

## Blue Shield of California and Blue Shield of California Life & Health Insurance Company

Blue Shield plans for groups with 2 to 50 eligible employees

**Effective January 1, 2010**

**It is very important that all questions be answered.**

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 15 or  Shield Spectrum PPO<sup>SM</sup> Plan 500 Premier)
3. Provide the Social Security number for each member enrolling.
4. Check the "Enroll in Medical Plan" 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 coverage is included in all Blue Shield group health plans. Please verify eligibility criteria with your employer. **If selecting Access+ HMO, Local Access+ HMO, or Added Advantage POS<sup>SM</sup> Plan, you must choose a Personal Physician.** Please enter the Provider Number and the name of the IPA or Medical Group. Refer to the HMO provider directory at [blueshieldca.com](http://blueshieldca.com) for the identification number. Please note the important dental plan enrollment guidelines described at right.

Dependent children 19 to 24 years of age who are not disabled must be enrolled full-time in college (minimum of 12 units) or trade school (or on an approved medical leave of absence from a college or trade school). To be considered eligible, you must check the "Full-Time Student" box as "Yes" for each dependent. Blue Shield of California/Blue Shield Life will deem this completed information to be a certification of full-time student status. Dependent coverage over age 18 for full-time students is not available to dependents of legal guardians. Dependent children over the age of 18 who are disabled may be eligible for continued benefits under a group plan providing the child is incapable of self-sustaining employment and chiefly dependent on the subscriber, spouse, or domestic partner for support and maintenance. A HIPAA certificate from the prior group carrier and a Physician's written certification of disability must be submitted (form C3674) with the application for enrollment. Certification of continued disability is required to maintain eligibility.

### 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. Dental and Life insurance are not available with Access Baja plans.

### Important dental plan enrollment guidelines

You must check the "Enroll in Dental Plan Coverage" box for each dependent listed in Section 3 of the Employee Application in order for each dependent to be covered. Employees may elect to enroll any number of their dependents in a Blue Shield of California Dental PPO or Dental HMO plan.

### Dental PPO

- Employee enrollment in a Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield Life) health plan is not required to select dental PPO coverage.

### Dental HMO

- Employee enrollment in a Blue Shield of California/Blue Shield Life health plan is not required to select dental HMO coverage.
  - To enroll in a dental HMO plan, **you must live or work sufficiently close to a participating dental provider to ensure reasonable access to care, as determined by the plan.**
  - Refer to the dental HMO dental provider directory for service areas
  - If selecting a dental HMO plan, you must list the identification number of the dental provider you have selected. Refer to the dental HMO dental provider directory at [blueshieldca.com](http://blueshieldca.com) for the identification number.
4. In the "Life Insurance Beneficiary" section, enter the name of the person who is to receive the group life insurance benefit, his or her relationship to the employee, and his or her current address.

5. The employee must sign and date the authorization for payroll deduction and disclosure of personal and health information. Blue Shield of California/Blue Shield Life cannot process the application without a signed authorization.

## Refusal of Coverage form

**This form (located on the last page of this application) is to be used for all employees who decline coverage for themselves or their dependents. This form is not required for dental or life insurance only applications.**

Enter the employee name, Social Security number, the employer (group) name, date of full-time hire, and marital status. Check the appropriate box if you, your spouse, domestic partner, 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 that 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 Shield Spectrum PPO plans, the Shield Savings plans and the Blue Shield Life Active Choice<sup>SM</sup> plans 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 of California or Blue Shield Life 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 of California or Blue Shield Life Health 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 of California/Blue Shield Life. If assistance is required, please contact your Blue Shield Customer Service Representative.

Blue Shield of California/Blue Shield Life protects the confidentiality and privacy of your personal and health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number, and Social Security number. We will not disclose this information, except as permitted by law.

**Blue Shield of California and  
Blue Shield of California Life & Health  
Insurance Company**

**Employee application (for 2 to 50 employees)**

**Do not write in shaded area**

- New group enrollment  New hire
- Family addition  Re-hire  Late enrollment
- Special enrollment period

B/U	OED	RSN	S	TOC	NP	PKG
-----	-----	-----	---	-----	----	-----

**Employee information (please type or print clearly, and use black ink)** If you, your spouse, or your dependent(s) are refusing coverage, please complete and sign the Refusal of Coverage form at the end of this application.

<b>1</b> Social Security number	Employer (group) name	Group number
<b>S</b> Last name		
<b>E</b> First name		MI
<b>L</b> Home address		Apartment
<b>F</b> City	State	ZIP
Mailing address (same as home address <input type="checkbox"/> )		
City	State	ZIP
Home phone ( )	Work phone ( )	E-mail address
Full-time hire date (Mo./Day/Yr.)	Job title	Life/AD&D insurance amount

How would you prefer we contact you? Select one of the following:  E-mail  Standard mail Telephone:  Home  Work  
Blue Shield will use your preferred method when possible.

Are you a full-time employee, actively 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  
If no, please explain.

Date of birth	Sex	Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic partner
Month Day Year	<input type="checkbox"/> Male <input type="checkbox"/> Female	Language preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other:
Height	Weight	Check yes if additional sheet(s) is attached to this application <input type="checkbox"/> Yes

Do you have eligible dependents?  Yes  No Are they enrolling?  Yes  No  
If no, are your dependents covered by any form of health insurance?  Yes  No  
**Please complete the Refusal of Coverage form included in this application for eligible dependents that are not enrolling.**

**Access+ HMO, Local Access+ HMO, and Added Advantage POS plans**

Name of Personal Physician	Provider number	Name of IPA/medical group	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
----------------------------	-----------------	---------------------------	---

**Dental HMO plan only**

Name of Dental Provider	Dental Provider number	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
-------------------------	------------------------	---

**2** Check plan(s) and fill in plan name(s) as appropriate

**Medical benefit plans**

- Access+ HMO \_\_\_\_\_
- Local Access+ HMO \_\_\_\_\_
- Added Advantage POS \_\_\_\_\_
- Access Baja HMO \_\_\_\_\_
- Active Choice<sup>1</sup> \_\_\_\_\_
- Shield Spectrum PPO \_\_\_\_\_
- Shield Savings<sup>2</sup> \_\_\_\_\_
- Other \_\_\_\_\_

**Optional benefits**

- Life/AD&D Insurance<sup>3</sup> \_\_\_\_\_
- Dependent Life Insurance/Amt.  
(max \$5,000) \_\_\_\_\_
- Dental PPO plan \_\_\_\_\_
- Dental HMO plan \_\_\_\_\_
- Vision plan \_\_\_\_\_
- Other \_\_\_\_\_

1 Underwritten by Blue Shield of California Life & Health Insurance Company.  
2 Shield Savings<sup>SM</sup> plans are HSA-eligible high-deductible health plans.  
3 Group term life insurance for groups of 2 to 9 eligible employees is administered and underwritten through a small group employer trust.

Applicant's full name	Social Security number
-----------------------	------------------------

**3 Dependent Information:** Access+ HMO, Local Access+ HMO, and Added Advantage POS applicants must select a Personal Physician in the Blue Shield *Access+ HMO Physician and Hospital Directory*. Dental HMO applicants must select a dental provider listed in the dental HMO provider directory. You may choose a different Access+ HMO or Local Access+ HMO Personal Physician for each family member. Be sure to include each physician's provider number and IPA number, as well as each dental provider number. For Access Baja HMO, please see Page 1.

Dependent's address if different from employee	Access+ HMO, Local Access+ HMO, and Added Advantage POS plans only – name of Personal Physician	Dental HMO plans only – dental provider
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Male <input type="checkbox"/> Female If family addition is spouse or domestic partner, date of marriage/ domestic partnership _____	Doctor's name	Dental provider name
First name _____ MI _____ Last name _____	First _____ Last _____	First _____ Last _____
Date of birth (mm/dd/yy) _____ Social Security number _____ Enroll in: <input type="checkbox"/> Health plan <input type="checkbox"/> Dental plan    Height _____ <input type="checkbox"/> Vision plan <input type="checkbox"/> Life insurance    Weight _____	Provider number _____ IPA/medical group: _____	Dental provider number _____
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter First name _____ MI _____ Last name _____	First _____ Last _____	First _____ Last _____
Date of birth (mm/dd/yy) _____ Social Security number _____ Enroll in: <input type="checkbox"/> Health plan <input type="checkbox"/> Dental plan    Height _____ <input type="checkbox"/> Vision plan <input type="checkbox"/> Life insurance    Weight _____	Provider number _____ IPA/medical group: _____	Dental provider number _____
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Full-time student status? (If over 18) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Son <input type="checkbox"/> Daughter First name _____ MI _____ Last name _____	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of birth (mm/dd/yy) _____ Social Security number _____ Enroll in: <input type="checkbox"/> Health plan <input type="checkbox"/> Dental plan    Height _____ <input type="checkbox"/> Vision plan <input type="checkbox"/> Life insurance    Weight _____	Provider number _____ IPA/medical group: _____	Dental provider number _____
Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Full-time student status? (If over 18) <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No



**Refusal of personal coverage** (Complete if you, your spouse, domestic partner, or dependent(s) are refusing your employer's Blue Shield of California/Blue Shield of California Life & Health Insurance Company health and/or dental plan coverage.) Please type or print. Use black ink.

Employee name	Social Security number
Employer (group) name	Hire date
Marital status Married <input type="checkbox"/> Yes <input type="checkbox"/> No Domestic partnership <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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you a part time employee, working at least 20 hours per week for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please explain:	

Declining coverage for:	Reason for declining coverage
<input type="checkbox"/> I decline health plan coverage for myself, my spouse/domestic partner, and all dependents. <input type="checkbox"/> I decline health plan coverage for: <input type="checkbox"/> My spouse/domestic partner only <input type="checkbox"/> My children only <input type="checkbox"/> My spouse/domestic partner and children <input type="checkbox"/> The following dependents only: _____ _____	<input type="checkbox"/> Covered by another employer's health plan (e.g., through your spouse/domestic partner) Carrier name _____ ID number _____  <input type="checkbox"/> Covered by an individual health or dental plan Carrier name _____ ID number _____  <input type="checkbox"/> Medicare, Medi-Cal, Healthy Families program <input type="checkbox"/> Covered by TRICARE <input type="checkbox"/> No other employer health coverage <input type="checkbox"/> Covered by another dental plan Carrier name _____ ID number _____  <input type="checkbox"/> Other _____ _____
<input type="checkbox"/> If dental plan offered, I decline dental plan coverage for myself, my spouse/domestic partner, and all dependents. <input type="checkbox"/> I decline dental plan coverage for: <input type="checkbox"/> My spouse/domestic partner only <input type="checkbox"/> My children only <input type="checkbox"/> My spouse/domestic partner and children <input type="checkbox"/> The following dependents only: _____ _____	

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's 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

Employers must retain a copy of any signed personal refusal of coverage for their records.