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

EMPLOYEE ENROLLMENT FORM

☐ ACCESS+ HMO ☐ SHIELD SELECT ☐ BLUE SHIELD POS
☐ PREFERRED SAVINGS ☐ PPO ☐ DENTAL HMO ☐ DENTAL PPO
☐ CPIC LIFE ONLY

Instructions: Complete entire form. Print using black ink. **Read all sections carefully and sign back of form.** Incomplete or omitted information may affect your effective date and payment of claims. Keep a copy of this form as Proof of Application until you receive your ID card(s). If you have questions concerning this form, please contact your Employer.

Employer Information:	**Company Name**	**Group No.**	**Effective Date**

Employee Information:				
Last Name **First** **MI**	**Occupation / Job Title**		❑ New ❑ Rehire ❑ Hourly ❑ Salaried	
Mailing Address	**City**		**State**	**ZIP**
Marital Status: ❑ Single ❑ Married ❑ Domestic Partner	**Work Telephone**	**Home Telephone**		

Below, list ONLY those persons that you wish to enroll in Blue Shield health coverage. All enrollees must live or work within the Blue Shield service area. To enroll more than four dependents, please attach another form.

Important: If declining coverage for any dependent(s), complete and sign the "Refusal of Coverage" section on the back of this form.

Enroll In		Name / Soc Sec # / Birth Date	Sex	**For HMO & POS*** Primary Care Physician	Existing patient?	**Dental HMO Only***
❑ Medical ❑ Dental	**SELF**	Last Name First Name MI **Soc Sec #** **Birth Date** / /	❑ M ❑ F	Dr.'s Name PCP# IPA / MG#	If Yes: ❑ Medical ❑ Dental	Dental Ctr. Name Dental Ctr. #
❑ Medical ❑ Dental	❑ **SPOUSE** ❑ **Dom. Part.** ❑ **CHILD**	Last Name First Name MI **Soc Sec #** **Birth Date** / /	❑ M ❑ F	Dr.'s Name PCP# IPA / MG#	If Yes: ❑ Medical ❑ Dental	Dental Ctr. Name Dental Ctr. #
❑ Medical ❑ Dental	**CHILD**	Last Name First Name MI **Soc Sec #** **Birth Date** / /	❑ M ❑ F	Dr.'s Name PCP# IPA / MG#	If Yes: ❑ Medical ❑ Dental	Dental Ctr. Name Dental Ctr. #
❑ Medical ❑ Dental	**CHILD**	Last Name First Name MI **Soc Sec #** **Birth Date** / /	❑ M ❑ F	Dr.'s Name PCP# IPA / MG#	If Yes: ❑ Medical ❑ Dental	Dental Ctr. Name Dental Ctr. #
❑ Medical ❑ Dental	**CHILD**	Last Name First Name MI **Soc Sec #** **Birth Date** / /	❑ M ❑ F	Dr.'s Name PCP# IPA / MG#	If Yes: ❑ Medical ❑ Dental	Dental Ctr. Name Dental Ctr. #

*HMO and POS applicants must select a Primary Care Physician in the Blue Shield Directory. Dental HMO applicants must select a Dental Center in the Dental HMO Dental Center Directory. You may choose a different PCP and Dental Center for each family member. Be sure to include each PCP's Provider Number and IPA/MG#, as well as each Dental Center Number.

GROUP TERM LIFE INSURANCE (if applicable)

Attach a separate sheet for additional or contingent beneficiaries

Life Beneficiary (Full Name):	Relationship to Applicant:	%
Life Beneficiary (Full Name):	Relationship to Applicant:	%

COORDINATION OF BENEFITS

Do you or any of your dependents have any other health plan or health insurance in addition to the Blue Shield health plan? ❑ Yes ❑ No If yes, please provide the following plan information (include Medicare if applicable).

Full Name of Insured (Last, First, MI)	Name of Other Insurance Carrier/Health Plan	Policy ID#	Employer

CERTIFICATION FOR STUDENTS OVER AGE 18 I hereby certify that my overage dependent(s) is/are currently enrolled as full time student(s) at the school(s) listed below.

Full Name of Dependent (Last, First, MI)	Name of Accredited College or Trade School	State	# of Hours	# of Units (min. of 12)

I agree: All information on this form is correct and true. 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/CPIC *Life*.

I authorize any "provider of care", insurer or health plan to disclose to Blue Shield of California, or their representatives, all "medical information" (as those terms are defined in the California Civil Code), including any medical information regarding substance abuse, or mental and emotional conditions, regarding me, my spouse or my children. This medical information is collected for the purpose of evaluating my employer's application, determining claims for benefits, or for quality assurance and peer review. This authorization will remain valid for the term of the coverage of the Blue Shield health service contract. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization.

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

Employee Signature	**Date**
X	

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

The Preferred Plan, Shield Select Plan, and the Preferred Savings Plan exclude preexisting conditions. Preexisting 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 preexisting 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 Plans within sixty-three (63) days of that prior creditable coverage (excluding any waiting period);

-- Employees and dependents, who are validly covered under the present employer's previous group health coverage when that coverage was terminated and who enrolled on the original effective date of the Blue Shield 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" form your prior employer, Insurer, or health plan and submit the certificate to Blue Shield.

REFUSAL OF COVERAGE: Complete this section only if you are NOT enrolling ALL eligible dependents.

I am declining coverage for my: ❑ Spouse only ❑ Child(ren) only ❑ Both spouse & child(ren)

Reason:
- ☐ Spouse's group health coverage (Health plan and ID#) ____________________
- ☐ Individual health coverage (Health plan and ID#) ____________________
- ☐ Other health coverage (Health plan and ID#) ____________________
- ☐ Medicare ❑ Champus or Champa
- ☐ Other reason ____________________

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 my dependent(s). I now decline to enroll my dependent(s) in my employer's Blue Shield 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, birth, adoption or placement for adoption, I acknowledge that I may request enrollment of any dependents I may have in my employer's health plan by applying for that coverage within 31 days of the marriage, birth, adoption, or placement for adoption.

If my dependent(s) has/have other health coverage at this time, and I have so indicated the other coverage(s) above, I acknowledge that if my dependent(s) involuntarily lose the other coverage(s) I must request enrollment in my employer's health plan within 31 days.

If I do not enroll eligible dependents within 31 days of the qualifying events described above, I understand that I may not enroll any dependents until the end of my employer's next open enrollment period, or after 12 months, whichever is earlier.

Employee Signature (**only if declining**)	Date
X	