



Health Plan Employee Enrollment Application

Blue Shield plans for 101+ employees

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:

<input type="checkbox"/> New hire	<input type="checkbox"/> Loss of coverage date _____	<input type="checkbox"/> Late enrollment
<input type="checkbox"/> Rehire date _____	<input type="checkbox"/> Open enrollment	<input type="checkbox"/> 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:

<input type="checkbox"/> Active Choice® Plus _____	<input type="checkbox"/> Active Choice® Classic _____	<input type="checkbox"/> Access+ HMO® _____
<input type="checkbox"/> Access+ HMO® SaveNet SM _____	<input type="checkbox"/> Local Access+ HMO® _____	<input type="checkbox"/> Trio HMO _____
<input type="checkbox"/> Added Advantage POS SM _____	<input type="checkbox"/> Full PPO _____	<input type="checkbox"/> Full PPO Savings [†] _____
<input type="checkbox"/> Full EPO _____	<input type="checkbox"/> Tandem PPO _____	<input type="checkbox"/> Virtual Blue SM _____
<input type="checkbox"/> Tandem EPO _____	<input type="checkbox"/> Blue Shield 65 Plus SM (HMO) _____	<input type="checkbox"/> Tandem PPO Savings [†] _____

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

Active Choice® Plus: <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA	Full PPO Savings [†] : <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA <input type="checkbox"/> HSA <input type="checkbox"/> LPFSA [‡]
Active Choice® Classic: <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA	Full EPO: <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA
Access+ HMO®: <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA	Tandem PPO: <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA
Access+ HMO® SaveNet SM : <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA	Virtual Blue SM : <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA
Local Access+ HMO®: <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA	Tandem PPO Savings [†] : <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA <input type="checkbox"/> HSA <input type="checkbox"/> LPFSA [‡]
Trio HMO: <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA	Tandem EPO: <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA
Full PPO: <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA	Blue Shield 65 Plus SM (HMO): <input type="checkbox"/> HRA <input type="checkbox"/> HIA <input type="checkbox"/> FSA

Specialty Benefits: Dental PPO _____ Dental HMO _____ Dental INO _____
 Vision* _____ Other _____

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

† Full PPO Savings and Tandem PPO Savings plans are HSA-eligible high-deductible health plans.

‡ 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 _____
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Section 3 – Employee information

Social Security number	Employer (group) name
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Last name	First name	MI
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Employment status: <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Retiree	Date of hire: _____	Job title/classification
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Home address (street, city, state, ZIP code)

Mailing address (if different from home address)

Cell phone number	Landline phone number	Email address (required for electronic communications)
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I agree that Blue Shield and its affiliated entities and agents may communicate with me about my account and various health and wellness programs available to me, and other promotional information that may benefit me and my dependents, including by phone or text to the numbers I have listed on this form, using an auto-dialer or artificial or prerecorded voice; standard data rates apply. Yes No
 Participation is voluntary, and you can opt out any time; for more information, visit blueshieldca.com/terms.

Communication preference: Electronic Paper

Date of birth _____ **Gender** Male Female **Marital status** Single Married Domestic partner

Language preference: English Spanish Chinese Vietnamese Persian Other _____

Are you enrolling your spouse/domestic partner and/or child dependents Yes No **If “yes,” complete Section 4 of application.**

Please tell us about yourself. How would you describe your race or ethnicity? These questions are optional and are only used to help ensure all members have the same access to the highest quality of care.

1. Are you of Hispanic or Latino origin?	2. If yes, please select one:	3. Which race(s) do you identify with? (select one)	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined	<input type="checkbox"/> Cuban <input type="checkbox"/> Guatemalan <input type="checkbox"/> Mexican, Mexican American, Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Salvadoran <input type="checkbox"/> 2 or more ethnicities <input type="checkbox"/> Other Hispanic, Latino, Spanish: _____	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian Indian <input type="checkbox"/> Black or African American <input type="checkbox"/> Cambodian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Hmong <input type="checkbox"/> Japanese	<input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Vietnamese <input type="checkbox"/> White <input type="checkbox"/> 2 or more races <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Declined

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of dental provider:	Dental provider number:
	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

Are all your dependents of the same Race and Ethnicity as the subscriber? Yes No
 If you answered "No", please include the race and ethnicity for each of your dependents.

Enrolling spouse/domestic partner information	Enroll in (please check all that apply)	HMO and Added Advantage POS only – name of primary care physician	Dental HMO only – dental provider
What race or ethnicity does this member identify with:			
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Male <input type="checkbox"/> Female First _____ MI _____ Last _____ Social Security number _____ Date of birth (mm/dd/yyyy) _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Doctor's name First _____ Last _____ Provider number _____ IPA/medical group name _____ IPA/medical group number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental provider name First _____ Last _____ Dental provider number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Communication preference <input type="checkbox"/> Electronic <input type="checkbox"/> Paper	Email address (Required for electronic communications) _____		
Enrolling dependent child(ren) information	Enroll in (please check all that apply)	HMO and Added Advantage POS only – name of primary care physician	Dental HMO only – dental provider
What race or ethnicity does this member identify with:			
<input type="checkbox"/> Male <input type="checkbox"/> Female First _____ MI _____ Last _____ Social Security number _____ Date of birth (mm/dd/yyyy) _____ Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Doctor's name First _____ Last _____ Provider number _____ IPA/medical group name _____ IPA/medical group number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental provider name First _____ Last _____ Dental provider number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Communication preference <input type="checkbox"/> Electronic <input type="checkbox"/> Paper	Email address (Required for electronic communications) _____		

Enrolling dependent child(ren) information	Enroll in (please check all that apply)	HMO and Added Advantage POS only – name of primary care physician	Dental HMO only – dental provider
What race or ethnicity does this member identify with:			
<input type="checkbox"/> Male <input type="checkbox"/> Female First _____ MI _____ Last _____ Social Security number _____ Date of birth (mm/dd/yyyy) _____ Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Doctor's name First _____ Last _____ Provider number _____ IPA/medical group name _____ IPA/medical group number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental provider name First _____ Last _____ Dental provider number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Communication preference <input type="checkbox"/> Electronic <input type="checkbox"/> Paper		Email address (Required for electronic communications)	

Enrolling dependent child(ren) information	Enroll in (please check all that apply)	HMO and Added Advantage POS only – name of primary care physician	Dental HMO only – dental provider
What race or ethnicity does this member identify with:			
<input type="checkbox"/> Male <input type="checkbox"/> Female First _____ MI _____ Last _____ Social Security number _____ Date of birth (mm/dd/yyyy) _____ Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	Doctor's name First _____ Last _____ Provider number _____ IPA/medical group name _____ IPA/medical group number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental provider name First _____ Last _____ Dental provider number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Communication preference <input type="checkbox"/> Electronic <input type="checkbox"/> Paper		Email address (Required for electronic communications)	

Section 5 – 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 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 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 _____

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

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.



NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: blueshieldca.com/notices. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en blueshieldca.com/notices. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 blueshieldca.com/notices。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。