Employee application

blue of california

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

Blue Shield plans for groups with 2 to 50 eligible employees

Effective January 1, 2011

It is very important that all questions be answered. Missing information may delay processing.

1. Provide the employee data requested.
2. Fill in the circles to indicate your coverage selection, and fill in plan name as appropriate.
   (Example: ● Dental HMO® Basic
   or ● Vision Standard 0/0/130)
3. Provide the Social Security number for each member enrolling.
4. Fill in the "Enroll in Medical Plan" circle 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 coverage is included in all Blue Shield group health plans. Please verify eligibility criteria with your employer. **If selecting Access+ HMO, Local Access+ HMO, or Added Advantage POS℠ Plan, you must choose a Personal Physician.** Please enter the Provider Number and the name of the IPA or Medical Group. Refer to the HMO provider directory at **blueshieldca.com** for the identification number. Please note the important Specialty benefits plan enrollment guidelines described at right. Dependent children may be eligible if less than 26 years of age.

   Dependent children over the age of 25 who are disabled may be eligible for continued benefits under a group plan providing the child is incapable of self-sustaining employment and chiefly dependent on the subscriber, spouse, or domestic partner for support and maintenance. A HIPAA certificate from the prior group carrier and a Physician's written certification of disability must be submitted (Form C3674) with the application for enrollment. Certification of continued disability is required to maintain eligibility.

   ○ **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. Dental, Vision, and Life insurance are not available with Access Baja plans.

Important Specialty benefits plan enrollment guidelines
You must fill in the "Enroll in Dental and/or Vision Plan Coverage" circle for each dependent listed in Section 3 of the Employee Application in order for each dependent to be covered. Employees may elect to enroll any number of their eligible dependents in a Blue Shield of California Dental PPO, Dental HMO, or Blue Shield of California/Blue Shield Life Vision plan.

○ **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 coverage.

○ **Dental HMO**

- Employee enrollment in a Blue Shield of California/ Blue Shield Life health plan is not required to select dental HMO coverage.
- 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 dental 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 dental provider directory at **blueshieldca.com** for the identification number. Assignment must be to a provider, not an office.

○ **Vision**

- 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 vision coverage.

5. In the "Life Insurance Beneficiary" section, enter the name of the person who is to receive the group life insurance benefit, his or her relationship to the employee, and his or her current address.
6. The employee must sign and date the authorization for payroll deduction and disclosure of personal and health information. Blue Shield of California/Blue Shield Life cannot process the application without a signed authorization.

Refusal of 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. This form is not required for dental or life insurance only applications.

Enter the employee name, Social Security number, the employer (group) name, date of full-time hire, and marital status. Fill in the appropriate circle if you, your spouse, domestic partner, or dependent(s) are declining health, dental, and/or vision coverage. Fill in the circle 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 that 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 Savings 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);
- Any enrollee under the age of 19
- Employees and dependents who were validly covered under the present employer's previous group health coverage for six consecutive months 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.

blue of california

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

Employee application (for 2 to 50 employees)

○ New group enrollment ○ New hire ○ Family addition ○ Re-hire ○ Late enrollment ○ Special enrollment period

B/U	OED	RSN	S	TOC	NP	PKG	
							Do not write in shaded area

1. Employee information (please type or print clearly, and use black ink) If you, your spouse, or your dependent(s) are refusing coverage, please complete and sign the Refusal of Coverage form at the end of this application.

Social Security Number **Employee Group Name** **Group Number**

Last Name **First Name** **MI**

Home Address **Apt**

City **State** **Zip**

Mailing Address (same as home address ○) **Apt**

City **State** **Zip**

Work phone – – Home phone – – –

E-mail address

Full-time hire date (Mo/Day/Yr) / / Job Title Life/AD&D insurance amount

How would you prefer we contact you? Select one of the following: ○ E-mail ○ Standard mail Telephone: ○ Home ○ Work

Blue Shield 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

Are you a part-time employee working at least 20 hours per week for this employer? ○ Yes ○ No If no, please explain.

Date of Birth (Mo/Day/Yr) / / Height Weight **Marital Status:** ○ Single ○ Married ○ Domestic Partner **Gender** ○ Male ○ Female

Language preference: ○ English ○ Spanish ○ Chinese ○ Vietnamese ○ Other:

Check yes if additional sheet(s) is attached to this application: ○ Yes

Do you have eligible dependents? ○ Yes ○ No **How many?** **How many are enrolling?**

Are any eligible dependents not enrolling on this plan covered by any form of health insurance? ○ Yes ○ No

Please complete the Refusal of Coverage form included in this application for eligible dependents that are not enrolling.

Applicant's Last Name | First Name | MI | Social Security Number

2. Plan Selection

Medical benefit plans

Access+ HMO ◯ 5 ◯ 10 ◯ 15 ◯ 20 ◯ 20 Value ◯ 30 ◯ 25 ◯ 40

Local Access+ HMO ◯ 5 ◯ 10 ◯ 15 ◯ 20 ◯ 20 Value ◯ 30 ◯ 25 ◯ 40

Shield Spectrum PPO ◯ Zero Deductible ◯ 250 Premier ◯ 250 Standard ◯ 500 Premier ◯ 500 Standard[1] ◯ 1000 ◯ 500 Value[1] ◯ 750 Value[1,4] ◯ 3000[1] ◯ 1000 Value[1,4] ◯ 1500 Value[1,4] ◯ 2000 Value[1,4,5]

Shield Savings[2] ◯ 1800/3600[1,4] ◯ 2000/4000[1,4] ◯ 2250/4500 ◯ QS 2000/4000 ◯ 3000/6000[1] ◯ 2500[1] ◯ 4800[1] ◯ QS 3000/6000 ◯ QS 4800[1]

Base PPO[1,4] ◯ 30 ◯ 40 ◯ 50 **Added Advantage POS** ◯

Active Choice[1] ◯ 750 ◯ 500 **Access Baja HMO** ◯ 5 ◯ 10

◯ **Other:**

Optional benefits

Check plan(s) and fill in names as appropriate

◯ Dental PPO plan

◯ Dental HMO plan

◯ Vision plan

◯ Life/AD&D Insurance[3]

◯ Dependent Life Insurance/Amt. (max $5,000)

◯ Other

HMO/POS Personal Physician name | **Provider number** | **IPA/MG No.**

Dental HMO Provider name | **Dental Provider number** (Do not use office number) | **Existing patient?** ◯ Yes ◯ No

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

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

3 Group term life insurance for groups of 2 to 9 eligible employees is administered and underwritten through a small group employer trust.

4 Shield Spectrum PPO Plan 750 Value, Shield Spectrum PPO Plan 1000 Value, Shield Spectrum PPO Plan 1500 Value, Shield Spectrum PPO Plan 2000 Value, Base PPO 30, Base PPO 40, Base PPO 50, Shield Savings℠ 1800/3600 and Shield Savings℠ 2000/4000 are pending regulatory approval.

5 Prescription drug coverage for this plan only provides coverage for generic drugs and specifically excludes coverage for brand name prescriptions

3.

Dependent Information: Access+ HMO, Local Access+ HMO, and Added Advantage POS applicants must select a Personal 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 or Local Access+ HMO Personal Physician for each family member. Be sure to include each physician's provider number and IPA number, as well as each dental provider number. For Access Baja HMO, please see Page 1.

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

Dependent's first Name | Last name | MI

Dependent's address (if different from employee)

City | State | Zip code

◯ Spouse ◯ Domestic Partner

◯ Male ◯ Female

Disabled? ◯ Yes ◯ No

Date of marriage/domestic partnership: / /

Height | Weight

Social Security Number

Date of Birth (Mo/Day/Yr) / /

First name | **Last name** | **MI**

Enroll in: ◯ Health plan ◯ Dental plan ◯ Vision plan ◯ Life insurance

HMO/POS Personal Physician name | **Provider number** | **IPA/MG No.**

Dental HMO Provider name | **Dental Provider number** (Do not use office number) | **Existing patient?** ◯ Yes ◯ No

Applicant's Last Name | First Name | MI | Social Security Number

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Son ○ Daughter ○

Social Security Number | Date of Birth (Mo/Day/Yr) | Height | Weight | Disabled? ○ Yes ○ No

First name | Last name | MI

Enroll in: ○ Health plan ○ Dental plan ○ Vision plan ○ Life insurance

HMO/POS Personal Physician name | Provider number | IPA/MG No.

Dental HMO Provider name | Dental Provider number (Do not use office number) | Existing patient? ○ Yes ○ No

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Son ○ Daughter ○

Social Security Number | Date of Birth (Mo/Day/Yr) | Height | Weight | Disabled? ○ Yes ○ No

First name | Last name | MI

Enroll in: ○ Health plan ○ Dental plan ○ Vision plan ○ Life insurance

HMO/POS Personal Physician name | Provider number | IPA/MG No.

Dental HMO Provider name | Dental Provider number (Do not use office number) | Existing patient? ○ Yes ○ No

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Son ○ Daughter ○

Social Security Number | Date of Birth (Mo/Day/Yr) | Height | Weight | Disabled? ○ Yes ○ No

First name | Last name | MI

Enroll in: ○ Health plan ○ Dental plan ○ Vision plan ○ Life insurance

HMO/POS Personal Physician name | Provider number | IPA/MG No.

Dental HMO Provider name | Dental Provider number (Do not use office number) | Existing patient? ○ Yes ○ No

Applicant's Last Name | First Name | MI | Social Security Number

4. Does any person applying for coverage currently have health insurance coverage? ◯ Yes ◯ No

If yes, Proof of Coverage must be submitted. (See below.)

Has any person applying for coverage had health insurance coverage at any time in the past six (6) months? ◯ Yes ◯ No

If yes, applicant/family member names:

Type of coverage: ◯ Group ◯ Individual ◯ Other (specify):

Insurance company | Policy/ID No

Date coverage began (Mo/Day/Yr) | Date ended (Mo/Day/Yr)

Is any person applying for coverage currently enrolled with Medicare? ◯ Yes ◯ No

If yes, name: Please provide copy of Medicare card.

To get credit for any prior creditable coverage, obtain Proof of Coverage in the form of 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.

5. Life insurance beneficiary

Last name | First name | MI

Relationship to applicant

Street Address | **Apt**

City | **State** | **Zip**

Disclosure statement and authorization: The following section is to be signed by all employees applying for coverage

6. Disclosure of personal and health information. Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, "Blue Shield") understand 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 Web site.

* 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 that my coverage may be cancelled or, following notice, 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 of California Life & Health Insurance Company ("Blue Shield Life").

Signature of employee | **Date**

Print employee name | **Date**

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 of California Life & Health Insurance Company health, dental, and/or vision plan coverage.) Please type or print. Use black ink.

Employee last name | Employee first name | MI

Social Security number | Employer (group) name | Hire date (Mo/Day/Yr) | Marital Status: ◯ Single ◯ Married ◯ Domestic Partner

Job Title

Are you a full-time employee, working at least 30 hours per week for this employer? ◯ Yes ◯ No If no, please explain:

Are you a part time employee, working at least 20 hours per week for this employer? ◯ Yes ◯ No

Declining coverage for:

I decline health plan coverage for:

◯ Myself and all dependents
- ◯ My spouse/domestic partner
- ◯ My children
- ◯ My spouse/domestic partner and children
- ◯ The following dependents only:

If dental plan offered, I decline dental plan coverage for:

◯ Myself and all dependents
- ◯ My spouse/domestic partner
- ◯ My children
- ◯ My spouse/domestic partner and children
- ◯ The following dependents only:

If vision plan offered, I decline vision plan coverage for:

◯ Myself and all dependents
- ◯ My spouse/domestic partner
- ◯ My children
- ◯ My spouse/domestic partner and children
- ◯ The following dependents only:

Reason for declining coverage

OTHER EMPLOYER HEALTH COVERAGE

◯ Enrolling as a dependent on this group health plan

◯ Covered by this employer's other health plan

◯ Covered by another employer's health plan (e.g., through your spouse/domestic partner)

Carrier name

ID number

◯ Covered by Tricare

OTHER NON-EMPLOYER HEALTH COVERAGE

◯ Covered by an individual health or dental plan

Carrier name

ID number

◯ Medicare, Medi-Cal, Healthy Families program

◯ Covered by another dental plan

Carrier name

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's 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 am declining enrollment for myself or my dependents because of other health coverage or because the employer stops contributing toward this coverage, I acknowledge that I may be able to enroll myself and my dependents in this plan if I request enrollment within 31 days (60 days if loss of Medi-Cal or Healthy Families coverage) after my or my dependents' other coverage ends or after the employer stops contributing toward the other coverage.

In addition, if I acquire a new dependent as the result of marriage/domestic partnership, birth, adoption or placement for adoption, I acknowledge that I, and my dependents, 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. I also acknowledge that if I, or my dependents, become eligible for the Healthy Families or the Medi-Cal Premium Assistance Programs, I or my dependents may request enrollment in my employer's health plan by applying for coverage within 60 days of the notice of eligibility for these premium assistance programs.

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 **Date**

Employers must retain a copy of any signed personal refusal of coverage for their records.