보다 자세한 문의 사항은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-249-4844 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-249-4844. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance) по телефону 1-800-927-4357. Russian

無料の言語サービス 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-249-4844までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357 までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-249-4844 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357تلفن کنید. Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ, ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-249-4844 'ਤੇ ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នក ជាភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទ មកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-249-4844 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول على مترجم وقراءة الوثائق لك باللغة العربية. للحصول على المساعدة، اتصل بنا على الرقم المبين على بطاقة عضويتك أو على الرقم 1-866-249-4844. للحصول على المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا على الرقم 1-800-927-4357.Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-249-4844. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357. Hmong

Anthem

Addendum to Individual Applications

A new law became effective January 1, 2009 (AB 2569) which requires all agents/brokers to include an attestation with each application submitted if that agent/broker assisted that applicant in completing the application.

__ __ __ __ __ __ __ __ __ Applicant's Social Security or ID No.   ____________ Type or Print Name

Fax: (805) 713-8829

Mail: Individual Services
P.O. Box 9041
Oxnard, CA 93031-9041

As the agent/broker, please check one of the following:

☐ I have not had any interactions whatsoever with this applicant either by phone, email or in person and did not provide any information, advice or assist the applicant in any manner in providing answers or responses to any questions in the application.

☐ I assisted the applicant in submitting this application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

NOTICE: If you state any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000), as authorized under California Health and Safety Code Section 1389.8(c)/ Insurance Code Section 10119.3.

HTonk
Signature of Agent *(required)*   Date

HARMINDER TONK
Type or Print Name

HLKMMMTSSZ
Agent Number

CAINDATT 3/09 MCAFR6059C 3/09

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Individual Services
P.O. Box 9041
Oxnard, CA 93031-9041

Anthem Blue Cross

Authorization for Use of Protected Health Information

By signing below:

I authorize Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, to obtain any medical records from any physicians, hospitals, pharmacies, pharmacy benefits managers, health benefits plans, and/or other health care providers or medical or pharmacy benefit administrators concerning my care and the care of any family member listed on my Application.

I also authorize any physicians, hospitals, pharmacies, pharmacy benefits managers, health benefit plans and/or other health care providers or medical or pharmacy benefit administrators to furnish any medical records concerning my care and the care of any family member listed on my Application to Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or an agent, subsidiary or affiliate that has a business associate contract with Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company. This information is needed to determine eligibility for coverage and Anthem Blue Cross' or Anthem Blue Cross Life and Health Insurance Company's acceptance of coverage requested for myself and/or any family members listed on my Application or so that a determination of coverage regarding a claim for specified benefits can be made.

I understand that my application will not be considered if this form is not signed and returned with my completed Application if I am initially applying for enrollment in a medically underwritten health plan offered by Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, or signed and returned with my completed Change of Coverage Form if I wish to add a family member or upgrade my coverage in the future. This Authorization will expire 24 months following Anthem Blue Cross' or Anthem Blue Cross Life and Health Insurance Company's acceptance of coverage, if not previously revoked.

I understand that I may revoke this Authorization at any time while Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company is determining eligibility for the coverage requested. To do so, I must submit a completed Authorization Revocation Form to Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company. An Authorization Revocation Form is available by calling 1-866-297-7647, going to our website, www.anthem.com/ca, or writing to: Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company, P.O. Box 9041, Oxnard, CA 93031. If I revoke this Authorization after I initially apply for coverage, I understand that I/we will not be considered by Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company for enrollment in one of its medically underwritten health plans. If I revoke this Authorization after I ask to upgrade my coverage or add a family member, I understand that the change will not be made. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by recipient and, in some circumstances, may no longer be protected by federal regulations governing the privacy of health information.

____
Printed name of Applicant/Member

______________________________ ________
Signature of Applicant/Member or his/her Personal Representative — Date

____
Printed name of Spouse or Dependent Child age 18 or over listed on Application

______________________________ ________
Signature of Spouse/Dependent Child or his/her Personal Representative — Date

____
Printed name of Dependent Child age 18 or over listed on Application

______________________________ ________
Signature of Dependent Child or his/her Personal Representative — Date

A photocopy of this form will be as valid as the original.
You have the right to receive a copy of this Authorization upon request.

For Anthem Blue Cross Use Only	**For Anthem Blue Cross Use Only**
HCID:	**WFI:**

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ® ANTHEM is a registered trademark. ® The Blue Cross name and symbol are registered marks of the Blue Cross Association.