blue of california

Group Vision Insurance Plan Employee Enrollment Form
Blue Shield of California Life & Health Insurance Company

P.O. Box 7725, San Francisco, California 94120 (888) 800-2742

Note: Please return this enrollment form to your employer. This form cannot be processed if information is incomplete.

Section 1: Group information

Group name	Group policy number (to be completed by Blue Shield Life)

Section 2: Employee information

Employee effective date of coverage	First name	MI	Last name		
Address		Social Security number		Birthdate	Gender
City		State	Zip code	Date of hire	
Language preference					

Section 3: Dependent information

List below all enrolling eligible dependents. Eligible dependents are your spouse/domestic partner and your unmarried children or your spouse's/domestic partner's unmarried children within the ages stated in your policy.

Relationship	Gender	First name	MI	Last name	Birthdate	Full time student
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Signature

Date

ABU1189 (8/08)