BLUE CROSS ENROLLMENT FORM

(SHADED SECTIONS I, II AND III ARE REQUIRED)

Effective Date | Group No.

I: PERSONAL INFORMATION

Last Name (Print)	First Name (Print)	M.I.	1 ☐ Male 2 ☐ Female
Street Address	City	State	ZIP
Telephone No. ( ) –	Employer	Job Title	
Date of Hire	Class	Dept. No.	E-mail Address

II: SELECTED COVERAGE

Type of Coverage: ☐ New Enrollment ☐ Re-Hire ☐ Part-time to Full-time ☐ Open-enrollment

Medical

- ☐ HMO (CaliforniaCare)*
- ☐ Preferred HMO (CaliforniaCare PLUS)*
- ☐ Power Advantage HMO*
- ☐ Power Select HMO (Select Network)*
- ☐ PPO (Prudent Buyer)
- ☐ Power CareAdvocate PPO
- ☐ EPO (Prudent Buyer Exclusive)
- ☐ POS (Blue Cross Plus)*
- ☐ BlueCard PPO
- ☐ BlueCard Exclusive
- ☐ BlueCard Power CareAdvocate PPO
- ☐ Medicare
- ☐ Other ____________

* indicate Medical Group/IPA# in Section III

Dental

- ☐ Choice Dental (Select One of the Following)
  - ☐ Dental Net* ☐ Prudent Buyer
- ☐ Dental Net*
- ☐ Dental SelectHMO*
- ☐ Fee-For-Service Dental
- ☐ National Dental PPO
- ☐ Prudent Buyer Dental PPO
- ☐ PPO Dental Exclusive
- ☐ Other ____________

* indicate Dental Office # in Section III

☐ UniAccount
(Flexible Spending Account)*
(Indicate Payroll Deductions)

I authorize payroll deductions on the following:

☐ Health Care Account $ ____________

☐ Dependent Care $ ____________

*Blue Cross or BC Life & Health PPO, Drug and Dental plan enrollees, will have out-of-pocket expenses, automatically deducted from their Health Care FSA account. Automatic FSA processing is not possible for HMO enrollees and those with coverage through another Health Plan. Reminder Automatic FSA processing is the equivalent of signing and submitting an FSA claim form, which states that you are eligible for FSA reimbursement and that you will not claim FSA reimbursed expenses on your income tax return.

III: EMPLOYEE & FAMILY INFORMATION Please list yourself and all eligible family members to be enrolled. (Attach additional sheets if necessary.)

	Sex	Last Name	First Name	M.I.	Date of Birth	Age	Social Security Number	If Children are age 19 or over, you must check the appropriate boxes below: Qualifies as IRS Dependent	Full-Time Student	Totally Disabled	Medical Group/IPA#	Blue Cross HMO IPA Primary Care Physician Code	Is this your current MD?	Dental Office No.
Self					Month Day Year					☐ Yes ☐ No			☐ Yes ☐ No	
☐ Spouse ☐ Domestic Partner	☐ M ☐ F				Month Day Year					☐ Yes ☐ No			☐ Yes ☐ No	
Child	☐ M ☐ F				Month Day Year			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	
Child	☐ M ☐ F				Month Day Year			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	
Child	☐ M ☐ F				Month Day Year			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	
Child	☐ M ☐ F				Month Day Year			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No			☐ Yes ☐ No	

IV: DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? IF YES, PLEASE COMPLETE THIS SECTION INCLUDING MEDICARE (if applicable)

	Name	Name and Address of Other Insurance Carrier	Effective Date	Group Number	Is this yours or your dependents' primary coverage?	Does it cover?
Self			Month Day Year		☐ Yes ☐ No	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
☐ Spouse ☐ Domestic Partner			Month Day Year		☐ Yes ☐ No	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
Dependent #1 Above			Month Day Year		☐ Yes ☐ No	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
Dependent #2 Above			Month Day Year		☐ Yes ☐ No	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
Dependent #3 Above			Month Day Year		☐ Yes ☐ No	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
Dependent #4 Above			Month Day Year		☐ Yes ☐ No	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No

MEDICARE SECTION

Are you retired?..☐ Yes ☐ No

If yes..Part A ☐ Yes ☐ No
Part B ☐ Yes ☐ No

Do any of your Dependents have Medicare?........................☐ Yes ☐ No

If yes for your dependent ....Part A ☐ Yes ☐ No
Part B ☐ Yes ☐ No

Name(s) of Medicare Dependent(s): ____________

If yes for Medicare for you and/or your Dependent(s), please provide your and/or their HIB number and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).

HIB # ____________
Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD
Effective Date of Medicare ____/____/____
Name ____________

HIB # ____________
Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD
Effective Date of Medicare ____/____/____
Name ____________

V: LIFE INSURANCE

Coverage Election

Complete the boxes by checking (✓) them to indicate your Coverage Elections.

- All the coverages listed may not be offered under your plan.
- To elect dependent coverage, the corresponding employee coverage must be elected.
- Annual Salary $ ____________

	Elected	Declined	Benefit Amount
Life (AD&D)	☐	☐	$
Dependent Life	☐	☐	$
Supplemental Life	☐	☐	$
Supplemental AD&D	☐	☐	$
Other ______	☐	☐	$

Beneficiary Employee Life Designation

***Note Dependent Life payments are always paid to the employee**

Primary Beneficiary – First to Receive Payment (required) –
If more than 1 beneficiary is named, enter a % for each. If no percentage is shown equal shares are assumed.

☐ Named Individuals (Enter the name, address, date of birth, Social Security Number and relationship to the insured for each name listed.)

Name	Date of Birth Month Day Year	Social Security Number	Relationship	%
Address	City		State	ZIP
Name	Date of Birth Month Day Year	Social Security Number	Relationship	%
Address	City		State	ZIP

☐ Estate of Insured ☐ Revocable or Irrevocable Trust (Enter the name of the Trustee, name of Trust and complete date of Trust.)
☐ Trustee Under Insured's Will (if choosing this option DO NOT enter additional names in the Primary Beneficiary field.)

Total: 100%

Secondary Beneficiary – Second to Receive Payment (optional) –
If more than 1 beneficiary is named, enter a % for each. If no percentage is shown equal shares are assumed.

☐ Named Individuals (Enter the name, address, date of birth, Social Security Number and relationship to the insured for each name listed.)

Name	Date of Birth Month Day Year	Social Security Number	Relationship	%
Address	City		State	ZIP
Name	Date of Birth Month Day Year	Social Security Number	Relationship	%
Address	City		State	ZIP

Total: 100%

VI: PRIOR COVERAGE FOR PPO (Prudent Buyer or BlueCard) PLANS ONLY

Please fill out the following information to receive proper credit for **PREVIOUS COVERAGE**, if immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

	Name	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage
Self					
☐ Spouse ☐ Domestic Partner					
Child					
Child					

VII - XI: PLEASE READ CAREFULLY – SIGNATURE REQUIRED

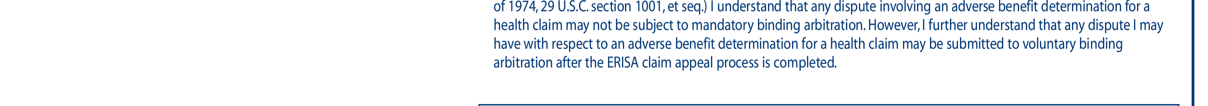
VII. DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required dues.

VIII. NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

IX. HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

X. EFFECTIVE DATE: The effective date of coverage is subject to Blue Cross of California approval.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.



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The Blue Cross name and symbol are registered service marks of the Blue Cross Association.
Medical and Dental coverage provided by Blue Cross of California and/or BC Life & Health Insurance Company.
Life insurance coverage provided by BC Life & Health Insurance Company.

www.bluecrossca.com

XI. ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employment Retirement Income Security Act of 1974), certain disputes may not be subject to the following arbitration provisions: I understand that any and all disputes between myself (and/or any enrolled family member) and Blue Cross of California/BC Life & Health, including claims for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and Blue Cross/BC Life & Health are giving up the right to have any dispute decided in a court of law before a jury. Blue Cross/BC Life & Health and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Evidence of Coverage/Certificate.

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

X ____________________
Employee Signature | Date

DISTRIBUTION: WHITE – Blue Cross of California Membership; **CANARY** – Blue Cross of California Marketing; **PINK** – Employee; **GOLDENROD** – Employer

GC4050 1/05

BLUE CROSS ENROLLMENT FORM

WORKSHEET INSTRUCTIONS

This dual application is for the purpose of enrolling in health, dental and other non-health products such as life coverage. The information on this application, except for health history and health status, will be shared with the non-health components of our parent company for the purpose of underwriting, maintaining enrollment and billing services.

SECTION I: PERSONAL INFORMATION

Requested information is required.

SECTION II: SELECTED COVERAGE

Check the appropriate boxes. Requested information is required.

SECTION III: EMPLOYEE & FAMILY INFORMATION

Requested information is required.

Please check the Totally Disabled box only if the condition prohibits you/your dependent from working or performing daily activities.

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

For Blue Cross HMO and POS members only: Each person listed must receive all medical care through the Medical Group or Independent Practice Association he or she has selected in order to receive the HMO benefit, and must live or work within the service area of the group selected. Select a Primary Care Physician from the listing in your Provider Directory. You must indicate the Primary Care Physician number which is listed below the physician's name or after the address. (If you select an IPA, you must select a Primary Care Physician from within the IPA.)

For Dental Net and Blue Cross Dental SelectHMO only: Each family member needs to select a dental office.

SECTION IV: DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE?

Please fill in requested information if applicable.

SECTION V: LIFE INSURANCE

Please fill in requested information if applicable. Be sure to designate a beneficiary. If you decline coverage at this time and later decide to apply for coverage, you will be subject to the rules governing late applicants.

SECTION VI: PRIOR COVERAGE FOR PPO (Prudent Buyer or BlueCard) PLANS ONLY

Please fill in requested information if applicable.

SECTIONS VII - XI: PLEASE READ CAREFULLY – SIGNATURE IS REQUIRED

Non-Participating Provider Agreement, Arbitration Agreement, please read.

EMPLOYEE COPY - Retain the pink copy of this form for your records.