

Employee Enrollment Application



Blue Shield plans for groups with 2-50 eligible employees

Effective January 1, 2013

Blue Shield of California and Blue Shield of California Life & Health Insurance Company (Blue Shield Life)

* Please note: It is very important that all questions be answered. Missing information may delay processing.

Reason for application:

- | | | |
|--|--|--|
| <input type="checkbox"/> New group enrollment | <input type="checkbox"/> Family addition | <input type="checkbox"/> Special enrollment period |
| <input type="checkbox"/> New hire (date) _____ | <input type="checkbox"/> Open enrollment | Qualifying event type _____ |
| <input type="checkbox"/> Re-hire (date) _____ | <input type="checkbox"/> Late enrollment | Date above event occurred _____ |

Section 1 – Plan selection – Select and/or fill in plan name(s) as appropriate.

Medical Benefit Plans:

- Premier PPO^{1,2} 5 15 25 35 45
 Enhanced PPO^{1,2} 15 25 35 45
 Base PPO^{1,2} 30 40 50
 Shield Spectrum PPO^{SM 1,2} 750 Value 1000 Value 1500 Value 2500 Value
 Simple Savings^{1,2,3} 2500/5000 3500/7000 4500/9000 5500/11000
 Access+ HMO Premier 15 25 35 45
 Access+ HMO Enhanced 15 25 35 45
 Local Access+ HMO Premier 15 25 35 45
 Local Access+ HMO Enhanced 15 25 35 45
 Premier PPO 20 Enhanced PPO 30^{1,2} Enhanced PPO 40^{1,2}
 Simple Savings 3400/6800^{1,2,3} Access+ HMO Enhanced 40
 Access Baja HMO 10 Other _____

Optional benefits:

Check plan(s) and fill in names as appropriate

- Dental PPO plan _____
 Dental INO^{1,2} plan _____
 Dental HMO plan _____
 Vision plan _____
 Life/ AD&D Insurance/Amt _____
 Dependent Life Insurance/Amt. (max \$5,000) _____
 Other _____

- Underwritten by Blue Shield of California Life & Health Insurance Company.
- All Premier PPO plans (except Premier PPO 20), Enhanced PPO, Base PPO, Shield Spectrum PPO, Simple Savings and Smile In Network Only dental plans are pending regulatory approval.
- Simple Savings plans are HSA-eligible high-deductible health plans.

Section 2 – Employee Information – (please type or print clearly, use black ink) Bolded items denote required fields.

Social Security number	Employer (group) name		Do not write in shaded area	
			Group number	BU
Last name	First name	MI	Effective date requested: ___/___/___	
Full time hire date:	Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____			

- Employment Status:** Full time employee, actively working at least 30 hours per week for this employer
 Part time employee working at least 20 hours per week for this employer

Job title/classification

Home address (street, city, state, ZIP)

Mailing address (if different than home address)

Work phone number:	Home phone number:	How would you prefer we contact you? <input type="checkbox"/> E-mail <input type="checkbox"/> Standard mail Telephone <input type="checkbox"/> Work <input type="checkbox"/> Home – Blue Shield will use your preferred method when possible.
Email address		

Date of birth: _____ **Gender:** Male Female **Marital Status:** Single Married Domestic partner

Do you have eligible dependents? Yes No **How many?** _____ **How many are enrolling?** _____

Are any additional sheet(s) attached to this application? How many sheets? _____

Are any eligible dependents not enrolling on this plan covered by any form of health insurance? Yes No

If you, your spouse, or your dependent(s) are refusing coverage, please complete and sign the Refusal of Coverage form at the end of this application.

HMO provider information: Blue Shield of California directory website: blueshieldca.com/fap/app/search.html

HMO Personal Physician name	Provider number	IPA/MG number	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dental HMO Provider name	Dental Provider number (Do not use office number)		Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please be sure to return all pages of this form as the last page contains your signature which is necessary to process these changes.

Missing information may delay processing. Fax requests to (209) 367-6475.

Applicant's Last Name

First Name

MI

Social Security number

Section 3 – Dependent Spouse/Domestic Partner/Dependent Child(ren) information

HMO applicants must select a Personal Physician. Dental HMO applicants must select a dental provider. You may choose a different Personal Physician for each family member. Be sure to include each physician's provider number and IPA number, as well as each dental provider number. * If you, your spouse/domestic partner, or your dependent(s) are refusing coverage, please complete and sign the Refusal of Personal Coverage Form at the end of this application.

Dependent's address, if different from employee – please indicate which dependent(s) this applies to:

Table with 4 columns: Enrolling Spouse/Domestic Partner Information, Enroll In, HMO Personal Physician, and Dental provider. It contains five rows of dependent information forms, each with checkboxes for gender, marital status, and enrollment options (Medical, Dental, Vision, Life).

Please be sure to return all pages of this form as the last page contains your signature which is necessary to process these changes. Missing information may delay processing. Fax requests to (209) 367-6475.

Applicant's Last Name

First Name

MI

Social Security number

Section 4 – Other health insurance information

Does any person applying for coverage currently have health insurance coverage? Yes No

If yes, Proof of Coverage must be submitted. (See below.)

Has any person applying for coverage had health insurance coverage at any time in the past six (6) months? Yes No

If yes, Applicant/Family member names: _____

Type of coverage: Group Individual Other (specify): _____

Insurance company: _____ Policy/ID No. _____

Date coverage began: _____ Date ended: _____

To get credit for any prior creditable coverage, obtain Proof of Coverage in the form of a Certificate of Creditable Coverage from your prior employer, insurer or health plan and submit the certificate to Blue Shield of California/Blue Shield Life. If assistance is required, please contact your Blue Shield Customer Service Representative.

Section 5 – Medicare information

Is any person applying for coverage currently enrolled with Medicare? Yes No

If yes, Name: _____

Please attach a copy of your Medicare card(s) and enter the type of coverage and effective date here:

Part A: Effective date: _____ Part B: Effective date: _____

Section 6 – Life insurance beneficiary

Life Insurance Beneficiary Name	Relationship to applicant
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Street address

City	State	ZIP code
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NOTE: If the applicant is married and the beneficiary is to someone other than the spouse of the Applicant, the spouse of the Applicant must sign this section.

Signature of Applicant's spouse, if required (See Note)

Section 7 – Disclosure of Personal and Health Information

Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, "Blue Shield") understand the importance of keeping your and your dependents' personal and health information private. Blue Shield protects this information in electronic, written, and oral forms when used throughout our company. Blue Shield will not disclose this information without your authorization except as permitted by law.

For the purpose of administering your Blue Shield coverage, Blue Shield is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, Blue Shield is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.

A complete explanation of Blue Shield's policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing Blue Shield's Web site.

Section 8 – Authorization – The following section is to be signed by all employees applying for coverage.

***I agree:** All information on this form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have committed fraud or made an intentional misrepresentation of any material fact that within 24 months of issuance, my coverage may be cancelled or, following notice, rescinded. I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California/Blue Shield of California Life & Health Insurance Company ("Blue Shield Life").

Signature of Employee

Date

Print Employee Name

Please be sure to return all pages of this form as the last page contains your signature which is necessary to process these changes.

Missing information may delay processing. Fax requests to (209) 367-6475.

Refusal of Personal Coverage

(Complete if you, your spouse, domestic partner or dependent(s) are refusing your employer's Blue Shield of California/Blue Shield of California Life & Health Insurance Company health, dental and/or vision plan coverage.) Please type or print. Use black ink.

Employee name _____

Social Security number _____

Employer (Group) Name _____

Hire date _____

Marital status Married Yes No
Domestic Partnership Yes No

Job title _____

Are you a full time employee, working at least 30 hours per week for this employer? Yes No

Are you a part time employee working at least 20 hours per week for this employer? Yes No

If no, please explain: _____

Declining Coverage For:

I decline health plan coverage for:

- Myself and all dependents.
- My Spouse/Domestic Partner
 - My Children
 - My Spouse/Domestic Partner and Children
 - The following dependents only:

If dental plan offered, I decline dental plan coverage for:

- Myself and all dependents.
- My Spouse/Domestic Partner
 - My Children
 - My Spouse/Domestic Partner and Children
 - The following dependents only:

If vision plan offered, I decline vision plan coverage for:

- Myself and all dependents
- My Spouse/Domestic Partner
 - My Children
 - My Spouse/Domestic Partner and Children
 - The following dependents only:

Reason For Declining Coverage

OTHER EMPLOYER HEALTH COVERAGE

- Enrolling as a dependent on this group health plan
 Covered by this employer's other health plan
 Covered by another employer's health plan (e.g., through your spouse/domestic partner).

Carrier Name _____

ID Number _____

- Covered by TRICARE

OTHER NON-EMPLOYER HEALTH COVERAGE

- Covered by an Individual health plan.

Carrier Name _____

ID Number _____

- Medicare, Medi-Cal, Healthy Families program

- Other _____

I acknowledge that the coverage available to me has been explained to me by my employer and I know that I have every right to enroll in this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I now decline to enroll myself, my spouse/ domestic partner and/or my dependent(s) in my employer Blue Shield of California/Blue Shield Life health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

If I am declining enrollment for myself or my dependents because of other health coverage or because the employer stops contributing toward this coverage, I acknowledge that I may be able to enroll myself and my dependents in this plan if I request enrollment within 31 days (60 days if loss of Medi-Cal or Healthy Families coverage) after my or my dependents' other coverage ends or after the employer stops contributing toward the other coverage.

In addition, if I acquire a new dependent as the result of marriage/domestic partnership, birth, adoption or placement for adoption, I acknowledge that I, and my dependents, may request enrollment in my employer's health plan by applying for that coverage within 31 days of the marriage/domestic partnership, birth, adoption, or placement for adoption. I also acknowledge that if I, or my dependents, become eligible for the Healthy Families or the Medi-Cal Premium Assistance Programs, I or my dependents may request enrollment in my employer's health plan by applying for coverage within 60 days of the notice of eligibility for these premium assistance programs.

If I have indicated above that the reason for declining coverage for myself or my dependent(s) is coverage under another employer health benefit plan, I acknowledge that, if I or my dependent(s) involuntarily lose coverage under the other employer health benefit plan, I must request enrollment for myself and/or my dependent(s) in my employer health benefit plan within 31 days. Otherwise, I understand I may not enroll myself and/or my dependents in my employer's health plan until the earlier of the end of my employer's next open enrollment period or 12 months.

Signature of Employee

Date

**EMPLOYERS MUST RETAIN A COPY OF ANY SIGNED
PERSONAL REFUSAL OF COVERAGE FOR THEIR RECORDS.**