Health Plan 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
☐ Rehire date ___/___/_____	☐ Open enrollment	☐ Other qualifying event type_____ Date above event occurred ___/___/___

Section 1 – Important enrollment guidelines for Specialty Benefits coverage

Dental and vision insurance – An employee may enroll in a dental and/or vision 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.

Section 2 – Plan(s) Select and fill in plan name(s) as appropriate.

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

- ☐ Access+ HMO _____
- ☐ Access+ HMO SaveNet _____
- ☐ Local Access+ HMO _____
- ☐ Added Advantage POS _____
- ☐ Active Choice[1] _____
- ☐ Trio ACO HMO _____
- ☐ Full PPO _____
- ☐ Full PPO Savings[2] _____
- ☐ Simplified plans _____
- ☐ Blue Shield 65 Plus

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

Access+ HMO: ☐ HRA ☐ HIA ☐ FSA

Local Access+ HMO: ☐ HRA ☐ HIA ☐ FSA

Full PPO: ☐ HRA ☐ HIA ☐ FSA

Full PPO Savings[2]: ☐ HSA ☐ HRA ☐ HIA ☐ FSA ☐ HSA ☐ LPFSA[3]

Simplified plans:

- ☐ Full PPO Savings 3500 70/50
- ☐ Full PPO Savings 5500 60/50

ABHP benefit options for Simplified plans:

☐ HRA ☐ HIA ☐ FSA ☐ HSA ☐ LPFSA[3]

Specialty Benefits

- ☐ Dental PPO _____
- ☐ Dental INO[1] _____
- ☐ 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 number	BU	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)		
Mailing address (if different from home address)		
Home phone number	Email address	How would you prefer we contact you? ☐ Email ☐ 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 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 you 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 ☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy)	☐ Medical ☐ Dental ☐ Vision	Doctor's name First Last Provider number IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number 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 First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision	Doctor's name First Last Provider number IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision	Doctor's name First Last Provider number IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision	Doctor's name First Last Provider number IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No

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 5 – Medicare information

Are you or any of your dependents currently covered by Medicare? ☐ Yes ☐ No
Please attach a copy of your Medicare card(s) and/or enter the type of coverage here:
Part A: ☐ Effective date: ____/____/____(mm/dd/yyyy) Part B: ☐ Effective date: ____/____/____(mm/dd/yyyy)
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 6 – 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, my coverage may be canceled, or rescinded within the first 24 months of coverage. 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 _____

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 information 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**