Health & Life Employee Enrollment Application

blue of california

Blue Shield plans for 51+ employees

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

Please note: Failure to complete this enrollment application legibly and completely may result in a delay in the enrollment process.

Reason for application:

☐ New hire	☐ Loss of coverage date ___/___/_____	☐ Late enrollment
☐ Rehire date ___/___/_____	☐ Open enrollment	☐ Other qualifying event type_____
		Date above event occurred ____/____/____

Section 1 – Important enrollment guidelines for Specialty Benefits coverage

Dental, vision, and life insurance coverage – An employee may enroll in a dental, vision, or life plan without enrolling in a health plan. In order for a dependent to enroll in a dental or vision plan, the employee must be enrolled in the same dental or vision plan.
All of an employee's dependents enrolled in the health plan will automatically be enrolled in the dependent basic life insurance plan if the employer offers dependent basic life insurance coverage.
An employee must enroll in basic group term life/AD&D insurance to be eligible to enroll in supplemental life or supplemental AD&D insurance coverage. The employee may also enroll their spouse/domestic partner and child (ren) in supplemental life or supplemental AD&D insurance only if supplemental dependent life or AD&D insurance is offered by the employer.
Evidence of insurability: For all basic group term life/AD&D insurance coverage, if an employer contributes 100% of the premium, then 100% of eligible employees must enroll and evidence of insurability is not required Evidence of insurability is required for basic group term life/AD&D coverage when the employee is a late enrollee or if the employer contributes less than 100% of the premium. Supplemental coverage is always subject to evidence of insurability.

Section 2 – Plan(s) Select and fill in plan name(s), if applicable.

Plans for 51+ employees

Medical benefits without ABHP (account-based health plan) plan options:

- ☐ Access+ HMO _____
- ☐ Access+ HMO SaveNet _____
- ☐ Local Access+ HMO_____
- ☐ Added Advantage POS_____
- ☐ Active Choice[1] _____
- ☐ Shield PPO _____
- ☐ Shield Spectrum PPO _____
- ☐ Shield PPO Savings Plus[2] _____
- ☐ Other _____

Medical benefits with ABHP (account-based health plan) plan options:

Access+ HMO: ☐ HRA ☐ HIA ☐ FSA
Local Access+ HMO: ☐ HRA ☐ HIA ☐ FSA
Shield PPO: ☐ HRA ☐ HIA ☐ FSA
Shield PPO Savings Plus: ☐ HRA ☐ HIA ☐ FSA ☐ HSA ☐ LFSA

51-100 Small Group Transition plans:

☐ HMO ☐ PPO ☐ PPO for HSA

ABHP benefit options for above plans:

For HMO: ☐ HRA ☐ HIA ☐ FSA
For PPO: ☐ HRA ☐ HIA ☐ FSA
For Shield PPO Savings Plus for HSA: ☐ HRA ☐ HIA ☐ FSA ☐ LFSA

Specialty Benefits

- ☐ Basic group term life/AD&D insurance[1]
- ☐ Dependent basic life insurance[1]
- ☐ Supplemental life insurance[1]
- ☐ Supplemental AD&D insurance[1]
- ☐ Dental PPO _____
- ☐ Dental INO[1] _____
- ☐ Dental HMO _____
- ☐ Vision _____
- ☐ Other_____

1 Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

2 Shield PPO Savings Plus are HSA-eligible high-deductible health plans.

Note: Blue Shield does not offer tax advice, nor do we offer HSAs, HRAs, HIAs, and FSAs.

Internal use only. Do not write in this section and skip to Section 3.

Department code	Group number	BU	Effective date ____/____/_____

Section 3 – Employee information

Social Security number	**Employer (group) name**		
Last name	**First name**		**MI**
Employment status: ☐ Full time ☐ Part time ☐ Retiree	**Date of hire:** ____/____/_____	Job title/classification	
Home address (street, city, state, ZIP)		Basic group term life/AD&D insurance amount:	
Mailing address (if different from home address)		Supp. life insurance amount:	Supp. AD&D insurance amount:
Home phone number	Email address	How would you prefer we contact you? ☐ Email ☐ Standard mail ☐ Telephone	

Date of birth _____/_____/_____ | **Gender** ☐ Male ☐ Female | **Marital status** ☐ Single ☐ Married ☐ Domestic partner

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

Are you enrolling your spouse/domestic partner and/or child dependents ☐ **Yes** ☐ **No If yes, complete Section 4 of application.**

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

Name of primary care physician (PCP):

Provider number: | IPA/medical group number: | Existing patient? ☐ Yes ☐ No

Name of dental provider: | Dental provider number: | Existing patient? ☐ Yes ☐ No

Section 4 – Dependent spouse/domestic partner/children information

If you, your spouse/domestic partner, or your dependents are refusing coverage, please complete and sign the Refusal of Personal Coverage form.

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

Enrolling spouse/domestic partner information	**Enroll in (please check all that apply)**	**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 ☐ Basic life/ AD&D $_____ ☐ Supp. life (I/A) $_____ ☐ Supp. AD&D (I/A) $_____	Doctor's name First Last Provider number IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
Enrolling dependent child(ren) information	**Enroll in (please check all that apply)**	**Access+ HMO and Added Advantage POS only – name of Personal Physician**	**Dental HMO only – dental provider**
☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision ☐ Basic life/ AD&D $_____ ☐ Supp. life (I/A) $_____ ☐ Supp. AD&D (I/A) $_____	Doctor's name First Last Provider number IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision ☐ Basic life/ AD&D $_____ ☐ Supp. life (I/A) $_____ ☐ Supp. AD&D (I/A) $_____	Doctor's name First Last Provider number IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No

Section 5 – 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

If beneficiary is a trust or corporation, please provide name and date of trust agreement and state of incorporation.

Name of trust/corporation	Date of trust	State of incorporation

COMMUNITY PROPERTY LAWS – If you are married or in a domestic partnership, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin), and name someone other than your spouse/domestic partner as beneficiary, it is possible that payment of benefits will be delayed or disputed unless your spouse/domestic partner also signs the beneficiary designation.
I agree to the above-stated beneficiary designation(s).

Print spouse/domestic partner name:_____
Spouse/domestic partner signature:_____ _____Date:_____

Section 6 – Medicare information

Are you or any of your dependents currently covered by Medicare? ☐ No ☐ Yes. Please attach a copy of your Medicare card(s) and/or enter the type of coverage here: Part A: ☐ Effective date: ____/____/____(mm/dd/yyyy) Part B: ☐ Effective date: ____/____/____(mm/dd/yyyy)
Is Medicare eligibility due to end-stage renal disease (ESRD)? ☐ Yes ☐ No
If yes, please answer the following questions:

a) What was the first date of dialysis treatment, and what type of dialysis are you receiving?
Date_____ Type: ☐ Hemo ☐ Self-dialysis (peritoneal)

b) If you have had a kidney transplant, what was the date of the transplant: ____/____/____(mm/dd/yyyy)

Section 7 – 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"). **This enrollment cannot be processed without your signed authorization.**

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 in conjunction with this application within the first 24 months of coverage, my coverage may be canceled, or 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") understands 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 website.