Health Plan 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 and vision insurance – An employee may enroll in a dental and/or vision 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.

Section 2 – Plan(s) Select and fill in plan name(s) as appropriate.

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[1] _____
- ☐ 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 ☐ HSA ☐ LFSA

Specialty Benefits

- ☐ Dental PPO _____
- ☐ Dental INO _____
- ☐ Dental HMO _____
- ☐ Vision _____
- ☐ Other _____

1 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)

Mailing address (if different from home address)

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	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	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	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	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

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.
Print spouse/domestic partner name:_____
Spouse/domestic partner signature:_____ Date:_____

Section 5 – 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 6 – Authorization

The following authorization section is to be signed by <u>all</u> employees applying for coverage with Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield Life"). **<u>This enrollment cannot be processed without your signed authorization.</u>**

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.