Employee Enrollment Application
Blue Shield of California

blue of california

Blue Shield plans for groups with 1-50 eligible employees

Effective January 1, 2014

* Please note: It is very important that all questions be answered. Missing information may delay processing.

Reason for application – Please indicate the reason for your enrollment below:

☐ New group enrollment Group effective date: ___ /___ /_____	☐ New hire/rehire Date of hire/rehire: ___ /___ /_____	☐ Open enrollment Renewal date: ___ /___ /_____
☐ COBRA/CalCOBRA enrollment	☐ New spouse/dependant Date of marriage/birth/adoption: ___ /___ /_____	☐ Other Qualifying Event (specify): _____ Qualifying Event Date: ___ /___ /_____

Section 1 – Plan selection – Select and/or fill in plan name(s) as appropriate.

Medical Benefit Plans*:

Blue Shield of California Off Exchange Package for Small Business

- ☐ Ultimate Exclusive HMO for Small Business $25
- ☐ Ultimate Full HMO for Small Business $25
- ☐ Ultimate Full PPO for Small Business 0
- ☐ Ultimate Full PPO for Small Business 150
- ☐ Preferred Exclusive HMO for Small Business $30
- ☐ Preferred Full HMO for Small Business $30
- ☐ Preferred Full PPO for Small Business 0
- ☐ Preferred Full PPO for Small Business 750
- ☐ Enhanced Exclusive HMO for Small Business $55
- ☐ Enhanced Full HMO for Small Business $55
- ☐ Enhanced Full PPO for Small Business 1250
- ☐ Enhanced Full PPO for Small Business 2000
- ☐ Enhanced Full PPO for HSA for Small Business 2000
- ☐ Basic Full PPO for Small Business 4500
- ☐ Basic Full PPO for HSA for Small Business 3500
- ☐ Basic Full PPO for HSA for Small Business 5500
- ☐ Basic Full PPO for Small Business 4500
- ☐ Basic Full PPO for HSA for Small Business 3500
- ☐ Basic Full PPO for HSA for Small Business 5500

Blue Shield of California Mirror Package for Small Business

- ☐ Ultimate Exclusive HMO for Small Business
- ☐ Ultimate Full HMO for Small Business
- ☐ Preferred Exclusive HMO for Small Business
- ☐ Preferred Full HMO for Small Business
- ☐ Enhanced Exclusive HMO for Small Business
- ☐ Enhanced Full HMO for Small Business
- ☐ Basic Exclusive PPO for Small Business
- ☐ Other_____

Pediatric Dental plan*:

- ☐ Pediatric Dental plan _____

Optional benefits: Check plan(s) and fill in names as appropriate

- ☐ Dental PPO plan _____
- ☐ Dental HMO plan _____
- ☐ Vision plan _____

Other Coverage (please specify)

- ☐ Other _____

*** Blue Shield medical products do not include pediatric dental benefits. Pursuant to federal law, you must have pediatric dental coverage for yourself and all dependents (even if you are enrolling in coverage as an adult). Therefore we will automatically enroll you in the pediatric dental plan offered by your employer even if you do not make a selection.**

Section 2 – Subscriber Information – (please type or print clearly, use black ink) Bolded items denote required fields.

Note: Social Security Numbers are required per CMS guidelines.

Social Security Number	**Employer (group) name**	**[Group ID]**

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

Home/Physical Address (PO Box is not acceptable)	**City**	**State**	**ZIP code**
Mailing Address (if different from Home address)	City	State	ZIP code

Work phone number: ( )	Home phone number: ( )	Language Preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____
Email address		How would you prefer we contact you? Blue Shield will use your preferred method when possible. ☐ E-mail ☐ Standard mail ☐ Telephone: ☐ Work ☐ Home

Date of birth: ____ /____ /_____	**Gender:** ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Married ☐ Domestic partner

Do you have any eligible dependent children under the age of 26? ☐ Yes ☐ No How many?_____ How many are enrolling?_____

Employment Status:

Do you actively work 30 hours or more per week for this employer? (full time employee) ☐ Yes ☐ No

Do you actively work between 20 and 29 hours per week for this employer? (part time employee) ☐ Yes ☐ No

If no to both of the above, are you an existing COBRA participant or enrolling due to a COBRA qualifying event?? ☐ Yes ☐ No If yes, proceed to Section 3.

Date of Hire (full time or part time if noted above) ____ /____ /_____	**Job Title/Classification**

An independent member of the Blue Shield Association C12914-NC (7/13)

Applicant's Last Name	First Name	MI	Social Security number

Section 3 – HMO Personal Physician Assignment

This section is only required if you selected an HMO product above. If you selected a PPO plan, please skip this section and proceed to Section 4.

HMO Provider Assignment

Would you like for Blue Shield to designate a Personal Physician for you and your dependents who is located near your home or work?

☐ Yes, I would like Blue Shield to designate a Personal Physician and/or Dental HMO Provider for me and my dependents.

☐ No, I would like to request a specific Personal Physician and/or Dental HMO Provider for myself and my dependents. (please specify below).

* Please note: if Blue Shield is unable to assign the Personal Physician and/or Dental HMO provider you requested, Blue Shield will designate a provider at random. HMO Personal Physicians can be changed by visiting **blueshieldca.com** after enrollment.

HMO Personal Physician name	**Provider number**	IPA/MG Name	Existing patient? ☐ Yes ☐ No
Dental HMO Provider name	**Provider number**	Dental Group Name	Existing patient? ☐ Yes ☐ No

Section 4 – Dependent information

Please note: If you, your spouse/domestic partner, or your dependent(s) are refusing coverage for any product offered by your employer, a Refusal of Personal Coverage Form at the end of this application must be completed and signed by you, the employee. Blue Shield will enroll your dependents under all plans that you are also enrolled/enrolling on unless indicated otherwise.

Dependent Type: ☐ Spouse ☐ Domestic Partner	Gender: ☐ Male ☐ Female	**Social Security Number**	**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No
First Name	MI	Last Name	Suffix
Date of Birth ____ /____ /_______	Address (if different from employee)		
HMO Personal Physician Name	Provider Number	IPA Name	Existing patient? ☐ Yes ☐ No

Dependent Type: ☐ Dependent Child ☐ Other Dependent Child: Legal Guardianship	**Gender:** ☐ Male ☐ Female	**Social Security Number**	**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No
First Name	MI	Last Name	Suffix
Date of Birth ____ /____ /_______	Address (if different from employee)		
HMO Personal Physician Name	Provider Number	IPA Name	Existing patient? ☐ Yes ☐ No

Dependent Type: ☐ Dependent Child ☐ Other Dependent Child: Legal Guardianship	**Gender:** ☐ Male ☐ Female	**Social Security Number**	**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No
First Name	MI	Last Name	Suffix
Date of Birth ____ /____ /_______	Address (if different from employee)		
HMO Personal Physician Name	Provider Number	IPA Name	Existing patient? ☐ Yes ☐ No

Dependent Type: ☐ Dependent Child ☐ Other Dependent Child: Legal Guardianship	**Gender:** ☐ Male ☐ Female	**Social Security Number**	**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No
First Name	MI	Last Name	Suffix
Date of Birth ____ /____ /_______	Address (if different from employee)		
HMO Personal Physician Name	Provider Number	IPA Name	Existing patient? ☐ Yes ☐ No

Applicant's Last Name	First Name	MI	Social Security number

Section 5 – Other health insurance information – If enrolling due to a loss of coverage under a prior health insurance plan and/or to receive credit towards any applicable employee waiting period, documentation may be required to verify the date of the qualifying event.

Does any person applying for coverage currently have health insurance coverage or previously had health insurance coverage at any time in the past six (6) months?
☐ Yes ☐ No

If yes, specify carrier:_____

Type of coverage: ☐ Group ☐ Individual ☐ Medicare ☐ Covered California/State Health Insurance Exchange ☐ Other (specify): _____

Policy/ID No._____ Date coverage began: ____ /____ /_____ Date ended (if coverage is active, please leave blank): ____ /____ /_____

Please list all Applicant/Family member names currently or previously enrolled on the health insurance coverage specified above:	Documentation attached? ☐ Yes ☐ No

Section 6 – COBRA Cal-COBRA enrollees

Please complete this section only if enrolling as a COBRA or Cal-COBRA participant. Blue Shield of California will accept those individuals already on COBRA or Cal-COBRA Coverage from a prior carrier. If an employer changes to a Blue Shield health plan, you may continue your COBRA or Cal-COBRA coverage with Blue Shield for the duration of your coverage period based on your original qualifying event. Proof of enrollment as a COBRA/Cal-COBRA participant is required.

Please identify the employee under whom the COBRA applicant was previously enrolled. If you (the applicant) were the employee and now qualify for COBRA or Cal-COBRA due to termination or reduction in hours worked, please provide your information below.

Employee/Subscriber Last Name	**Employee/Subscriber First Name**	**MI**
Employee/Subscriber Blue Shield ID (if applicable)	Original Qualifying Event Date ____ /____ /_____	

Qualifying Event Reason:

☐ Termination or Reduction in Hours (last day worked)
☐ Termination or Reduction in Hours due to disability
☐ Divorce or Legal Separation of the covered employee
☐ Entitlement to Medicare Benefits by covered employee
☐ Disqualification of dependent child under the plan
☐ Death of covered employee
☐ Termination of Domestic Partnership

Section 7 – Life beneficiary

Life Insurance Beneficiary Name	Relationship to applicant

Street address

City	State	ZIP code

Note: If beneficiary is different from subscriber's spouse, spouse's signature is required.

Spouse's signature (if applicable)

Section 8 - Disclosure of Personal and Health Information

Blue Shield of California 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.

Applicant's Last Name	First Name	MI	Social Security number

Section 9 – Authorization – The following 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 committed fraud or made an intentional misrepresentation of any material fact that within 24 months of issuance, my coverage may be cancelled or, following notice, 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.

Signature of Employee **Date**

Print Employee Name

All pages of this form are necessary to process your enrollment.
Missing information may delay processing.
If submitting for an existing Blue Shield plan, fax requests to (855) 808-8598
or email to Small.Group@blueshieldca.com.

Refusal of Personal Coverage

Complete if you, your spouse, domestic partner or dependent(s) are refusing your employer's Blue Shield of California health, dental, vision, and/or life plan coverage.) Please type or print. Use black ink. ***Note: Social Security number is required for all eligible employees that are refusing coverage under this employer. Employer must retain a copy of this refusal for their records.**

Employee name	**Social Security number**	**Date of birth**
Employer (Group) Name	**Hire date** ____ /____ /_____	**State of residence**
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
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 Only
- ☐ My Children Only
- ☐ My Spouse/Domestic Partner and Children Only
- ☐ 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:

_____

If life plan offered, I decline life plan coverage for:
☐ Myself and all dependents
- ☐ My Spouse/Domestic Partner and Children

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 (through another carrier)
- ☐ 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 plan.
  - Carrier Name _____
  - ID Number _____
- ☐ Covered California or other State Health Exchange
- ☐ Medicare, Medi-Cal, Healthy Families program
- ☐ Other _____

OTHER DENTAL COVERAGE
- ☐ Enrolling as a dependent on this group dental plan
- ☐ Covered by another employer's dental plan (e.g., through your spouse/domestic partner).
  - Carrier Name _____
  - ID Number _____
- ☐ Other _____

OTHER VISION COVERAGE
- ☐ Enrolling as a dependent on this group vision plan
- ☐ Covered by another employer's vision plan (e.g., through your spouse/domestic partner).
  - 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 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** _____