

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

Internal use only. Do not write in shaded area.

- New enrollment
- Re-hire

Effective date (mo/day/yr)	Dept. code	BU	RSN	S	TOC	NP	PKG
/ /							

Section 1 – Employee information Please type or print clearly. Use black ink.

Social Security number Employer (group) name Group number Life/AD&D amount

Name (last, first, MI)

Mailing address (street, city, state, ZIP)

Home address (street, city, state, ZIP)

Home phone number Full-time hire date / / E-mail address

How would you prefer we contact you?
 E-mail Standard mail Telephone

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

Blue Shield of California/Blue Shield Life will use your preferred method when possible.

Birthdate (mo/day/yr) Gender Marital status Language preference Check Yes if additional sheet(s) attached

Male Single Married English Spanish
 Female Domestic partner Chinese Other _____ Yes

Access+ HMO or Added Advantage POS only: Provider number IPA/MG number Existing patient?
 Name of primary care physician Yes No

Dental HMO only: Name of dental provider Dental provider number

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.

Section 2 – Plan(s) Check and fill in plan name(s) as appropriate (see Important Enrollment Guidelines on page 1)

Plans for 51+ employees

Medical benefits

- Access+ HMO _____
- Access+ HMO SaveNet _____
- Added Advantage POS _____
- Access Baja HMO _____
- Active Choice* _____
- Shield Spectrum PPO _____
- Shield Spectrum PPO Savings Plus¹ _____
- Other _____

Plans for 300+ employees

- 100/50 PPO Plan A or B _____

* 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.

Note: Blue Shield does not offer tax advice, nor do we offer HSAs, HRAs, or FSAs.

Optional benefits

- Life Insurance only* _____
- Dental PPO _____
- Dental HMO _____
- Vision _____
- Other _____

Tax savings options (for Blue Shield use only)

Please indicate if you plan on enrolling in any of the following options (check all that apply):

- Health Savings Account through (name of financial institution): _____
- Health Reimbursement Arrangement through (name of financial institution): _____
- Flexible Spending Account through (name of financial institution): _____
- Premium Only Plan through (name of financial institution): _____

An Independent member of the Blue Shield Association

Section 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 name, provider number, and their IPA number, as well as each dental provider name and provider number (See coverage for your dependents on page 1 and 2).

Do you have eligible dependents? Yes No
 Are they enrolling? Yes No
 If No, please complete the Refusal of Personal Coverage Form

Dependent's address, if different from employee (indicate which dependent)

Dependent information	Enroll in	Access+ HMO and Added Advantage POS only – name of Personal Physician	Dental HMO only – dental provider
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Male <input type="checkbox"/> Female First _____ Last _____ Social Security number _____ Date of birth (mo/day/year) _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Doctor's name First _____ Last _____ Provider number _____ IPA/MG number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental provider name First _____ Last _____ Dental provider number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter First _____ Last _____ Social Security number _____ Date of birth (mo/day/year) _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Doctor's name First _____ Last _____ Provider number _____ IPA/MG number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental provider name First _____ Last _____ Dental provider number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Full-time student? (if over 18) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Son <input type="checkbox"/> Daughter First _____ Last _____ Social Security number _____ Date of birth (mo/day/year) _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Doctor's name First _____ Last _____ Provider number _____ IPA/MG number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dental provider name First _____ Last _____ Dental provider number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Full-time student? (if over 18) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Son <input type="checkbox"/> Daughter First _____ Last _____ Social Security number _____ Date of birth (mo/day/year) _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Doctor's name First _____ Last _____ Provider number _____ IPA/MG number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Dental provider name First _____ Last _____ Dental provider number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

MUST BE COMPLETED

* Section 4 - Life insurance 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.

Form for Primary Beneficiary 1: First name, MI, Last name, Social Security number, Relationship, % of benefits, Date of birth, Address, City, State, ZIP code.

Form for Primary Beneficiary 2: First name, MI, Last name, Social Security number, Relationship, % of benefits, Date of birth, Address, City, State, ZIP code.

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

Form for Contingent Beneficiary: First name, MI, Last name, Social Security number, Relationship, % of benefits, Date of birth, Address, City, State, ZIP code.

Section 5 - 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.

Signature of Employee _____ Date _____

Print Employee Name _____

Section 5 – Authorization (continued)

The following authorization section is to be signed by all employees applying for coverage.

Authorization for Use and Disclosure of Personal and Health Information: By signing below you are authorizing the release of your and/or your dependents' personal and health information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent or broker, to Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, Blue Shield), or its representatives, for the purpose of determining eligibility, processing claims for benefits, quality assurance, peer review, or any other administrative functions related to your Blue Shield coverage.

Further, by signing this form you are authorizing Blue Shield to disclose such personal and health information to a healthcare provider, insurer, self-funded employer plan, insurance support organization, health plan, or your insurance agent or broker for the purpose of investigating or evaluating a claim for benefits. The information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under the federal health information privacy laws.

Blue Shield has the right to condition your and your dependents eligibility for coverage upon receipt of this signed authorization.

This authorization will remain valid for the longer of (1) 30 months from the date signed below for the purposes of processing the application, a policy restatement or a request for change in policy benefits; or (2) for as long as may be necessary for the processing of claims incurred during the term of coverage and for all other activities performed under the health services agreement/policy. You are entitled to a copy of this Authorization after you sign it.

Signature of Employee _____ Date _____

Print Employee Name _____