Health Plan & Life Insurance
Employee Enrollment Application
Blue Shield plans for 101+ employees

blue of california

# 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 |
| ☐ Re-hire date _____ | ☐ Open enrollment | ☐ Other qualifying event type_____ |
| | | Date above event occurred _____ |

## Section 1 – Important enrollment guidelines for Specialty Benefits coverage

Dental, vision, and life insurance coverage - An employee may enroll in a dental, vision, or life 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.

Life insurance enrollment is subject to the following rules:

1. All Basic Term Life insurance amounts for employees who enroll when first eligible for benefits are fully Guarantee Issued (no Evidence of Insurability required). Evidence of Insurability is required for late enrollees.
2. For Voluntary Life, Evidence of Insurability is required for all amounts over the Guarantee Issue.
3. An employee must be enrolled in Voluntary Life/AD&D coverage for their spouse/domestic partner or dependent children to be eligible for Voluntary Life coverage. Spouse/Domestic Partner and/or children do not have to be covered under the Basic Dependent Life coverage to be eligible for Voluntary Life coverage.

## Section 2 – Plan(s) Select and fill in plan name(s), if applicable.

**Medical benefits without ABHP (account-based health plan) options:**

- ☐ Access+ HMO® _____
- ☐ Access+ HMO® SaveNet℠ _____
- ☐ Local Access+ HMO® _____
- ☐ Added Advantage POS℠ _____
- ☐ Trio ACO HMO_____
- ☐ Active Choice®[1] _____
- ☐ Full PPO _____
- ☐ Full PPO Savings[2]_____
- ☐ Full PPO ASO/Full PPO ASO Savings[2] _____
- ☐ Blue Shield 65 Plus℠ (HMO)

**Medical benefits with ABHP (account-based health plan) options:**

- Access+ HMO: ☐ HRA ☐ HIA ☐ FSA
- Active Choice[1]: ☐ HRA ☐ HIA ☐ FSA
- Local Access+ HMO: ☐ HRA ☐ HIA ☐ FSA
- Full PPO: ☐ HRA ☐ HIA ☐ FSA
- Full PPO Savings[2]: ☐ HRA ☐ HIA ☐ FSA ☐ HSA ☐ LPFSA[3]
- Full PPO ASO: ☐ HRA ☐ HIA ☐ FSA
- Full PPO ASO Savings[2]: ☐ HRA ☐ HIA ☐ LPFSA[3] ☐ HSA ☐ FSA

**Specialty Benefits**

- ☐ Basic group term life/AD&D insurance[1] _____
- ☐ Dependent basic life insurance[1] _____
- ☐ Voluntary Life insurance[1] _____
- ☐ Voluntary AD&D insurance[1]_____
- ☐ Dental PPO _____
- ☐ Dental HMO _____
- ☐ Vision[1]_____
- ☐ Other _____

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

2 Full PPO Savings plans are HSA-eligible high-deductible health plans.

3 Must be paired with an HSA plan only.

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

**Internal use only. Do not write in this section and skip to Section 3.**

| Department code | Group ID | Subgroup ID | Class ID | 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 code) | Basic group term life/AD&D insurance amount: |
|---|---|
| | Voluntary Life insurance amount: |
| Mailing address (if different from home address) | Voluntary AD&D insurance amount: |

| Home phone number | E-mail address |
|---|---|

How would you prefer we contact you? ☐ E-mail ☐ 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 name: | 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 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<br>☐ Male ☐ Female<br>_____<br>First MI<br>_____<br>Last<br>_____<br>**Social Security number**<br>_____<br>Date of birth (mm/dd/yyyy) | ☐ Medical<br>☐ Dental<br>☐ Vision<br>☐ Basic life $_____<br>☐ Voluntary Life $_____ | Doctor's name<br>_____<br>First<br>_____<br>Last<br>_____<br>Provider number<br>_____<br>IPA/medical group name<br>_____<br>IPA/medical group number<br>Existing patient? ☐ Yes ☐ No | Dental provider name<br>_____<br>First<br>_____<br>Last<br>_____<br>Dental provider number<br>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<br>_____<br>First MI<br>_____<br>Last<br>_____<br>**Social Security number**<br>_____<br>Date of birth (mm/dd/yyyy)<br>Disabled? ☐ Yes ☐ No | ☐ Medical<br>☐ Dental<br>☐ Vision<br>☐ Basic life $_____<br>☐ Voluntary Life $_____ | Doctor's name<br>_____<br>First<br>_____<br>Last<br>_____<br>Provider number<br>_____<br>IPA/medical group name<br>_____<br>IPA/medical group number<br>Existing patient? ☐ Yes ☐ No | Dental provider name<br>_____<br>First<br>_____<br>Last<br>_____<br>Dental provider number<br>Existing patient? ☐ Yes ☐ No |

## Section 4 – Dependent spouse/domestic partner/children information (continued)

| 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<br>First MI<br>Last<br>**Social Security number**<br>Date of birth (mm/dd/yyyy)<br>Disabled? ☐ Yes ☐ No | ☐ Medical<br>☐ Dental<br>☐ Vision<br>☐ Basic life $_____<br>☐ Voluntary Life $_____ | Doctor's name<br>First<br>Last<br>Provider number<br>IPA/medical group name<br>IPA/medical group number<br>Existing patient? ☐ Yes ☐ No | Dental provider name<br>First<br>Last<br>Dental provider number<br>Existing patient? ☐ Yes ☐ No |
| ☐ Male ☐ Female<br>First MI<br>Last<br>**Social Security number**<br>Date of birth (mm/dd/yyyy)<br>Disabled? ☐ Yes ☐ No | ☐ Medical<br>☐ Dental<br>☐ Vision<br>☐ Basic life $_____<br>☐ Voluntary Life $_____ | Doctor's name<br>First<br>Last<br>Provider number<br>IPA/medical group name<br>IPA/medical group number<br>Existing patient? ☐ Yes ☐ No | Dental provider name<br>First<br>Last<br>Dental provider number<br>Existing patient? ☐ Yes ☐ No |

## Section 5 – 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 % of benefits field.

| | | | |
|---|---|---|---|
| First name | MI | Last name | |
| Social Security number | Relationship | % of benefits | Date of birth |
| Address | | | |
| City | State | ZIP code | |
| 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.

| | | | |
|---|---|---|---|
| First name | MI | Last name | |
| Social Security number | Relationship | % of benefits | Date of birth |
| Address | | | |
| City | State | ZIP code | |

**If beneficiary is a trust or corporation, please provide name and date of trust agreement and state of incorporation.**

| Name of trust/corporation | Date of trust | State of incorporation |
|---|---|---|
| | | |

**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(s).**

Print spouse/domestic partner name:_____

Spouse/domestic partner signature:_____ Date:_____

## Section 6 – Medicare information

1. Are you or any of your dependents currently covered by Medicare? ☐ Yes ☐ No
   If "yes," please attach a copy of your Medicare card(s) and/or select the type of coverage below:
   Part A: ☐ Effective date: _____ (mm/dd/yyyy)
   Part B: ☐ Effective date: _____ (mm/dd/yyyy)
2. 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 7 – Authorization

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

**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 Blue Shield of California/Blue Shield Life may pursue one of the following remedies within the first 24 months of coverage: my coverage may be canceled, or following 30-day notice, rescinded. 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 _____

I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

Signature of employee _____ Date _____

Print employee name _____

**Disclosure of personal and health information**

At Blue Shield of California/Blue Shield Life, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously. We are required by law to maintain the privacy and security of your personal information in whatever format it is held – paper, electronic, or oral. This statement applies to personal information that Blue Shield obtains, creates, and/or maintains about you and your covered dependents.

In the course of administering your Blue Shield coverage, we collect, use, and disclose information about you and your covered dependents, and we create records about you, your medical treatment, and the services we provide to you. The information in these records is called protected health information ("PHI") and includes individually identifiable personal information such as your name, address, telephone number, and Social Security number, as well as your health information, such as healthcare diagnosis or claim information.

We obtain PHI about you and/or your covered dependents from you, at your direction, and/or with your permission. We also obtain your PHI from other sources as permitted by law, including, for example, from your healthcare provider, insurer, insurance support organization, health information exchange, health plan, or insurance agent. We use and disclose your PHI to administer your Blue Shield coverage and as otherwise permitted or required by law. In doing so, we may disclose your PHI to others including, for example, a healthcare provider, insurer, insurance support organization, health insurance exchange, health plan, or your insurance agent.

Blue Shield maintains a Notice of Privacy Practices ("Notice") that describes your privacy rights, our obligations to protect your privacy, and how we use your PHI with and without your specific authorization. When we use or disclose your PHI, we are bound by the terms of the Notice, which applies to all records that we create, obtain, and/or maintain that contain your PHI. You will receive our Notice when you enroll for Blue Shield insurance coverage. You may also obtain a copy of our Notice by calling the customer service number on your Blue Shield member ID card or by visiting our website at: **blueshieldca.com/bsca/about-blue-shield/privacy/confidentiality.sp**.

I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

**Signature of employee** _____ **Date** _____

**Print employee name** _____

**California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

**Agent/Broker Attestation**

Attestation of Agent/Broker assisting in the submission of this application: (1) to the best of my knowledge, the information on the application is complete and accurate; and (2) I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.

Signature of Agent/Broker_____ Date _____

If an Agent/Broker willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Insurance Fund.

## ADDRESS AND BANK CHANGES:

Please notify Integrity Administrators of any change in your home address, bank, bank account number, or bank routing number to avoid disruption in your coverage.

## PAYMENT AUTHORIZATION:

Complete the authorization form below and we will deduct your contribution automatically from your account on or before the 10th of the month preceding your coverage month.

---

## PLEASE RETURN THIS PORTION WITH YOUR ENROLLMENT FORM

I authorize the following amount to be withdrawn from my bank checking or savings account listed below to pay my monthly premiums for the Prepaid Dental Plan coverage.
**(PLEASE CHECK APPLICABLE BOX)**

☐ Member only - $67.88 ☐ Member plus One - $117.70 ☐ Member plus Family - $161.22

**BANK NAME** _____ **ACCT #** _____

**BANK ROUTING #** _____
(Routing number is usually located at the bottom of your check just before the account number. If unsure, please send a "**VOIDED**" check with this form.)

**NAME (print):** _____ **Signature** _____

---

Mail this payment authorization form along with your Blue Shield Enrollment form to:

**INTEGRITY ADMINISTRATORS, INC.**
P O Box 13128
Sacramento, CA 95813-3128

Contact Integrity Administrators at 800.562.9363
for a current Blue Shield Enrollment form.

Variable fields:
Blue Shield & DentAssure are both "premiums"
The Pre-Paid Plan is "contributions"