employee enrollment application

Blue Shield plans for 51+ employees

Employee instructions

1. Answer all questions as completely and accurately as possible.
2. Check the box(es) to indicate your coverage selection and fill in plan name as appropriate.

   (Example: ☑ Access+ HMO® 5-0 Inpatient
   Or
   ☑ Shield Spectrum PPO℠ Plan 500-90/70
3. Provide the Social Security number for each member enrolling.
4. Review and complete all questions in Section 4 – Life insurance beneficiary.
5. You must sign and date Section 5. Blue Shield of California and Blue Shield of California Life & Health Insurance Company (Blue Shield Life) cannot process the application without signed authorization.

Important enrollment guidelines for medical coverage

Access Baja HMO

- To enroll in an Access Baja® HMO plan, you must live or work within the Access Baja service area.
- Refer to the Access Baja HMO Provider and Pharmacy Directory at **blueshieldca.com** or call **(800) 248-5451** for customer service in Spanish or English for selection of Personal Physician and service area information.
- Legal requirements for and generally accepted practice standards of medical care in Mexico are different from those of California or elsewhere in the United States. Therefore, the care received through providers in Mexico in the Access Baja HMO health plan will be care that is consistent with generally accepted medical standards of Mexico, not of California.

Access+ HMO SaveNet

- To enroll in an Access+ HMO SaveNet℠ plan, you must live or work within the SaveNet service area.
- Refer to the provider directory at **blueshieldca.com** for selection of your primary care physician and service area information.

Medical coverage for your dependents

Check the "Medical" box in the "Enroll in" column for each dependent listed in Section 3. In the space provided, list all eligible dependents you wish to enroll (including spouse or domestic partner), their dates of birth, and Social Security number, and check the box to indicate relationship to the employee. If selecting an Access+ HMO or Added Advantage POS℠ Plan, you must choose a Personal Physician. Please enter the name, provider number, and the IPA number.

If a dependent is over 18 and under 25, you must check the "Full-time student" box in Section 3 for each appropriate dependent this applies to. To be considered a full-time student, dependent children ages 19 through 24 must be enrolled full-time (minimum of 12 units) in college, trade school, or on an approved medical leave of absence from a college or trade school. Blue Shield of California/Blue Shield Life will deem this completed information to be a certification of full-time student status. Dependent coverage for full-time students over age 18 is not available to dependents of legal guardians.

If a dependent over the age of 18 is disabled due to a physical or mental injury or illness, you must check the "Disabled" box in Section 3. You will be required to submit a physician's written certification of the disability or confirmation that your current health carrier is providing coverage for this disabled dependent.

Important enrollment guidelines for specialty benefit coverage

Dental coverage

An employee may enroll in a dental plan without enrolling in a Blue Shield of California/Blue Shield Life health plan.

In order for a dependent to enroll in a Blue Shield of California dental plan, the employee must be enrolled in the same dental plan.

Vision coverage
An employee may enroll in a vision plan without enrolling in a Blue Shield of California/Blue Shield Life health plan.

In order for a dependent to enroll in a Blue Shield of California/Blue Shield Life vision plan, the employee must be enrolled in the same vision plan.

Life insurance coverage
An employee may enroll in a life insurance plan without enrolling in a Blue Shield of California/Blue Shield Life health plan.

If the employer offers dependent life insurance coverage, and the employee chooses life plus dependent life insurance coverage, and the employee and any dependents enroll in a Blue Shield of California/Blue Shield Life health plan, then the employee and all dependents covered by the health plan will be enrolled in the life insurance plan.

If the employer does not offer dependent life insurance coverage, only the employee can be enrolled in a life insurance plan.

Refusal of Personal Coverage Form

This form (located in Section 6 on the last page of this enrollment form) is to be used for all employees who decline coverage for themselves or their dependents.

Enter the employee name. Check the appropriate box if you, your spouse/domestic partner, or dependent(s) are declining health and/or dental coverage. Check the box that meets your reason for refusing coverage for you, your spouse/domestic partner, or dependent(s). Indicate the name of the other health and/or dental insurance carrier with whom you or your dependents have coverage. Sign and date if you have refused personal or dependent coverage.

The pre-existing condition exclusion

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that limits when coverage may be excluded for pre-existing conditions. Under the law, if a person's health coverage terminates, and he or she enrolls in new health coverage within 63 days (excluding any waiting period), the new coverage must credit the time he or she was enrolled in the prior coverage toward the new coverage's pre-existing condition exclusion. In addition, the state law requires that the time a person was enrolled in prior coverage be credited if he or she enrolls in new coverage within 180 days (excluding any waiting period) if the "prior creditable coverage" was employer-sponsored coverage.

The Shield Spectrum PPO℠ plans, the Shield Spectrum PPO Savings Plus plans, and the Blue Shield Life Active Choice℠ plans exclude pre-existing conditions. Pre-existing conditions are covered only after you have been continuously covered for six (6) consecutive months including your present employer's waiting period, if any. The pre-existing condition does not apply to:

- Pregnancy benefits;
- Newborns or adopted children who had prior creditable coverage within thirty (30) days of their birth, adoption, or placement for adoption, and who enrolled in one of the Blue Shield of California or Blue Shield Life plans within sixty three (63) days of that prior creditable coverage (excluding any waiting period);
- Employees and dependents who were validly covered under the present employer's previous group health coverage when that coverage was terminated and who are enrolled on the original effective date, of the Blue Shield of California or Blue Shield Life Health plan within (63) days of the termination of that previous coverage.

To get credit for any prior creditable coverage, obtain 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. Blue Shield of California/Blue Shield Life protects the confidentiality and privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, and Social Security number. We will not disclose this information, except as permitted by law.

blue of california

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

☐ New enrollment hire date ___/___/_____(mm/dd/yyyy)
☐ Re-hire date ___/___/_____(mm/dd/yyyy)

Are you enrolling your spouse/domestic partner or dependent children in any Blue Shield of California plan at this time? ☐ Yes ☐ No If yes, complete page 4 of application.

Section 1 – Employee information Please type or print clearly. Use black ink.

Internal use only. Do not write in shaded area.

Social Security number	Employer (group) name	Dept code	Group number	BU
Last name	First name	Middle initial	Effective date (mm/dd/yyyy)	RSN
Mailing address (street, city, state, ZIP)			TOC / NP	PKG
Home address – required for all HMO and POS (street, city, state, ZIP)			Life/AD&D insurance or salary amount	
Home phone number	E-mail address	Job title/classification		

How would you prefer we contact you? ☐ E-mail ☐ Standard mail ☐ Telephone (Blue Shield of California/Blue Shield Life will use your preferred method when possible)

Are you a full-time employee, actively working at least 30 hours per week for this employer? ☐ Yes ☐ No If no, please explain.

Birthdate (mm/dd/yyyy) ___/___/_____ **Gender** ☐ Male ☐ Female Marital status ☐ Single ☐ Married ☐ Domestic partner

Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____ (Note: Your language preference may be indicated on your ID card)

Access+ HMO or Added Advantage POS only: Name of primary care physician

Provider number | IPA/MG number | Existing patient? ☐ Yes ☐ No

Dental HMO only: Name of dental provider | 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.

Section 2 – Plan(s) Check and fill in plan name(s) as appropriate (see Important Enrollment Guidelines on page 1).

Plans for 51+ employees

Medical benefits

- ☐ Access+ HMO _____
- ☐ Access+ HMO SaveNet _____
- ☐ Added Advantage POS _____
- ☐ Access Baja HMO _____
- ☐ Active Choice* _____
- ☐ Shield Spectrum PPO _____
- ☐ Shield Spectrum PPO Savings Plus[1] _____
- ☐ Core Flex Basic[1] _____
- ☐ Core Flex 70/50 _____
- ☐ Core Flex 80/60 _____
- ☐ Core Flex 90/70 _____
- ☐ Core Flex 90/70 Premier _____
- ☐ Core Flex Basic HMO 45 _____
- ☐ Core Flex HMO 40 _____
- ☐ Core Flex HMO 30 _____
- ☐ Core Flex HMO 20 _____
- ☐ Other _____

Plans for 300+ employees

100/50 PPO Plan A or B _____

Specialty benefits

- ☐ Life insurance* _____
- ☐ Dental PPO _____
- ☐ Dental HMO _____
- ☐ Vision with a Blue Shield medical plan _____
- ☐ Vision without a Blue Shield medical plan* _____
- ☐ Other _____

Core Flex dental plans

- ☐ Core Flex Basic Dental PPO 75/1000/No Ortho/MAC
- ☐ Core Flex Dental PPO 50/1000/No Ortho/MAC
- ☐ Core Flex Dental PPO 50/1000/Ortho/U90
- ☐ Core Flex Dental PPO Premier Plus 50/1500/Ortho/U90

Core Flex vision plans

- ☐ Core Flex Vision Standard 0/25/75
- ☐ Core Flex Vision Plus 0/10/100
- ☐ Core Flex Vision Deluxe 0/0/130

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life)
1 Shield Spectrum PPO Savings Plus and Core Flex Basic are HSA-eligible, high-deductible health plans. Note: Blue Shield does not offer tax advice, nor do we offer HSAs, HRAs, or FSAs.

Tax savings options (for Blue Shield use only)
Please indicate if you plan on enrolling in any of the following options (check all that apply)

- ☐ Health Savings Account through (name of administrator): _____
- ☐ Health Reimbursement Arrangement through (name of administrator): _____
- ☐ Flexible Spending Account through (name of administrator): _____
- ☐ Premium Only Plan through (name of administrator) _____

Section 3 – Dependent Information

Access+ HMO and Added Advantage POS applicants must select a primary care physician in the Blue Shield Access+ HMO physician and hospital directory. Dental HMO applicants must select a dental provider listed in the dental HMO provider directory. You may choose a different Access+ HMO primary care physician for each family member, but your dependents must live (or work) in the physician's IPA service area. Be sure to include each primary care physician's name, provider number, and their IPA number, as well as each dental provider name and provider number (see coverage for your dependents on page 1 and 2).

Do you have eligible dependents? ☐ Yes ☐ No Are they enrolling? ☐ Yes ☐ No If no, please complete the Refusal of Personal Coverage Form.

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

Dependent information	Enroll in	Access+ HMO and Added Advantage POS only – name of Personal Physician	Dental HMO only – dental provider
☐ Spouse ☐ Domestic partner ☐ Male ☐ Female First MI Last Social Security number – – Date of birth (mm/dd/yyyy)	☐ Medical ☐ Dental ☐ Vision	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
☐ Son ☐ Daughter First MI Last Social Security number – – Date of birth (mm/dd/yyyy) Full-time student? (if over 18) ☐ Yes ☐ No Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision	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
☐ Son ☐ Daughter First MI Last Social Security number – – Date of birth (mm/dd/yyyy) Full-time student? (if over 18) ☐ Yes ☐ No Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision	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
☐ Son ☐ Daughter First MI Last Social Security number – – Date of birth (mm/dd/yyyy) Full-time student? (if over 18) ☐ Yes ☐ No Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision	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

Section 4 – Life insurance beneficiary

Primary beneficiary – Blue Shield Life will pay the proceeds to the primary beneficiary. If more than one person is named as primary beneficiary, the proceeds will be distributed equally to those who survive the insured, unless otherwise specified in the % of benefits field.

First name MI Last name

Social Security number Relationship % of benefits Date of birth

Address

City State ZIP code

First name MI Last name

Social Security number Relationship % of benefits Date of birth

Address

City State ZIP code

Contingent beneficiary – Proceeds will be paid to a contingent beneficiary only if no primary beneficiary survives the insured.

First name MI Last name

Social Security number Relationship % of benefits Date of birth

Address

City State ZIP code

Section 5 – Authorization

The following authorization section is to be signed by *all* employees applying for coverage with Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield Life").

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 misrepresented or omitted any material fact that my coverage may be cancelled or my employer's contract 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 Life.

Signature of employee_____ Date _____

Print employee name _____

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 6 – 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 Life health and/or dental plan coverage.

Employee name	Social Security number
Employer group name	Date of hire (mm/dd/yyyy) Group number

Declining coverage for:

- ☐ I decline health plan coverage for myself, my spouse/domestic partner, and all dependents.
- ☐ I decline health plan coverage for:
  - ☐ My spouse/domestic partner only
  - ☐ My children only
  - ☐ My spouse/domestic partner and children
  - ☐ The following dependents only:

    _____

    _____
- ☐ If dental offered, I decline dental coverage for myself, my spouse, and all dependents.
- ☐ I decline dental plan coverage for:
  - ☐ My spouse/domestic partner only
  - ☐ My children only
  - ☐ My spouse/domestic partner and children
  - ☐ The following dependents only:

    _____

    _____

Reason for declining coverage:

- ☐ Covered by another employer's health plan (e.g., through your spouse/domestic partner)
  Carrier name and ID number _____
- ☐ Covered by an individual health plan
  Carrier name _____
- ☐ Medicare, Medi-Cal, Healthy Families Program
- ☐ Covered by TRICARE
- ☐ No other employer health coverage
- ☐ Covered by another dental plan
  Carrier name and ID number _____
- ☐ 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 Medi-Cal or Healthy Families coverage is lost) 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 Refusal of Personal Coverage forms for their records.