



Blue Shield of California

An Independent Member of the Blue Shield Association

**The Blue Shield Plans
For 2–24 Employees
(includes Health Statement)**



® Registered mark of the Blue Shield Association, an Association of Independent Blue Shield Plans

® Registered mark of CPIC Life Insurance Company

IT IS VERY IMPORTANT THAT ALL QUESTIONS BE ANSWERED.

EMPLOYEE APPLICATION

- 1 Provide the employee data requested.
- 2 Check the box(es) to indicate your coverage selection and fill in plan name as appropriate.
(Example: ACCESS+ HMO PLAN \$5 COPAY HMO
or PPO PLAN \$250 DED PPO 90/70 \$15 COPAY)
- 3 Check the "Enroll in Medical" box for each dependent listed in this section. In the space provided, list all eligible dependents you wish to enroll (including spouse or domestic partner), their dates of birth, Social Security Number and relationship to the employee. Domestic partner enrollment is only available if your employer has elected to offer this option. **If selecting Access+ HMO or Blue Shield POS, you must choose a Primary Care Physician.** Please enter the Provider Number and the IPA Number. Please note the important dental enrollment guidelines described below.

IMPORTANT DENTAL ENROLLMENT GUIDELINES

You must check the "Enroll in Dental" box for each dependent listed in Section 3 of the Employee Application in order for each dependent to be covered.

Dental PPO

- Employee enrollment in a Blue Shield health plan is not required to select Dental PPO.
- If you are enrolled in a Blue Shield health plan and select Dental PPO, dental benefits will apply to you and the dependents enrolled in the health plan.
- Any eligible dependent not covered by the employee's Blue Shield health plan will not be covered by the employee's Dental PPO plan.

Dental HMO

- Employee enrollment in a Blue Shield health plan is not required to select Dental HMO.
- To enroll in a Dental HMO plan, you must live **or work sufficiently close to** a participating Dental Center **to ensure reasonable access to care, as determined by the Plan.**
- Refer to the Dental HMO Dental Center Directory for service areas.
- If selecting a Dental HMO plan, you must list the identification number of the Dental Center you have selected. Refer to the Dental HMO Dental Center Directory for the identification number.

- 4 Enter information on any other health coverage you or your dependents have including Medicare. This **must** be completed for coordination of benefits.
- 5 If dependent is over 18, you must provide information regarding full time student status. To be considered eligible, dependent children ages 19-24 must be enrolled full time in college (minimum of 12 units) or trade school. Blue Shield will deem this completed information to be a certification of full time student status.
- 6 In the "CPIC Life Insurance" section, enter the name of the person who is to receive the group life benefit, his/her relationship to the employee and his/her current address.
- 7 The employee must sign and date the authorization for payroll deduction and disclosure of personal information. Blue Shield cannot process the application without signed authorization.

REFUSAL OF COVERAGE FORM

This form (located on the back of this application) is to be used for all employees who decline coverage for themselves or their dependents.

Enter the employee name, Social Security Number, the employer (group) name and number, date of full-time hire and marital status. Check the appropriate box if you, your spouse or dependent(s) are declining health and/or dental coverage. Check the box that meets your reason for refusing coverage for you, your spouse or dependent(s). Indicate the name of the other health and/or dental insurance carrier with whom you or your dependents have coverage. **Sign and date if you have refused personal or dependent coverage.**

THE PRE-EXISTING CONDITION EXCLUSION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law which limits when coverage may be excluded for pre-existing conditions. Under the law, if a person's health coverage terminates and he or she enrolls in new health coverage within 63 days (excluding any waiting period), the new coverage must credit the time he or she was enrolled in the prior coverage towards the new coverage's pre-existing condition exclusion. In addition, the state law requires that the time a person was enrolled in prior coverage be credited if he or she enrolls in new coverage within 180 days (excluding any waiting period) if the "prior creditable coverage" was employer-sponsored coverage.

The PPO Plan and the Preferred Savings Plan exclude pre-existing conditions. Pre-existing conditions are covered only after you have been continuously covered for six (6) consecutive months including your present employer's waiting period, if any. The pre-existing condition does not apply to:

- pregnancy benefits;
- newborns or adopted children, who had prior creditable coverage within thirty (30) days of their birth, adoption, or placement for adoption and who enrolled in one of the Blue Shield Plans within sixty-three (63) days of that prior creditable coverage (excluding any waiting period);
- employees and dependents, who were validly covered under the present employer's previous group health coverage when that coverage was terminated and who are enrolled on the original effective date of the Blue Shield Plan within 60 days of the termination of that previous coverage.

To get credit for any prior creditable coverage, obtain a "Certificate of Creditable Coverage" from your prior employer, insurer or health plan and submit the certificate to Blue Shield. If assistance is required, please contact your Blue Shield Customer Service Representative.

Access Baja HMO

- To enroll in the Access Baja HMO, you must live or work within the Access Baja service area to ensure reasonable access to care.
- Refer to the Access Baja HMO Provider and Pharmacy Directory for selection of Primary Care Physician and service area information.
- You must understand the standards of care as reflected in the Disclosure Form.

NEW ENROLLMENT RE-HIRE

EMPLOYEE INFORMATION (Please type or print clearly. Use black ink.)

S E L E C T	1 SOCIAL SECURITY #		EMPLOYER (GROUP) NAME		DEPT. CODE	GROUP NUMBER		B/U		
	LAST NAME			FIRST NAME		M.I.	OED		RSN	
	MAILING ADDRESS			CITY	STATE	ZIP	S	TOC	NP	PKG
	HOME PHYSICAL ADDRESS			CITY	STATE	ZIP	CPIC LIFE/AD&D AMOUNT			
	BUSINESS PHONE		HOME PHONE		E-MAIL ADDRESS		FULL-TIME-HIRE DATE		JOB TITLE	
	() ()		() ()							
	HOW WOULD YOU LIKE US TO CONTACT YOU? SELECT ONE OF THE FOLLOWING OPTIONS AS YOUR PREFERENCE FOR COMMUNICATION: <input type="checkbox"/> Electronic Mail <input type="checkbox"/> Standard Mail Telephone: <input type="checkbox"/> Home <input type="checkbox"/> Work Blue Shield will use your preferred method when possible.						Are you a full-time employee, working at least 30 hours per week for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.			
DATE OF BIRTH		SEX		MARITAL STATUS:		LANGUAGE PREFERENCE		Check yes if additional sheet(s) is attached to this Application <input type="checkbox"/> YES		
MO DAY YEAR		M F		<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Other				
HMO & POS ONLY – NAME OF PRIMARY CARE PHYSICIAN:				Prov. #	Existing Patient? Y / N	DENTAL HMO ONLY – NAME OF DENTAL CENTER:		DENTAL CENTER #		
				IPA/MG #						

IF YOU, YOUR SPOUSE OR YOUR DEPENDENT(S) ARE REFUSING COVERAGE, PLEASE COMPLETE AND SIGN THE REVERSE SIDE.

2 **CHECK PLAN(S):** (See Important Guidelines on Page 2) ACCESS+HMO _____ PPO _____
 BLUE SHIELD POS PSP ACCESS BAJA HMO DENTAL HMO DENTAL PPO CPIC LIFE ONLY ACTIVE CHOICE

3 **DEPENDENT INFORMATION:**
ACCESS+ HMO AND 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 CENTER LISTED IN THE DENTAL HMO DENTAL CENTER DIRECTORY. YOU MAY CHOOSE A DIFFERENT ACCESS+ HMO PRIMARY CARE PHYSICIAN FOR EACH FAMILY MEMBER. BE SURE TO INCLUDE EACH PRIMARY CARE PHYSICIAN'S PROVIDER NUMBER AND THEIR IPA NUMBER AS WELL AS EACH DENTAL CENTER NUMBER. FOR ACCESS BAJA HMO, PLEASE SEE PAGE 2. DOMESTIC PARTNER ENROLLMENT IS ONLY AVAILABLE IF YOUR EMPLOYER HAS ELECTED TO OFFER THIS OPTION.

ARE YOU ENROLLING ELIGIBLE DEPENDENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PLEASE COMPLETE REFUSAL OF COVERAGE	Enroll In	HMO and POS ONLY – NAME OF PRIMARY CARE PHYSICIAN	Existing Patient?	DENTAL HMO ONLY – DENTAL CENTER
<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Dr's Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Center Name:
FIRST NAME		Prov. #		
SOCIAL SECURITY #		IPA/MG#		Dental Center #
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Dr's Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Center Name:
FIRST NAME		Prov. #		
SOCIAL SECURITY #		IPA/MG#		Dental Center #
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Dr's Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Center Name:
FIRST NAME		Prov. #		
SOCIAL SECURITY #		IPA/MG#		Dental Center #
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Dr's Name:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Center Name:
FIRST NAME		Prov. #		
SOCIAL SECURITY #		IPA/MG#		Dental Center #

4 **COORDINATION OF BENEFITS:**
DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH PLAN OR HEALTH INSURANCE (INCLUDING MEDICARE) IN ADDITION TO THIS BLUE SHIELD COVERAGE? Yes No
WILL THIS COVERAGE REMAIN IN EFFECT AFTER THE BLUE SHIELD COVERAGE BEGINS? Yes No

5 **CERTIFICATION FOR STUDENTS OVER AGE 18:** I HEREBY CERTIFY THAT MY DEPENDENT(S) IS/ARE CURRENTLY ENROLLED AS A FULL TIME STUDENT(S) AT THE SCHOOL(S) LISTED BELOW.

NAME: _____ # OF HOURS: _____	NAME: _____ # OF HOURS: _____
SCHOOL: _____ STATE: _____ # OF UNITS: _____	SCHOOL: _____ STATE: _____ # OF UNITS: _____

6 **LIFE INSURANCE BENEFICIARY**

NAME	RELATIONSHIP TO APPLICANT
STREET ADDRESS	
CITY	
STATE	
ZIP	

7 **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. 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/CPIC Life.

I authorize any "provider of care", insurer or health plan to disclose to Blue Shield of California, or their representatives, all "medical information" (as those terms are defined in the California Civil Code), including any medical information regarding substance abuse, or mental or emotional conditions, regarding me, my spouse or my children. This medical information is collected for the purpose of evaluating my employer's application, determining claims for benefits, or for quality assurance and peer review. This authorization will remain valid for the term of the coverage of the Blue Shield health service contract. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization.

I, the applicant, acknowledge that I have read and understood this Application in its entirety.

Signature of Employee X _____ **Date X** _____

HEALTH STATEMENT

**IF YOU WOULD LIKE TO KEEP THIS STATEMENT CONFIDENTIAL,
PLEASE SUBMIT IT IN A SEALED ENVELOPE ALONG WITH YOUR COMPLETED APPLICATION.**

(Please print)

Employee Name	Social Security #	Height	Weight	
Dependent Name		Height	Weight	
Dependent Name		Height	Weight	
Dependent Name		Height	Weight	
1. Have you, or has any dependent you are enrolling, ever been diagnosed, treated or hospitalized for:			YES	NO
a. CANCER, DIABETES, CHEST PAIN, HIGH BLOOD PRESSURE, DIZZINESS, SEIZURES MENTAL/EMOTIONAL DISORDER, ALCOHOLISM, ALCOHOL ABUSE, OR DRUG ABUSE?				
b. Any disease or disorder of the: HEART, BLOOD, LIVER, COLON, DIGESTIVE SYSTEM OR LUNGS, IMMUNE DEFICIENCY, AIDS, OR AIDS RELATED COMPLEX (ARC)? <i>(California Law prohibits an HIV Test from being required or used by Health Care Service Plans as a condition of obtaining coverage.)</i>				
c. Any disease or disorder of the: MUSCLES, BACK, BONES OR JOINTS? KIDNEY, URINARY TRACT SYSTEM, MALE/FEMALE ORGANS (such as prostate or venereal disease, infertility, endometriosis)?				
2. Is anyone enrolling, including yourself, currently under medical treatment, currently pregnant, taking medication or been advised of possible need for further treatment, testing or surgery?				
3. Within the past two years, have you, or has any dependent you are enrolling, been disabled and/or incurred medical costs exceeding \$5,000.00?				
4. Within the last 12 months have you, or has any dependent you are enrolling, consulted a doctor for medical testing for reasons not identified above, such as laboratory testing, x-rays, or EKG, etc.?				
5. Have you, or has any dependent you are enrolling, ever smoked cigarettes? Name: _____ Packs Per Day: _____ How many years? _____ When did you/they stop? _____				

COMPLETE THE FOLLOWING FOR ANY YES RESPONSES FROM QUESTIONS 1 TO 5:

(Please indicate the question number above)

Q. #	Dependent (or Self) Name	Name and Address of Physician or Clinic	Date Treatment Began AND Ended	Name of Condition(s) Illness(es) Treated	Indicate Treatment Rendered and Current Status (Recovered, Still in Treatment?). Include Name of Medication (if taken) and Dates Prescribed

Attach additional sheets if necessary.

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand that this Employee Application, including this Health Statement, is a part of my and my dependents' application to be added to my employer's Blue Shield health plan contract. I understand that if I have misrepresented or omitted any material fact that my coverage may be cancelled or my employer's contract rescinded.

Signature of Employee X _____ **Date X** _____

REFUSAL OF PERSONAL COVERAGE

(Complete if you, your spouse or dependent(s)
are refusing your employer's Blue Shield health and/or dental plan coverage)

PLEASE PRINT

EMPLOYEE NAME	SOCIAL SECURITY #	
EMPLOYER (GROUP) NAME	HIRE DATE	GROUP NUMBER
MARITAL STATUS	MARRIED <input type="checkbox"/> YES <input type="checkbox"/> NO	JOB TITLE

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

<p>DECLINING COVERAGE FOR:</p> <p><input type="checkbox"/> I decline health plan coverage for myself, my spouse and all dependents.</p> <p><input type="checkbox"/> I decline health plan coverage for my:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Spouse Only _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Children Only _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Spouse and Children _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Following Dependents Only: _____</p> <p>_____</p> <p><input type="checkbox"/> If dental offered, I decline dental coverage for myself, my spouse and all dependents.</p> <p><input type="checkbox"/> I decline dental coverage for my:</p> <p style="margin-left: 20px;"><input type="checkbox"/> Spouse Only _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Children Only _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Spouse and Children _____</p> <p style="margin-left: 20px;"><input type="checkbox"/> Following Dependents Only: _____</p> <p>_____</p>	<p>REASON FOR DECLINING COVERAGE</p> <p><input type="checkbox"/> Covered by another employer's health plan (e.g., through your spouse). Carrier Name and ID Number _____</p> <p><input type="checkbox"/> Covered by an Individual Health Plan. Carrier Name _____</p> <p><input type="checkbox"/> Medicare</p> <p><input type="checkbox"/> Covered by Champus or Champva.</p> <p><input type="checkbox"/> Other – e.g., any other individual or employer health coverage. (explain) _____</p> <p><input type="checkbox"/> No other employer health coverage.</p> <p><input type="checkbox"/> Covered by another dental plan. Carrier Name and ID Number _____</p>
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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 and/or my dependent(s) in my employer Blue Shield 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 acquire a new dependent as the result of marriage, birth, adoption or placement for adoption, I acknowledge that I, and any dependents I may have, may request enrollment in my employer's health plan by applying for that coverage within 31 days of the marriage, birth, adoption, or placement for adoption.

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 **X** _____ Date **X** _____

**EMPLOYERS MUST RETAIN A COPY OF ANY SIGNED
PERSONAL REFUSAL OF COVERAGE FOR THEIR RECORDS**