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:

☐ New hire ☐ Rehire date _____	☐ Loss of coverage date _____ ☐ Open enrollment	☐ Late enrollment ☐ Other qualifying event type_____ Date above event occurred _____

Section 1 – Important enrollment guidelines for Specialty Benefits coverage

Dental and vision insurance – An employee may enroll in a dental and/or vision plan without enrolling in a health plan. In order for a dependent to enroll in a dental or vision plan, the employee must be enrolled in the same dental or vision plan.

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

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

☐ Active Choice®* _____ ☐ Active Choice® Plus _____ ☐ Active Choice® Classic _____ ☐ Access+ HMO® _____
☐ Access+ HMO® SaveNet℠ _____ ☐ Local Access+ HMO® _____ ☐ Trio HMO _____
☐ Added Advantage POS℠ _____ ☐ Full PPO _____ ☐ Full PPO Savings† _____ ☐ Full EPO _____
☐ Tandem PPO _____ ☐ Tandem PPO Savings† _____ ☐ Tandem EPO _____ ☐ Blue Shield 65 Plus℠ (HMO) _____

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

Active Choice®: ☐ HRA ☐ HIA ☐ FSA
Active Choice® Plus: ☐ HRA ☐ HIA ☐ FSA
Active Choice® Classic: ☐ HRA ☐ HIA ☐ FSA
Access+ HMO®: ☐ HRA ☐ HIA ☐ FSA
Access+ HMO® SaveNet℠: ☐ HRA ☐ HIA ☐ FSA
Local Access+ HMO®: ☐ HRA ☐ HIA ☐ FSA
Trio HMO: ☐ HRA ☐ HIA ☐ FSA
Full PPO: ☐ HRA ☐ HIA ☐ FSA
Full PPO Savings†: ☐ HRA ☐ HIA ☐ FSA ☐ HSA ☐ LPFSA‡
Full EPO: ☐ HRA ☐ HIA ☐ FSA
Tandem PPO: ☐ HRA ☐ HIA ☐ FSA
Tandem PPO Savings†: ☐ HRA ☐ HIA ☐ FSA ☐ HSA ☐ LPFSA‡
Tandem EPO: ☐ HRA ☐ HIA ☐ FSA
Blue Shield 65 Plus℠ (HMO): ☐ HRA ☐ HIA ☐ FSA

Specialty Benefits: ☐ Dental PPO _____ ☐ Dental HMO _____ ☐ 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 _____

Section 3 – Employee information

Social Security number	**Employer (group) name**	
Last name	**First name**	**MI**
Employment status: ☐ Full time ☐ Part time ☐ Retiree	**Date of hire:** _____	Job title/classification

Home address (street, city, state, ZIP code)

Mailing address (if different from home address)

Cell phone number	Landline phone number	**Email address (required for electronic communications)**

I consent to Blue Shield and their covered entities contacting me about health and wellness education or promotional information to serve me better. Communications can be by phone or text using auto-dialer or prerecorded message. ☐ Yes ☐ No

BSC follows TCPA guidelines and will always provide you with an option to Opt-Out at any time. https://www.blueshieldca.com/terms.

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

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)	
☐ Yes ☐ No ☐ Unknown ☐ Declined	☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Salvadoran ☐ 2 or more Ethnicities ☐ Other Hispanic, Latino, Spanish: _____	☐ 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

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? ☐ Yes ☐ No
Name of dental provider:	Dental provider number:	Existing patient? ☐ Yes ☐ No

Section 4 – Dependent spouse/domestic partner/children information

If you, your spouse/domestic partner, or 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:			
☐ Spouse ☐ Domestic partner ☐ Male ☐ Female _____ First MI _____ Last _____ **Social Security number** _____ Date of birth (mm/dd/yyyy)	☐ Medical ☐ Dental ☐ Vision	Doctor's name _____ First _____ Last _____ Provider number _____ IPA/medical group name _____ IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name _____ First _____ Last _____ Dental provider number Existing patient? ☐ Yes ☐ No
Communication preference ☐ Electronic ☐ Paper	**Email address (Required for electronic communications)**		

Section 4 – Dependent spouse/domestic partner/children information (continued)

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:			
☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision	Doctor's name First Last Provider number IPA/medical group name IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
Communication preference ☐ Electronic ☐ 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:			
☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision	Doctor's name First Last Provider number IPA/medical group name IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
Communication preference ☐ Electronic ☐ 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:			
☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy) Disabled? ☐ Yes ☐ No	☐ Medical ☐ Dental ☐ Vision	Doctor's name First Last Provider number IPA/medical group name IPA/medical group number Existing patient? ☐ Yes ☐ No	Dental provider name First Last Dental provider number Existing patient? ☐ Yes ☐ No
Communication preference ☐ Electronic ☐ 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 _____

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.