Small Business Employee Enrollment Form

Effective October 1, 2022

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

SUBSCRIBER INFORMATION – Please note: Missing information may delay processing.

Additional subscriber information is located in Section 2.

Subscriber's last name | First name | MI

Social Security number

Reason for application – Please indicate the reason for your enrollment below:

- ☐ New group enrollment
  Group effective date: ___ /___ /_____
- ☐ New hire
- ☐ Rehire
  Date of rehire: ___ /___ /_____
- ☐ Open enrollment
  Renewal date: ___ /___ /_____
- ☐ COBRA/Cal-COBRA enrollment
- ☐ New spouse/dependent
  Date of marriage/birth/adoption: ___ /___ /_____
- ☐ Other qualifying event (specify): _____
  Qualifying event date: ___ /___ /_____

SECTION 1A – HEALTH PLAN SELECTION – Select one health plan from the package(s) offered by your employer.

Blue Shield of California Off-Exchange Package for Small Business

PPO plans – Full PPO Network
- ☐ Platinum Full PPO 0/0 OffEx
- ☐ Platinum Full PPO 0/10 OffEx
- ☐ Platinum Full PPO 250/10 OffEx
- ☐ Platinum Full PPO 250/15 OffEx
- ☐ Gold Full PPO 0/25 OffEx
- ☐ Gold Full PPO 500/30 OffEx
- ☐ Gold Full PPO 750/30 OffEx
- ☐ Gold Full PPO 1000/35 OffEx
- ☐ Silver Full PPO 1800/45 OffEx
- ☐ Silver Full PPO 2225/50 OffEx*
- ☐ Silver Full PPO 2400/55 OffEx
- ☐ Bronze Full PPO 6250/65 OffEx
- ☐ Bronze Full PPO 6850/55 OffEx
- ☐ Bronze Full PPO 7500/65 OffEx
- ☐ Bronze Full PPO 5500/65 OffEx
- ☐ Bronze Full PPO 6500/70 OffEx

HSA-compatible HDHP plans – Full PPO Network
- ☐ Gold Full PPO Savings 1750/15% HDHP PrevRx OffEx
- ☐ Silver Full PPO Savings 2100/25% OffEx
- ☐ Silver Full PPO Savings 2600/35% HDHP PrevRx OffEx
- ☐ Bronze Full PPO Savings 5700/40% OffEx
- ☐ Bronze Full PPO Savings 7000 OffEx

HSA-compatible HDHP plans – Tandem PPO Network
- ☐ Gold Tandem PPO Savings 1750/15% HDHP PrevRx OffEx
- ☐ Silver Tandem PPO Savings 2100/25% OffEx
- ☐ Silver Tandem PPO Savings 2600/35% HDHP PrevRx OffEx
- ☐ Bronze Tandem PPO Savings 5700/40% OffEx
- ☐ Bronze Tandem PPO Savings 7000 OffEx

Tandem PPO plans – Tandem PPO Network
- ☐ Platinum Tandem PPO 0/0 OffEx
- ☐ Platinum Tandem PPO 0/10 OffEx
- ☐ Platinum Tandem PPO 250/10 OffEx
- ☐ Platinum Tandem PPO 250/15 OffEx
- ☐ Gold Tandem PPO 0/25 OffEx
- ☐ Gold Tandem PPO 500/30 OffEx
- ☐ Gold Tandem PPO 750/30 OffEx
- ☐ Gold Tandem PPO 1000/35 OffEx
- ☐ Silver Tandem PPO 1800/45 OffEx
- ☐ Silver Tandem PPO 2225/50 OffEx*
- ☐ Silver Tandem PPO 2400/55 OffEx
- ☐ Bronze Tandem PPO 6250/65 OffEx
- ☐ Bronze Tandem PPO 6850/55 OffEx
- ☐ Bronze Tandem PPO 7500/65 OffEx
- ☐ Bronze Tandem PPO 5500/65 OffEx
- ☐ Bronze Tandem PPO 6500/70 OffEx

Access+ HMO plans – Access+ HMO Network
- ☐ Platinum Access+ HMO® 0/20 OffEx
- ☐ Platinum Access+ HMO® 0/25 OffEx
- ☐ Platinum Access+ HMO® 0/30 OffEx
- ☐ Gold Access+ HMO® 0/30 OffEx
- ☐ Gold Access+ HMO® 500/35 OffEx
- ☐ Gold Access+ HMO® 1000/35 OffEx
- ☐ Gold Access+ HMO® 1500/35 OffEx
- ☐ Silver Access+ HMO® 2000/60 OffEx
- ☐ Silver Access+ HMO 2750/65 OffEx

Local Access+ HMO plans – Local Access+ HMO Network
- ☐ Platinum Local Access+ HMO® 0/20 OffEx
- ☐ Platinum Local Access+ HMO® 0/25 OffEx
- ☐ Platinum Local Access+ HMO® 0/30 OffEx
- ☐ Gold Local Access+ HMO® 0/30 OffEx
- ☐ Gold Local Access+ HMO® 500/35 OffEx
- ☐ Gold Local Access+ HMO® 1000/35 OffEx
- ☐ Gold Local Access+ HMO® 1500/35 OffEx
- ☐ Silver Local Access+ HMO® 2000/60 OffEx
- ☐ Silver Local Access+ HMO 2750/65 OffEx

Trio HMO plans – Trio ACO HMO Network
- ☐ Platinum Trio HMO 0/20 OffEx
- ☐ Platinum Trio HMO 0/25 OffEx
- ☐ Platinum Trio HMO 0/30 OffEx
- ☐ Gold Trio HMO 0/30 OffEx
- ☐ Gold Trio HMO 500/35 OffEx
- ☐ Gold Trio HMO 1000/35 OffEx
- ☐ Gold Trio HMO 1500/35 OffEx
- ☐ Silver Trio HMO 2000/60 OffEx
- ☐ Silver Trio HMO 2750/65 OffEx
- ☐ Bronze Trio HMO 7000/70 OffEx

* The Silver Full PPO 2225/50 OffEx and Silver Tandem PPO 2225/50 OffEx offer enhanced coverage for members diagnosed with diabetes, asthma, COPD, and CAD.

Subscriber's last name | First name | MI | Social Security number

Blue Shield of California Mirror Package for Small Business

- ☐ Blue Shield Trio Platinum 90 HMO 0/20 + Child Dental
- ☐ Blue Shield Platinum 90 PPO 0/15 + Child Dental
- ☐ Blue Shield Trio Gold 80 HMO 250/35 + Child Dental
- ☐ Blue Shield Gold 80 PPO 350/25 + Child Dental
- ☐ Blue Shield Trio Silver 70 HMO 2250/55 + Child Dental
- ☐ Blue Shield Silver 70 PPO 2250/50 + Child Dental
- ☐ Blue Shield Bronze 60 PPO 6300/65 + Child Dental

SECTION 1B – SPECIALTY BENEFITS – dental,* vision,* and life insurance* plan selection

*Only benefits your employer group offers are available for selection. Any benefits selected that are not offered by your employer group will be omitted from your enrollment.

Select specialty plan(s) from the package offered by your employer.

Section SB1 – Dental coverage

Dental HMO plans

- ☐ DHMO Basic
- ☐ DHMO Standard
- ☐ DHMO Plus
- ☐ DHMO Deluxe
- ☐ DHMO Voluntary

New 2022 DPPO plans:

- ☐ Bronze DPPO/$1000/MAC
- ☐ Bronze DPPO/$1000/MAC/Child Only Ortho
- ☐ Silver DPPO/$1500/MAC
- ☐ Silver DPPO/$1500/MAC/Adult+Child Ortho
- ☐ Silver DPPO/$1500/U90
- ☐ Silver DPPO/$1500/U90/Adult+Child Ortho
- ☐ Gold DPPO/$1500/U90
- ☐ Gold DPPO/$1500/U90/Adult+Child Ortho
- ☐ Gold DPPO/$2000/U90
- ☐ Gold DPPO/$2000/U90/Adult+Child Ortho
- ☐ Platinum DPPO/$2500/U90
- ☐ Platinum DPPO/$2500/U90/Adult+Child Ortho
- ☐ Platinum DPPO/$3000/U90
- ☐ Platinum DPPO/$3000/U90/Adult+Child Ortho
- ☐ Platinum DPPO/$5000/U90
- ☐ Platinum DPPO/$5000/U90/Adult+Child Ortho
- ☐ Diamond DPPO/$3000/U95
- ☐ Diamond DPPO/$3000/U95/Adult+Child Ortho
- ☐ Diamond DPPO/$5000/U95
- ☐ Diamond DPPO/$5000/U95/Adult+Child Ortho

Dental PPO plans (only available for groups enrolled in these plans prior to 12/31/2021)

- ☐ Smile℠ Value 50/1500/No Ortho/MAC/NR
- ☐ Smile℠ 50/1500/No Ortho/MAC/NR
- ☐ Smile℠ Plus 50/1500/Ortho/MAC/NR
- ☐ Smile℠ Basic 75/1000/No Ortho/MAC/NR
- ☐ Smile℠ Basic 50/1000/No Ortho/MAC
- ☐ Smile℠ Basic 50/1000/Ortho/U85
- ☐ Smile℠ Plus 50/1500/No Ortho/MAC
- ☐ Smile℠ Plus 50/1500/No Ortho/MAC/WP
- ☐ Smile℠ Deluxe 50/1500/Ortho/MAC/NR
- ☐ Smile℠ Deluxe 2000 50/2000/No Ortho/MAC/NR
- ☐ Smile℠ Deluxe Plus 2000 50/2000/Ortho/MAC/NR
- ☐ Smile℠ Deluxe Gold 50/1500/Ortho/U85/NR
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U85/NR
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U80
- ☐ Smile℠ Plus Gold 50/1500/No Ortho/U80
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U80/ADV
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U90/ADV
- ☐ Smile℠ Plus Gold 50/1500/No Ortho/U90/ADV
- ☐ Smile℠ Plus Gold 50/2500/Ortho/U90/ADV
- ☐ Smile℠ Plus Gold 50/2500/No Ortho/U90/ADV
- ☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/MAC/NR
- ☐ Ultimate Dental Plus PPO for Small Business 50/2000/Ortho/MAC/NR
- ☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/U80
- ☐ Ultimate Dental PPO for Small Business 50/2000/Lifetime Ortho/U90
- ☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/U90

New 2022 Voluntary Dental PPO plans**

- ☐ Bronze Voluntary DPPO/$1000/MAC
- ☐ Bronze Voluntary DPPO/$1000/MAC/Child Only Ortho

Voluntary Dental PPO plans (only available for groups enrolled in these plans prior to 12/31/2021)

- ☐ Smile℠ Basic Voluntary 75/1000/No Ortho/MAC/NR
- ☐ Smile℠ Basic Voluntary 50/1000/No Ortho/MAC
- ☐ Smile℠ Basic Voluntary 50/1500/Ortho/U80
- ☐ Smile℠ Basic Voluntary 50/1000/No Ortho/U80 (No Wait)‡

Dental In-Network Only (INO) plans† (only available for groups enrolled in these plans prior to 12/31/2018)

- ☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/Ortho
- ☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho
- ☐ Smile℠ INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/Ortho*
- ☐ Smile℠ INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/No Ortho*
- ☐ Smile℠ INO Dental Plan 50/2500/Endo-Perio 80%/Ortho
- ☐ Smile℠ INO Dental Plan 50/2500/Endo-Perio 80%/No Ortho
- ☐ Smile℠ INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/Ortho*
- ☐ Smile℠ INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/No Ortho*

Subscriber's last name | First name | MI | Social Security number

Dental PPO plans (only available for groups enrolled in these plans prior to 12/31/2018)

- ☐ Ultimate Dental Plus PPO for Small Business 50/2000/Ortho/MAC
- ☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/MAC
- ☐ Smile℠ Deluxe 2000 50/2000/No Ortho/MAC
- ☐ Smile℠ Deluxe Plus 2000 50/2000/Ortho/MAC
- ☐ Smile℠ Deluxe 50/1500/Ortho/MAC
- ☐ Smile℠ Deluxe Gold 50/1500/Ortho/U85
- ☐ Smile℠ 50/1500/No Ortho/MAC
- ☐ Smile℠ Plus 50/1500/Ortho/MAC
- ☐ Smile℠ Value 50/1500/No Ortho/MAC
- ☐ Smile℠ Plus Gold 50/1500/Ortho/U85
- ☐ Smile℠ Basic 75/1000/No Ortho/MAC
- ☐ Smile℠ Basic Voluntary 75/1000/No Ortho/MAC

* Voluntary dental plans require a minimum of one (1) enrolling, eligible employee.

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

‡ This Voluntary plan does not include Waiting Periods and submission of proof of any prior coverage is not required.

ADV stands for Advantage. ADV plans incentivize members to use in-network providers. NR stands for No Rollover.

** The voluntary plans include a 12-month waiting period on major services and orthodontic services (ortho plan)

Section SB2 – Vision coverage*

Ultimate Vision for Small Business (12-12-12)

- ☐ Ultimate Vision Plus 0/0/150/150
- ☐ Ultimate Vision 0/0/150
- ☐ Ultimate Vision Plus 10/25/150/150
- ☐ Ultimate Vision 10/25/150
- ☐ Ultimate Vision 0/0/120
- ☐ Ultimate Vision 10/25/120
- ☐ Ultimate Vision Voluntary 10/25/150[1]

Preferred Vision for Small Business (12-12-24)

- ☐ Preferred Vision Plus 0/0/150/150
- ☐ Preferred Vision 0/0/150
- ☐ Preferred Vision Plus 10/25/150/150
- ☐ Preferred Vision 10/25/150
- ☐ Preferred Vision 0/0/120
- ☐ Preferred Vision 10/25/120
- ☐ Preferred Vision Voluntary 10/25/120[1]

Basic Vision for Small Business (12-24-24)

- ☐ Basic Vision Plus 0/0/150/150
- ☐ Basic Vision 0/0/150
- ☐ Basic Vision Plus 10/25/150/150
- ☐ Basic Vision 10/25/150
- ☐ Basic Vision 0/0/120
- ☐ Basic Vision 10/25/120
- ☐ Basic Vision Voluntary 10/25/120[1]

☐ Other (please specify) _____

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

1 Voluntary vision plans require a minimum of one (1) enrolling, eligible employee.

Section SB3 – Life/AD&D insurance

Group term life insurance* (Note: Please fill out if group is offering Blue Shield Life and life is being requested).

Employee information

Full-time employment date | Average hours worked per week | Rehire date | Job class/occupation | Earnings $ _____ (excluding overtime, bonuses, etc.) ☐ Hour ☐ Week ☐ Month ☐ Year

Designation of beneficiary

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 stated beneficiary designation(s).

Spouse/domestic partner signature: | Date:

Spouse/domestic partner name (please print)

Primary beneficiary – Blue Shield Life will pay the life insurance benefits to the primary beneficiary/beneficiaries identified. An employee may designate more than one primary beneficiary. Please show percentages for each primary beneficiary in the "% of benefits" column to total 100% of benefits. If the percentage is not defined, the benefits will be distributed equally to those primary beneficiaries who survive the employee. To designate more than two primary beneficiaries, please provide on a separate sheet of paper, which is signed and dated by the employee, and attach to this form.

Subscriber's last name	First name	MI	Social Security number

First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits

Address	City	State	ZIP code

First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits

Address	City	State	ZIP code

Contingent beneficiary – Proceeds will be paid to a contingent beneficiary only if no designated primary beneficiary survives the insured.

First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits

Address	City	State	ZIP code

Information on benefit amounts

Please contact your benefits administrator for more information regarding your group life insurance coverage. Coverage granted to individuals listed in this enrollment form shall be subject to all provisions and limitations stated in the Blue Shield of California Life & Health Insurance Company group life insurance policy.

Employee Basic Life and AD&D Insurance amount: $ _____ Amount of coverage requested for dependent(s): $ _____

Number of eligible dependents: _____ Basic Dependent Life Insurance: ☐ Yes ☐ No

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

SECTION 2A – SUBSCRIBER INFORMATION

Note: Social Security numbers are required per CMS.

Social Security number	**Employer (group) name**	**Blue Shield Group ID**

Last name	**First name**	**MI**

Home (physical) address (no P.O. Box addresses)	**City**	**State**	**ZIP code**

Mailing address (if different from home address)	City	State	ZIP code

Cell phone number:	Landline phone number:	Language preference:
( )	( )	☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

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 at any time, for more information visit **blueshieldca.com/terms**.

Subscriber's last name | First name | MI | Social Security number

Email address (required for electronic communications)

Communication preference

☐ Electronic ☐ Paper

Go paperless! Please watch for an email with a link which will allow you to register your account, customize your communication preferences, and access your digital ID card and benefit information.

Date of birth: ____ /____ /_____

Gender:
☐ Male ☐ Female

Marital Status:
☐ Single ☐ Married ☐ Domestic partner

Do you have any eligible dependent children under the age of 26? ☐ Yes ☐ No How many?_____ How many are enrolling?_____

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?
   - ☐ Yes
   - ☐ No
   - ☐ Unknown
   - ☐ Declined

2. If yes, please select one:
   - ☐ Cuban
   - ☐ Guatemalan
   - ☐ Mexican, Mexican American, Chicano
   - ☐ Puerto Rican
   - ☐ Salvadoran
   - ☐ 2 or more Ethnicities
   - ☐ Other Hispanic, Latino, Spanish:

3. Which race(s) do you identify with? (select one
   - ☐ American Indian or Alaska Native
   - ☐ Asian Indian
   - ☐ Black or African American
   - ☐ Cambodian
   - ☐ Chinese
   - ☐ Filipino
   - ☐ Guamanian or Chamorro
   - ☐ Hmong
   - ☐ Japanese
   - ☐ Korean
   - ☐ Laotian
   - ☐ Native Hawaiian
   - ☐ Samoan
   - ☐ Vietnamese
   - ☐ White
   - ☐ 2 or more Races
   - ☐ Other
   - ☐ Unknown
   - ☐ Declined

If there are applicable dependents included on your application, are all dependents listed of the same race and ethnicity as the primary applicant? ☐ Yes ☐ No If you answered "No", please include the race and ethnicity for each of your dependents in Part 4.

SECTION 2B – EMPLOYMENT INFORMATION

Date of hire: ____ /____ /_____
(Full time or part time as noted below. If orientation period is applied, the date of hire is the first day after completion of the orientation period.)

Job title:

Job classification:

Employment status: Mark one option

I am a full-time employee actively working 30 hours or more per week for this employer. ☐ Yes ☐ No
I am a part-time employee actively working between 20-29 hours per week for this employer. ☐ Yes ☐ No
I am an existing COBRA participant or enrolling due to a COBRA qualifying event. If yes, complete section 7 (required). ☐ Yes ☐ No

Subscriber's last name	First name	MI	Social Security number

SECTION 3 – HMO PRIMARY CARE PHYSICIAN/DENTAL HMO PROVIDER ASSIGNMENT

This section is only required if you selected an HMO plan. If you selected a PPO plan, please proceed to Section 4.

HMO plan primary care physician selection

Would you like for Blue Shield to designate a primary care physician for you and your dependents who is located near your home or work?

☐ Yes, I would like Blue Shield to designate a primary care physician and/or dental HMO provider for me and my dependents.

☐ No, I would like to request a specific primary care physician and/or dental HMO provider for myself and my dependents (please specify below).

* Please note: If Blue Shield is unable to assign the primary care physician and/or Dental HMO provider you requested, Blue Shield will designate a provider. HMO primary care physicians can be changed by visiting **blueshieldca.com** after enrollment.

HMO primary care physician name	**Provider number**	IPA/MG name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	**Provider number**	Dental group name	Existing patient? ☐ Yes ☐ No

SECTION 4 – DEPENDENT INFORMATION

Please note: If the employee, spouse/domestic partner, or child dependent(s) are refusing coverage for some or all products offered by the group, the employee must complete and sign a Refusal of Personal Coverage form at the end of this application. Blue Shield will enroll dependents under all plans that the employee is also enrolled/enrolling in unless indicated otherwise.

Dependent type:	**Gender:**	**Social Security number (required)**	**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No
☐ Spouse ☐ Domestic partner	☐ Male ☐ Female		If no, please attach the completed and signed Refusal of Coverage form.

First name	MI	Last name	Suffix

Date of birth	Address (if different from employee)
____ /____ /_____	

Communication preference	**Email address (required for electronic communications)**
☐ Electronic ☐ Paper	

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	Provider number	Dental group name	Existing patient? ☐ Yes ☐ No

Dependent type:	**Gender:**	**Social Security number (required)**	**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No
☐ Dependent child ☐ Other dependent child: legal guardianship	☐ Male ☐ Female		If no, please attach the completed and signed Refusal of Coverage form.

First name	MI	Last name	Suffix

Date of birth	Address (if different from employee)
____ /____ /_____	

Communication preference	**Email address (required for electronic communications)**
☐ Electronic ☐ Paper	

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	Provider number	Dental group name	Existing patient? ☐ Yes ☐ No

Subscriber's last name | First name | MI | Social Security number

Dependent type:
☐ Dependent child
☐ Other dependent child: legal guardianship

Gender:
☐ Male
☐ Female

Social Security number (required)

Enrolling in all products selected by subscriber? ☐ Yes ☐ No

If no, please attach the completed and signed Refusal of Coverage form.

First name | MI | Last name | Suffix

Date of birth ____ /____ /_______ | Address (if different from employee)

Communication preference ☐ Electronic ☐ Paper | **Email address (required for electronic communications)**

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name | Provider number | IPA name | Existing patient? ☐ Yes ☐ No

Dental HMO provider name | Provider number | Dental group name | Existing patient? ☐ Yes ☐ No

Dependent type:
☐ Dependent child
☐ Other dependent child: legal guardianship

Gender:
☐ Male
☐ Female

Social Security number (required)

Enrolling in all products selected by subscriber? ☐ Yes ☐ No

If no, please attach the completed and signed Refusal of Coverage form.

First name | MI | Last name | Suffix

Date of birth ____ /____ /_______ | Address (if different from employee)

Communication preference ☐ Electronic ☐ Paper | **Email address (required for electronic communications)**

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name | Provider number | IPA name | Existing patient? ☐ Yes ☐ No

Dental HMO provider name | Provider number | Dental group name | Existing patient? ☐ Yes ☐ No

Dependent type:
☐ Dependent child
☐ Other dependent child: legal guardianship

Gender:
☐ Male
☐ Female

Social Security number (required)

Enrolling in all products selected by subscriber? ☐ Yes ☐ No

If no, please attach the completed and signed Refusal of Coverage form.

First name | MI | Last name | Suffix

Date of birth ____ /____ /_______ | Address (if different from employee)

Communication preference ☐ Electronic ☐ Paper | **Email address (required for electronic communications)**

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name | Provider number | IPA name | Existing patient? ☐ Yes ☐ No

Dental HMO provider name | Provider number | Dental group name | Existing patient? ☐ Yes ☐ No

Subscriber's last name | First name | MI | Social Security number

Dependent type:
☐ Dependent child
☐ Other dependent child: legal guardianship

Gender:
☐ Male
☐ Female

Social Security number (required)

Enrolling in all products selected by subscriber? ☐ Yes ☐ No

If no, please attach the completed and signed Refusal of Coverage form.

First name | MI | Last name | Suffix

Date of birth ____ /____ /_______

Address (if different from employee)

Communication preference
☐ Electronic ☐ Paper

Email address (required for electronic communications)

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name | Provider number | IPA name | Existing patient? ☐ Yes ☐ No

Dental HMO provider name | Provider number | Dental group name | Existing patient? ☐ Yes ☐ No

Dependent type:
☐ Dependent child
☐ Other dependent child: legal guardianship

Gender:
☐ Male
☐ Female

Social Security number (required)

Enrolling in all products selected by subscriber? ☐ Yes ☐ No

If no, please attach the completed and signed Refusal of Coverage form.

First name | MI | Last name | Suffix

Date of birth ____ /____ /_______

Address (if different from employee)

Communication preference
☐ Electronic ☐ Paper

Email address (required for electronic communications)

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name | Provider number | IPA name | Existing patient? ☐ Yes ☐ No

Dental HMO provider name | Provider number | Dental group name | Existing patient? ☐ Yes ☐ No

Dependent type:
☐ Dependent child
☐ Other dependent child: legal guardianship

Gender:
☐ Male
☐ Female

Social Security number (required)

Enrolling in all products selected by subscriber? ☐ Yes ☐ No

If no, please attach the completed and signed Refusal of Coverage form.

First name | MI | Last name | Suffix

Date of birth ____ /____ /_______

Address (if different from employee)

Communication preference
☐ Electronic ☐ Paper

Email address (required for electronic communications)

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name | Provider number | IPA name | Existing patient? ☐ Yes ☐ No

Dental HMO provider name | Provider number | Dental group name | Existing patient? ☐ Yes ☐ No

Subscriber's last name | First name | MI | Social Security number

Dependent type:
☐ Dependent child
☐ Other dependent child: legal guardianship

Gender:
☐ Male
☐ Female

Social Security number (required)

Enrolling in all products selected by subscriber? ☐ Yes ☐ No

If no, please attach the completed and signed Refusal of Coverage form.

First name | MI | Last name | Suffix

Date of birth
____ /____ /_____

Address (if different from employee)

Communication preference
☐ Electronic ☐ Paper

Email address (required for electronic communications)

If different from Subscriber, which Race and Ethnicity does this dependent identify with?

HMO primary care physician name | Provider number | IPA name | Existing patient? ☐ Yes ☐ No

Dental HMO provider name | Provider number | Dental group name | Existing patient? ☐ Yes ☐ No

SECTION 5 – OTHER HEALTH PLAN INFORMATION

If enrolling due to a loss of coverage under a prior health plan and/or to receive credit toward any employer waiting period, documentation is required to verify the date of the qualifying event.

Does any person applying for coverage currently have health coverage or previously had health coverage at any time in the past six (6) months? ☐ Yes ☐ No

If yes, specify carrier: _____

Type of coverage: ☐ Group ☐ Individual ☐ Medicare ☐ Covered California/State Health Insurance Exchange
☐ Other (specify): _____

Policy/ID number_____

Date coverage began: ____ /____ /_____ Date ended (if coverage is active, please leave blank): ____ /____ /_____

Please list all subscriber and dependent member names currently or previously enrolled in the health coverage identified above:

Documentation attached? ☐ Yes ☐ No

SECTION 6 – 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 ____ /____ /_____ (mm/dd/yyyy)

Type: ☐ Hemodialysis ☐ Self-dialysis (peritoneal)

b) If you had a kidney transplant, what was the date of the transplant: ____ /____ /_____ (mm/dd/yyyy)

Subscriber's last name	First name	MI	Social Security number

SECTION 7 – COBRA/CAL-COBRA GROUP CONTINUATION COVERAGE

Please complete this section only if enrolling in COBRA or Cal-COBRA group continuation coverage. Those individuals already enrolled in COBRA or Cal-COBRA coverage from a prior carrier are eligible to continue that coverage with Blue Shield for the remaining duration of time allowed through COBRA and/or Cal-COBRA (as applicable). Proof of enrollment as a COBRA/Cal-COBRA participant is required.

Please provide the name of the employee through whom group coverage was obtained prior to the qualifying event, in order to be eligible for COBRA/Cal-COBRA continuation coverage.

Employee last name	**Employee first name**	**MI**

Employee's/subscriber's Blue Shield ID (if applicable)	Original qualifying event date ____ /____ /_____

Qualifying event reason:

- ☐ Termination or reduction in hours (last day worked)
- ☐ Termination or reduction in hours due to disability
- ☐ Divorce or legal separation
- ☐ Entitlement to Medicare by covered employee
- ☐ Attainment of maximum age for a dependent child
- ☐ Death of covered employee
- ☐ Termination of domestic partnership

SECTION 8 - DISCLOSURE OF PERSONAL AND HEALTH INFORMATION

At Blue Shield of California, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously. Blue Shield protects the privacy and security of the personal information that we maintain, use, and disclose for purposes of administering your Blue Shield coverage.

Blue Shield obtains personal information about you and/or your covered dependents, including health and/or financial information, from you, at your direction, and/or with your permission. We are also permitted by federal and state law to obtain your personal information from other sources, including, for example, from your healthcare provider, insurer, insurance support organization, health plan, or insurance agent. We use and disclose your personal information to administer your Blue Shield coverage and as otherwise permitted or required by law. In doing so, we may disclose your personal information to others including, for example, a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Blue Shield will not disclose your personal information without your authorization except as permitted or required by law.

Blue Shield is required to provide you with a Notice of Privacy Practices ("Notice") that describes your privacy rights, our obligations to protect your privacy, and how we use and disclose your personal information with and without your specific authorization. When we use or disclose your personal information, we are bound by the terms of the Notice, which applies to all records that we create, obtain, and/or maintain that contain your personal information. You will receive our Notice when you enroll for Blue Shield 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/privacy**.

ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge and agree: All information I have provided on this enrollment 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 enrollment within 24 months of issuance, Blue Shield may pursue one of the following remedies: coverage may be cancelled, or the applicable premium may be adjusted, or, following notice, coverage may be 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 of California.

_____ _____

Signature of employee **Date**

_____

Print employee name

All pages of this form are necessary to process your enrollment.
Missing information may delay processing.
If submitting for an existing Blue Shield plan, go to blueshieldca.com.

REFUSAL OF COVERAGE FORM

Complete this form if you, your spouse, domestic partner, or child dependent(s) are refusing this group health, dental, vision, and/or life insurance coverage offered through the employer. (The employer must retain a copy of this form to provide to Blue Shield upon request.) Please type or print. Use black ink. ***Note: The employee's Social Security number is required for all eligible employees.**

Employee name | **Social Security number** | **Date of birth**

Employer (Group) name | **Hire date** ____ /____ /_____ | **State of residence**

Marital status Married ☐ Yes ☐ No
Domestic partnership ☐ Yes ☐ No

Job title

Is the employee a full-time employee, working at least 30 hours per week for this employer? ☐ Yes ☐ No **Or**
Is the employee a part-time employee, working at least 20 hours per week for this employer? ☐ Yes ☐ No

Declining coverage for:

I decline health plan coverage for:

- ☐ Myself and all dependents.
- ☐ My spouse/domestic partner only
- ☐ My children only
- ☐ My spouse/domestic partner and children only
- ☐ The following dependents only:

_____

If dental plan offered, I decline dental plan coverage for:

- ☐ Myself and all dependents.
- ☐ My spouse/domestic partner
- ☐ My children
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:

_____

If vision plan offered, I decline vision plan coverage for:

- ☐ Myself and all dependents
- ☐ My spouse/domestic partner
- ☐ My children
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:

_____

If life insurance plan offered, I decline life plan coverage for:

- ☐ Myself

Reason employee is declining health coverage

OTHER EMPLOYER HEALTH COVERAGE

- ☐ Enrolling as a dependent or an employee on this group health plan
- ☐ Covered by this employer's other health plan (through another carrier)
- ☐ Covered by another employer's health plan, including COBRA or Cal-COBRA coverage, through your spouse/domestic partner, parent, or previous employer

OTHER NON-EMPLOYER HEALTH COVERAGE

- ☐ Covered by an individual/family health plan
- ☐ Covered by Government program, including Medicare, Medi-Cal, Healthy Families Program, TRICARE, Indian Health Service, Tribal and Urban Indian Health Program, and Veterans Health Administration (VA)

☐ **OTHER REASONS**

Reason employee is declining dental coverage

OTHER DENTAL COVERAGE

- ☐ Enrolling as a dependent or an employee on this group dental plan
- ☐ Covered by another employer's dental plan, including COBRA or Cal-COBRA dental coverage, through your spouse/domestic partner, parent, or previous employer
- ☐ Covered by an individual/family dental plan

☐ **OTHER REASONS**

Reason employee is declining vision coverage

OTHER VISION COVERAGE

- ☐ Enrolling as a dependent or an employee on this group vision plan
- ☐ Covered by another employer's vision plan, including COBRA or Cal-COBRA vision coverage, through your spouse/domestic partner, parent, or previous employer
- ☐ Covered by an individual/family vision plan

☐ **OTHER REASONS**

Reason employee is declining life insurance coverage

OTHER LIFE INSURANCE COVERAGE

- ☐ Covered by another employer's life insurance coverage through your spouse/domestic partner, or parent

OTHER REASONS

- ☐ Cost of coverage
- ☐ Do not need or do not want coverage

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 child dependent(s) in my employer's group 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 60 days 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 60 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 60 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**

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)**。