Blue Shield
of California
Life & Health
Insurance Company
An Independent Licensee
of the Blue Shield Association

Blue Shield
of California
An Independent Member
of the Blue Shield Association

Employee Application

Blue Shield Plans
For 51+ Employees

C-15390 (8/05)

IT IS VERY IMPORTANT THAT ALL QUESTIONS BE ANSWERED.

Employee Application

1 Please make sure you 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 Check the "Enroll in Medical" box for each dependent listed in this section. In the space provided, list all eligible dependents you wish to enroll (including spouse or domestic partner), their dates of birth, Social Security Number and relationship to the employee. Domestic partner enrollment is only available if your employer has elected to offer this option. **If selecting Access+ HMO® or Added Advantage℠ POS, you must choose a Primary Care Physician.** Please enter the Provider Number and the IPA Number. Please note the important dental enrollment guidelines described below.

If dependent is over 18, you must check the "Full Time Student" box as "Yes" for each dependent. To be considered eligible, dependent children ages 19-24 must be enrolled full time in college (minimum of 12 units) 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 over age 18 for full time students is not available to dependents of legal guardians.

Important Dental Enrollment Guidelines

You must check the "Enroll in Dental" box for each dependent listed in Section 3 of the Employee Application in order for each dependent to be covered.

☐ **Dental PPO**

- Employee enrollment in a Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield Life) health plan is not required to select Dental PPO.
- If you are enrolled in a Blue Shield of California/Blue Shield Life health plan and select Dental PPO, dental benefits will apply to you and the dependents enrolled in the health plan.
- Any eligible dependent not covered by the employee's Blue Shield of California/Blue Shield Life health plan will not be covered by the employee's Dental PPO plan.

☐ **Dental HMO**

- Employee enrollment in a Blue Shield of California/Blue Shield Life health plan is not required to select Dental HMO.
- To enroll in a Dental HMO plan, **you must live or work sufficiently close to a participating Dental Provider to ensure reasonable access to care, as determined by the Plan.**
- Refer to the Dental HMO Provider Directory for service areas.
- If selecting a Dental HMO plan, you must list the identification number of the Dental Provider you have selected. Refer to the Dental HMO Provider Directory for the identification number.

4 Enter information on any other health coverage you or your dependents have including Medicare. This **must** be completed for coordination of benefits.

5 In the "Life Insurance Beneficiary" section, enter the name of the person who is to receive the group life benefit, his/her relationship to the employee and his/her current address.

6 The employee must sign and date the authorization for payroll deduction and disclosure of personal information. Blue Shield of California/Blue Shield Life cannot process the application without signed authorization.

Refusal of Personal Coverage Form

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

Enter the employee name, Social Security Number, the employer (group) name and number, date of full-time hire and marital status. Check the appropriate box if you, your spouse or dependent(s) are declining health and/or dental coverage. Check the box that meets your reason for refusing coverage for you, your spouse 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 which 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 towards 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 60 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.

☐ **Access Baja HMO®**

- To enroll in the Access Baja HMO, you must live or work within the Access Baja service area to ensure reasonable access to care.
- Refer to the Access Baja HMO Provider and Pharmacy Directory for selection of Primary Care Physician and service area information.
- You must understand the standards of care as reflected in the Disclosure Form.

C-15390 (8/05)

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EMPLOYEE APPLICATION
(for 51+ employees)

Blue Shield of California
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☐ New Enrollment ☐ Re-Hire

OUTLINED BOX BELOW FOR OFFICE USE ONLY

Employee Information (Please type or print clearly. Use black ink.)

1 SELF

Social Security Number	Employer (Group) Name	Dept. Code	Group Number	B/U
___ ___ ___ - ___ ___ - ___ ___ ___ ___				

Last Name	First Name	M.I.	OED	RSN

Mailing Address	City	State	Zip	S	TOC	NP	PKG

Home Physical Address	City	State	Zip	Life/AD&D Amount

Business Phone	Home Phone	E-mail Address
( )	( )	

Full-Time Hire Date (Mo / Day / Year)	Job Title

How would you prefer we contact you? Select one of the following:
☐ Electronic Mail ☐ Standard Mail Telephone: ☐ Home ☐ Business
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.

Date of Birth (Mo / Day / Year)	Sex (M F)	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner	Language Preference: ☐ English ☐ Spanish ☐ Chinese ☐ Other _____	Check Yes If additional sheet(s) is attached to this Application ☐ Yes

ACCESS+ HMO & ADDED ADVANTAGE POS – Name of Primary Care Physician:	Prov. #	IPA/MG #	Existing Patient? ☐ Yes ☐ No

DENTAL HMO ONLY – Name of Dental Provider:	Dental Provider #

If you, your spouse or your dependent(s) are refusing coverage, please complete and sign The Refusal of Personal Coverage Form at the end of this application.

2

Check Plan(s) and fill in plan name(s) as appropriate.
(See Important Guidelines on Page 2)

(Plans for 51+ Employees)

Medical Benefits

- ☐ Access+ HMO_____
- ☐ Added Advantage POS_____
- ☐ Access Baja HMO_____
- ☐ Active Choice*_____
- ☐ Shield Spectrum PPO_____
- ☐ Shield Spectrum PPO Savings Plus[1]_____
- ☐ Other_____

(Plans for 300+ Employees)

- ☐ Member Select[SM]_____
- ☐ 100/50 PPO Plan A or B _____

- ☐ Life Only_____
- ☐ Dental PPO_____
- ☐ Dental HMO_____
- ☐ Vision_____
- ☐ Other_____

*Active Choice plans are underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).
[1]Shield Spectrum PPO Savings Plus are HSA-eligible high-deductible health plans.

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. Be sure to include each primary care physician's provider number and their IPA number as well as each dental provider number. For Access Baja HMO, please see page 2.

Dependent's address if different from employee

City | State | Zip

Do you have eligible dependents? ☐ Yes ☐ No Are they enrolling? ☐ Yes ☐ No If No, please complete the Refusal of Personal Coverage Form	Enroll In	Access+ HMO and Added Advantage POS Only – Name of Primary Care Physician	Existing Patient?	Dental HMO Only – Dental Provider	Existing Patient?
☐ Spouse ☐ Domestic Partner ☐ Male ☐ Female First Name Last Name Social Security # Date of Birth	☐ Medical ☐ Dental	Doctor's Name (First) (Last) Prov. # IPA/MG#	☐ Yes ☐ No	Dental Provider Name: Dental Provider #	☐ Yes ☐ No
Full Time Student Status? (If over 18) ☐ Yes ☐ No					
☐ Son ☐ Daughter First Name Last Name Social Security # Date of Birth	☐ Medical ☐ Dental	Doctor's Name (First) (Last) Prov. # IPA/MG#	☐ Yes ☐ No	Dental Provider Name: Dental Provider #	☐ Yes ☐ No
Full Time Student Status? (If over 18) ☐ Yes ☐ No					
☐ Son ☐ Daughter First Name Last Name Social Security # Date of Birth	☐ Medical ☐ Dental	Doctor's Name (First) (Last) Prov. # IPA/MG#	☐ Yes ☐ No	Dental Provider Name: Dental Provider #	☐ Yes ☐ No
Full Time Student Status? (If over 18) ☐ Yes ☐ No					
☐ Son ☐ Daughter First Name Last Name Social Security # Date of Birth	☐ Medical ☐ Dental	Doctor's Name (First) (Last) Prov. # IPA/MG#	☐ Yes ☐ No	Dental Provider Name: Dental Provider #	☐ Yes ☐ No
Full Time Student Status? (If over 18) ☐ Yes ☐ No					

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EMPLOYEE APPLICATION

(for 51+ employees, continued)

Blue Shield of California
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APPLICANT'S SOCIAL SECURITY NUMBER
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Employee Information, Continued

4 **Coordination of Benefits:** Do you or any of your dependents have any other health plan or health insurance (including Medicare) in addition to this Blue Shield of California/Blue Shield Life coverage? ☐ Yes ☐ No

Will this coverage remain in effect after the Blue Shield of California/Blue Shield Life coverage begins? ☐ Yes ☐ No

5 **Life Insurance Beneficiary**
Name

Relationship to Applicant

Street Address City State Zip

6 **AUTHORIZATION: The Following Authorization 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 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.

Authorization for Disclosure of Personal Information: By signing below, you authorize any "provider of care," insurer, health plan, or your Blue Shield of California agent or broker, to disclose to Blue Shield of California or Blue Shield of California Life & Health Insurance Company (individually or collectively referred to as "Blue Shield"), or its representatives, and vice versa, all "medical information" (as those terms are defined in the California Civil Code) regarding you and your applying family members, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for the purposes of evaluating this application, determining eligibility and claims for benefits, quality assurance, peer review, or administrative functions reasonably related to executing and managing this Agreement/Policy. In addition, you authorize Blue Shield of California to obtain personal and medical record information (as those terms are defined in the California Insurance Code) from an institutional source or an insurance support organization that gathers this type of information, for the purposes of determining eligibility for coverage. This authorization will remain valid as follows: (1) for 30 months from the date of authorization for the purposes of processing the application, a policy reinstatement, or a request for change in policy benefits; and (2) for all other activities under the policy, for the term of the coverage or for as long as may be necessary for processing of claims incurred during the term of coverage. You understand that you are entitled to a copy of this form and that a photocopy is as valid as the original.

***I, the applicant, acknowledge that I have read and understood this Application in its entirety.**

Signature of Employee X _____ **Date X** _____

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)

Please print

Employee Name	Social Security #	
Employer (Group) Name	Hire Date Mo / Day / Year	Group Number
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 If No, please explain _____

_____

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 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

☐ 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 acquire a new dependent as the result of marriage/domestic partnership, birth, adoption or placement for adoption, I acknowledge that I, and any dependents I may have, 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.

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 X _____ **Date X** _____

EMPLOYERS MUST RETAIN A COPY OF ANY SIGNED REFUSAL OF PERSONAL COVERAGE FOR THEIR RECORDS