Employee Enrollment Application

blue of california

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:

☐ New group enrollment ☐ New hire ☐ Re-hire
☐ Family addition ☐ Open enrollment ☐ Late enrollment
☐ Special enrollment period
Qualifying event type _____
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 _____

1 Underwritten by Blue Shield of California Life & Health Insurance Company.
2 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.
3 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: ____ /____ /_____

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

Full time hire date: ____ /____ /_____

Language Preference:
☐ English ☐ Spanish ☐ Chinese
☐ Vietnamese ☐ Other _____

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? ☐ E-mail ☐ Standard mail Telephone ☐ Work ☐ 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?** ☐ Yes ☐ No
Dental HMO Provider name	**Dental Provider number** (Do not use office number)		**Existing patient?** ☐ Yes ☐ 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:

Enrolling Spouse/Domestic Partner Information	**Enroll In**	**HMO Personal Physician** * HMO Plans Only	**Dental provider** *Dental HMO only
☐ Spouse ☐ Domestic Partner ☐ **Male** ☐ **Female** Date of marriage/domestic partnership ____ /____ /_______ **First** ________________________ **MI** __ **Last** ____________________________ **Social Security** ___________________ **Date of birth (mm/dd/yyyy):** ____ /____ /_______	* Please check all that apply: ☐ Medical ☐ Dental ☐ Vision ☐ Life	Doctor's name: First ____________________ Last ____________________ Provider number ____________ IPA/MG number ____________ Existing patient? ☐ Yes ☐ No	Dental provider name: First ____________________ Last ____________________ Dental provider number: ______________________ Existing patient? ☐ Yes ☐ No

Enrolling Dependent Children Information	**Enroll In**	**HMO Personal Physician** * HMO Plans Only	**Dental provider** *Dental HMO only
☐ **Male** ☐ **Female** **First** ________________________ **MI** __ **Last** ____________________________ Social Security ___________________ **Date of birth (mm/dd/yyyy):** ____ /____ /_______	* Please check all that apply: ☐ Medical ☐ Dental ☐ Vision ☐ Life	Doctor's name: First ____________________ Last ____________________ Provider number ____________ IPA/MG number ____________ Existing patient? ☐ Yes ☐ No	Dental provider name: First ____________________ Last ____________________ Dental provider number: ______________________ Existing patient? ☐ Yes ☐ No
☐ **Male** ☐ **Female** **First** ________________________ **MI** __ **Last** ____________________________ Social Security ___________________ **Date of birth (mm/dd/yyyy):** ____ /____ /_______	* Please check all that apply: ☐ Medical ☐ Dental ☐ Vision ☐ Life	Doctor's name: First ____________________ Last ____________________ Provider number ____________ IPA/MG number ____________ Existing patient? ☐ Yes ☐ No	Dental provider name: First ____________________ Last ____________________ Dental provider number: ______________________ Existing patient? ☐ Yes ☐ No
☐ **Male** ☐ **Female** **First** ________________________ **MI** __ **Last** ____________________________ Social Security ___________________ **Date of birth (mm/dd/yyyy):** ____ /____ /_______	* Please check all that apply: ☐ Medical ☐ Dental ☐ Vision ☐ Life	Doctor's name: First ____________________ Last ____________________ Provider number ____________ IPA/MG number ____________ Existing patient? ☐ Yes ☐ No	Dental provider name: First ____________________ Last ____________________ Dental provider number: ______________________ Existing patient? ☐ Yes ☐ No
☐ **Male** ☐ **Female** **First** ________________________ **MI** __ **Last** ____________________________ Social Security ___________________ **Date of birth (mm/dd/yyyy):** ____ /____ /_______	* Please check all that apply: ☐ Medical ☐ Dental ☐ Vision ☐ Life	Doctor's name: First ____________________ Last ____________________ Provider number ____________ IPA/MG number ____________ Existing patient? ☐ Yes ☐ No	Dental provider name: First ____________________ Last ____________________ Dental provider number: ______________________ Existing patient? ☐ Yes ☐ No

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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
Street address	
City	State / ZIP code

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

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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.