blue of california

P.O. Box 7725, San Francisco, CA 94120 1-888-800-2742

Enrollment Form for Group Life Insurance for Blue Shield of California Life & Health Insurance Company (Blue Shield Life)

NOTE: Please complete the entire enrollment form and return it to your employer. This form cannot be processed if information is incomplete.

GROUP NAME	GROUP POLICY NO.	SECTION NUMBER

SECTION 1 – APPLICANT

FIRST NAME	M.I.	LAST NAME

ADDRESS	CITY	STATE	ZIP

GENDER	BIRTHDATE	SOCIAL SECURITY NO.	MARITAL STATUS
☐ MALE ☐ FEMALE			☐ SINGLE ☐ MARRIED ☐ DOMESTIC PARTNER

FULLTIME EMPLOYMENT DATE	AVERAGE HOURS WORKED PER WEEK	REHIRE DATE	CLASS/OCCUPATION	EARNINGS $ ______ (EXCLUDING OVERTIME, BONUSES, ETC.) ☐ HOUR ☐ WEEK ☐ MONTH ☐ YEAR

SECTION 2 – 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 % column.

FIRST NAME	MI	LAST	SOCIAL SECURITY NUMBER	RELATIONSHIP	% OF BENEFITS	D.O.B.

STREET ADDRESS	CITY	STATE	ZIP

FIRST NAME	MI	LAST	SOCIAL SECURITY NUMBER	RELATIONSHIP	% OF BENEFITS	D.O.B.

STREET ADDRESS	CITY	STATE	ZIP

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

FIRST NAME	MI	LAST	SOCIAL SECURITY NUMBER	RELATIONSHIP	% OF BENEFITS	D.O.B.

STREET ADDRESS	CITY	STATE	ZIP

SECTION 3 – COVERAGE (COMPLETE ONLY TO APPLY FOR GROUP LIFE INSURANCE COVERAGE)

Please contact your employer's or association's administrative office to clarify coverages available. Coverage granted shall be subject to all provisions and limitations stated in the Blue Shield Life Group Insurance Policy. Evidence of Insurability must be submitted for amounts exceeding non-medical maximum limits or when enrolling outside of the initial eligibility period.

APPLICANT: ☐ **BASIC LIFE** ☐ **AD&D** ☐ SUPPLEMENTAL LIFE (& SUPPLEMENTAL AD&D IF WITHIN GROUP INSURANCE POLICY) AMOUNT OF COVERAGE REQUESTED: $

DEPENDENT(S): ☐ BASICDEPENDENT LIFE ☐ SUPPLEMENTAL DEPEN-DENT LIFE
NUMBER OF ELIGIBLE DEPENDENTS: AMOUNT OF COVERAGE REQUESTED FOR SPOUSE: $ ______ CHILD(REN): $ ______

I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. I reserve the right to revoke this deduction at any time on written notice.

Sign Here to Apply for Coverage ______________________ Date Applicant Signed ______________

SECTION 4 – WAIVER OF COVERAGE (COMPLETE ONLY TO WAIVE GROUP LIFE INSURANCE COVERAGE)

The group program has been offered to me and after seriously considering it's benefits, I have decided:

(Please indicate your choice) ☐ (A) not to enroll myself or dependents ☐ (B) not to enroll my dependents

I understand that if I desire to participate in the program at some future date, my coverage or my dependent's coverage will not be effective until after Evidence of Insurability is submitted and approved. I understand that if a physical examination or other further medical information is required, it will be at my own expense.

Sign Here to Waive Coverage ______________________ Date Coverage Waived ______________

An Independent Licensee of the Blue Shield Association