



Small Business subscriber change request

Effective July 1, 2025

Blue Shield of California and

Blue Shield of California Life & Health Insurance Company

All change requests must be received within 31 days of the effective date of the change. This form is used to request changes in personal information, add/cancel dependent coverage, or change plans during open enrollment. For employees requesting a new primary care physician (HMO plans), visit [blueshieldca.com](https://www.blueshieldca.com) or call Blue Shield at the number on the back of your Blue Shield member ID card.

Which changes are you making? (select all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Subscriber address | <input type="checkbox"/> Date of birth | <input type="checkbox"/> Dependent address change | <input type="checkbox"/> Date of hire |
| <input type="checkbox"/> Phone/email address change | <input type="checkbox"/> Social Security number | <input type="checkbox"/> Dependent addition coverage | <input type="checkbox"/> Waiving employee coverage |
| <input type="checkbox"/> Subscriber name change | <input type="checkbox"/> Dependent name change | <input type="checkbox"/> Effective date update | <input type="checkbox"/> Waiving dependent coverage |
| | | | <input type="checkbox"/> Plan change |

Special Enrollment Period

If you are making enrollment or coverage changes during a Special Enrollment Period, enter the qualifying event: _____

Date of qualifying event: _____

Subscriber information – All information requested in this section is required for all changes.

Enrolled employee (subscriber) name

Blue Shield subscriber ID number

Social Security number (required per CMS)

Employment status ☐ Full time (30 hrs) ☐ Part time (20-29 hrs)
☐ COBRA/Cal-COBRA beneficiary

Group/employer name

Blue Shield Group ID (from ID card)

Requested effective date

Please tell us about yourself. How would you describe your race or ethnicity? These race and ethnicity 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)

- | | |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Korean |
| <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Laotian |
| <input type="checkbox"/> Black or African American | <input type="checkbox"/> Native Hawaiian |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Samoan |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> White |
| <input type="checkbox"/> Guamanian or Chamorro | <input type="checkbox"/> 2 or more Races |
| <input type="checkbox"/> Hmong | <input type="checkbox"/> Other |
| <input type="checkbox"/> Japanese | <input type="checkbox"/> Unknown |
| | <input type="checkbox"/> Declined |

Member information update

Address change

Please complete this section to update your address. Include both your full previous address and full new address. HMO plans: If you have moved outside your primary care physician's service area, you will need to change your primary care physician. Visit [blueshieldca.com](https://www.blueshieldca.com), or call Blue Shield at the number on your ID card for more information.

Old address

City

State

ZIP code

County

New address

City

State

ZIP code

County

Dependent name (if address change is applicable for dependent only):

Phone/email address change

Please complete this section to update your phone or email address information with Blue Shield.

Old phone number

- ☐ Cell
☐ Landline

Old email address

New phone number

- ☐ Cell
☐ Landline

New email address

Subscriber name	Subscriber ID number	Group/employer name
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Employee name change – documentation may be required

Note: A copy of court order, marriage license, driver's license, or ID card are examples of required documentation.

Prior name (first name, last name)	New name (first name, last name)
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Reason for change: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Other (please specify):	Documentation attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Date of birth correction – documentation required

Note: A copy of the driver's license, ID card, or birth certificate are examples of required documentation.

Member's name	Date of birth	Documentation attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Social Security number correction/change – documentation required

A copy of the Social Security card, letter of verification from the Social Security Office, and a written statement explaining the reason for the change are examples of required documentation.

Old Social Security number	New Social Security number	Documentation attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Member eligibility changes**Dependent addition of coverage**

Please complete this section to add a spouse, domestic partner, or dependent child to the employee's coverage. Please copy and attach additional pages as needed if adding multiple dependents. The request must be received within the time frame allowed per the qualifying event, or during the group's open enrollment period. Documentation may be required to verify the date of the qualifying event, including for loss of coverage, adoption, or court-ordered coverage. A completed **Refusal of Coverage (C19927)** is required for any dependent that is refusing coverage under the plan.

Note: Social Security number is required per CMS.

Dependent 1

Relationship to employee <input type="checkbox"/> Dependent child <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Dependent child: legal guardianship	Reason for addition <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Court order* <input type="checkbox"/> Marriage	<input type="checkbox"/> Domestic partnership <input type="checkbox"/> Loss of coverage <input type="checkbox"/> Open enrollment <input type="checkbox"/> Other qualifying event (specify)
* Court order required.		Qualifying event date:
Social Security number	Date of birth	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

Which race does this dependent identify with?

Which ethnicity does this dependent identify with?

First name	MI	Last name	Suffix
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Address (if different from employee)	City	State	ZIP code
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Was the dependent covered under another health insurance plan within the past 12 months? ☐ Yes ☐ No

If yes, please specify carrier and plan name, start and end dates of coverage:

Carrier and plan name:	to		
HMO provider name	HMO provider number	IPA/MG name	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dental HMO provider name	Dental HMO provider number		Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Enrolling in same products selected by subscriber? ☐ Yes ☐ No If no, please attach completed Refusal of Coverage form.

Subscriber name	Subscriber ID number	Group/employer name
Dependent 2		
Relationship to employee <input type="checkbox"/> Dependent child <input type="checkbox"/> Spouse/domestic partner <input type="checkbox"/> Dependent child: legal guardianship	Reason for addition <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption <input type="checkbox"/> Court order* <input type="checkbox"/> Marriage	<input type="checkbox"/> Domestic partnership <input type="checkbox"/> Loss of coverage <input type="checkbox"/> Open enrollment <input type="checkbox"/> Other qualifying event (specify) _____
* Court order required.		Qualifying event date: _____

Social Security number	Date of birth	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
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Which race does this dependent identify with?

Which ethnicity does this dependent identify with?

First name	MI	Last name	Suffix
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Address (if different from employee)	City	State	ZIP code
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Was the dependent covered under another health insurance plan within the past 12 months? ☐ Yes ☐ No
If yes, please specify carrier and plan name, start and end dates of coverage:

Carrier and plan name: _____ to _____

HMO provider name	HMO provider number	IPA/MG name	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Dental HMO provider name	Dental HMO provider number	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Enrolling in same products selected by subscriber? ☐ Yes ☐ No If no, please attach completed Refusal of Coverage form.

Dependent cancellation of coverage

Please complete this section to cancel all Blue Shield coverage for a dependent spouse, domestic partner, or child due to loss of eligibility. If any dependents being cancelled remain eligible for coverage, or if coverage is being partially cancelled (not all plans), a completed Refusal of Coverage form is required for those plans being declined/cancelled.

Relationship to employee <input type="checkbox"/> Dependent child <input type="checkbox"/> Spouse/domestic partner	Reason for cancellation <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Military deployment	<input type="checkbox"/> Other insurance coverage <input type="checkbox"/> Termination of domestic partnership	Event date
Social Security number	Date of birth	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
First name	MI	Last name	Suffix
Address (if different from employee)	City	State	ZIP code

Cancel coverage for all Blue Shield plans? ☐ Yes ☐ No If no, please attach completed Refusal of Coverage form.

Relationship to employee <input type="checkbox"/> Dependent child <input type="checkbox"/> Spouse/domestic partner	Reason for cancellation <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Military deployment	<input type="checkbox"/> Other insurance coverage <input type="checkbox"/> Termination of domestic partnership	Event date
Social Security number	Date of birth	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
First name	MI	Last name	Suffix
Address (if different from employee)	City	State	ZIP code

Cancel coverage for all Blue Shield plans? ☐ Yes ☐ No If no, please attach completed Refusal of Coverage form.

Subscriber name		Subscriber ID number		Group/employer name	
Relationship to employee <input type="checkbox"/> Dependent child <input type="checkbox"/> Spouse/domestic partner		Reason for cancellation <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Military deployment		<input type="checkbox"/> Other insurance coverage <input type="checkbox"/> Termination of domestic partnership	
Social Security number		Date of birth		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
First name		MI	Last name		Suffix
Address (if different from employee)			City	State	ZIP code
Cancel coverage for all Blue Shield plans? <input type="checkbox"/> Yes <input type="checkbox"/> No			If no, please attach completed Refusal of Coverage form.		

Plan changes

Plan change request

Please indicate the requested changes to coverage through an annual or special open enrollment period by completing all sections below for medical plan and specialty plan options.

Medical benefit plans: Please check with your employer to determine the benefit plans available to you. ☐ **No change to medical benefits.**

Blue Shield of California Off-Exchange Package Plans

PPO plans – Full PPO Network

- | | |
|---|---|
| <input type="checkbox"/> Platinum Full PPO 0/0 OffEx | <input type="checkbox"/> Silver Full PPO 1700/60 OffEx |
| <input type="checkbox"/> Platinum Full PPO 0/10 OffEx | <input type="checkbox"/> Silver Full PPO 2100/65 OffEx* |
| <input type="checkbox"/> Platinum Full PPO 250/10 OffEx | <input type="checkbox"/> Silver Full PPO 2350/70 OffEx |
| <input type="checkbox"/> Platinum Full PPO 250/15 OffEx | <input type="checkbox"/> Bronze Full PPO 4500/65 OffEx |
| <input type="checkbox"/> Gold Full PPO 0/35 OffEx | <input type="checkbox"/> Bronze Full PPO 6250/65 OffEx |
| <input type="checkbox"/> Gold Full PPO 500/30 OffEx | <input type="checkbox"/> Bronze Full PPO 6500/70 OffEx |
| <input type="checkbox"/> Gold Full PPO 750/30 OffEx | <input type="checkbox"/> Bronze Full PPO 6850/55 OffEx |
| <input type="checkbox"/> Gold Full PPO 1000/30 OffEx | <input type="checkbox"/> Bronze Full PPO 7500/65 OffEx |

HSA-compatible HDHP plans – Full PPO Network

- ☐ Gold Full PPO Savings 1750/15% HDHP PrevRx OffEx
☐ Silver Full PPO Savings 2300/30% OffEx
☐ Silver Full PPO Savings 2600/35% HDHP PrevRx OffEx
☐ Bronze Full PPO Savings 5700/40% OffEx
☐ Bronze Full PPO Savings 7500 OffEx

HSA-compatible HDHP plans – Tandem PPO Network

- ☐ Gold Tandem PPO Savings 1750/15% HDHP PrevRx OffEx
☐ Silver Tandem PPO Savings 2300/30% OffEx
☐ Silver Tandem PPO Savings 2600/35% HDHP PrevRx OffEx
☐ Bronze Tandem PPO Savings 5700/40% OffEx
☐ Bronze Tandem PPO Savings 7500 OffEx

Tandem PPO plans – Tandem PPO Network

- | | |
|--|---|
| <input type="checkbox"/> Platinum Tandem PPO 0/0 OffEx | <input type="checkbox"/> Silver Tandem PPO 1700/60 OffEx |
| <input type="checkbox"/> Platinum Tandem PPO 0/10 OffEx | <input type="checkbox"/> Silver Tandem PPO 2100/65 OffEx* |
| <input type="checkbox"/> Platinum Tandem PPO 250/10 OffEx | <input type="checkbox"/> Silver Tandem PPO 2350/70 OffEx |
| <input type="checkbox"/> Platinum Tandem PPO 250/15 OffEx | <input type="checkbox"/> Virtual Blue SM Silver Tandem PPO 2700/75 OffEx |
| <input type="checkbox"/> Virtual Blue SM Platinum Tandem PPO 250/20 OffEx | <input type="checkbox"/> Bronze Tandem PPO 4500/65 OffEx |
| <input type="checkbox"/> Gold Tandem PPO 0/35 OffEx | <input type="checkbox"/> Bronze Tandem PPO 6250/65 OffEx |
| <input type="checkbox"/> Gold Tandem PPO 500/30 OffEx | <input type="checkbox"/> Bronze Tandem PPO 6500/70 OffEx |
| <input type="checkbox"/> Gold Tandem PPO 750/30 OffEx | <input type="checkbox"/> Bronze Tandem PPO 6850/55 OffEx |
| <input type="checkbox"/> Gold Tandem PPO 1000/30 OffEx | <input type="checkbox"/> Bronze Tandem PPO 7500/65 OffEx |
| <input type="checkbox"/> Virtual Blue SM Gold Tandem PPO 1500/45 OffEx | <input type="checkbox"/> Virtual Blue SM Bronze Tandem PPO 7500/75 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[®] 0/35 OffEx
☐ Gold Access+ HMO[®] 500/35 OffEx
☐ Gold Access+ HMO[®] 1000/35 OffEx
☐ Gold Access+ HMO[®] 1500/35 OffEx
☐ Silver Access+ HMO[®] 2300/70 OffEx
☐ Silver Access+ HMO[®] 2750/70 OffEx
☐ Bronze Access+ HMO[®] 7000/70 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[®] 0/35 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[®] 2300/70 OffEx
☐ Silver Local Access+ HMO[®] 2750/70 OffEx
☐ Bronze Local Access+ HMO[®] 7000/70 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 0/35 OffEx
☐ Gold Trio HMO 500/35 OffEx
☐ Gold Trio HMO 1000/35 OffEx
☐ Gold Trio HMO 1500/35 OffEx
☐ Silver Trio HMO 2300/70 OffEx
☐ Silver Trio HMO 2750/70 OffEx
☐ Bronze Trio HMO 7000/70 OffEx

Blue Shield of California Mirror Package Plans

- | | |
|---|--|
| <input type="checkbox"/> Blue Shield Platinum 90 PPO 0/15 PCP + Child Dental | <input type="checkbox"/> Blue Shield Access+ Gold 80 HMO [®] 250/35 PCP + Child Dental |
| <input type="checkbox"/> Blue Shield Gold 80 PPO 350/25 PCP + Child Dental | <input type="checkbox"/> Blue Shield Access+ Silver 70 HMO [®] 2500/55 PCP + Child Dental |
| <input type="checkbox"/> Blue Shield Silver 70 PPO 2500/55 PCP + Child Dental | <input type="checkbox"/> Blue Shield Trio Platinum 90 HMO 0/20 PCP + Child Dental |
| <input type="checkbox"/> Blue Shield Bronze 60 PPO 5800/60 PCP + Child Dental | <input type="checkbox"/> Blue Shield Trio Gold 80 HMO 250/35 PCP + Child Dental |
| <input type="checkbox"/> Blue Shield Silver 70 HDHP PPO 2300/30% PCP + Child Dental Alt | <input type="checkbox"/> Blue Shield Trio Silver 70 HMO 2500/55 PCP + Child Dental |
| <input type="checkbox"/> Blue Shield Bronze 60 HDHP PPO 7500/0% PCP + Child Dental Alt | <input type="checkbox"/> Blue Shield Trio Bronze 60 HMO 7000/70 PCP + Child Dental Alt |
| <input type="checkbox"/> Blue Shield Access+ Platinum 90 HMO [®] 0/20 PCP + Child Dental | |

* The Silver Full PPO 2100/65 OffEx and Silver Tandem PPO 2100/65 OffEx offer enhanced coverage for members diagnosed with diabetes, asthma, COPD, and CAD.

Specialty benefit plans – 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 one dental plan (Section SB1) and/or one vision plan (Section SB2) if offered by your employer.
Complete Section SB3 for Life/AD&D insurance if offered by your employer.

Section SB1 – Dental coverage

Dental HMO plans

☐ DHMO Basic ☐ DHMO Standard ☐ DHMO Plus ☐ DHMO Deluxe ☐ DHMO Voluntary†

Dental PPO plans

<input type="checkbox"/> Bronze DPPO/\$1000/MAC	<input type="checkbox"/> Gold DPPO/\$1500/U90/Adult+Child Ortho
<input type="checkbox"/> Bronze DPPO/\$1000/MAC/Child Only Ortho	<input type="checkbox"/> Gold DPPO/\$2000/U90
<input type="checkbox"/> Bronze DPPO/\$1500/MAC	<input type="checkbox"/> Gold DPPO/\$2000/U90/Adult+Child Ortho
<input type="checkbox"/> Bronze DPPO/\$1500/MAC/Child Only Ortho	<input type="checkbox"/> Platinum DPPO/\$2500/U90
<input type="checkbox"/> Silver DPPO/\$1500/MAC	<input type="checkbox"/> Platinum DPPO/\$2500/U90/Adult+Child Ortho
<input type="checkbox"/> Silver DPPO/\$1500/MAC/Adult+Child Ortho	<input type="checkbox"/> Platinum DPPO/\$3000/U90
<input type="checkbox"/> Silver DPPO/\$1500/U90	<input type="checkbox"/> Platinum DPPO/\$3000/U90/Adult+Child Ortho
<input type="checkbox"/> Silver DPPO/\$1500/U90/Adult+Child Ortho	<input type="checkbox"/> Platinum DPPO/\$5000/U90
<input type="checkbox"/> Gold DPPO/\$1500/MAC	<input type="checkbox"/> Platinum DPPO/\$5000/U90/Adult+Child Ortho
<input type="checkbox"/> Gold DPPO/\$1500/MAC/Adult+Child Ortho	<input type="checkbox"/> Diamond DPPO/\$3000/U95
<input type="checkbox"/> Gold DPPO/\$2000/MAC	<input type="checkbox"/> Diamond DPPO/\$3000/U95/Adult+Child Ortho
<input type="checkbox"/> Gold DPPO/\$2000/MAC/Adult+Child Ortho	<input type="checkbox"/> Diamond DPPO/\$5000/U95
<input type="checkbox"/> Gold DPPO/\$1500/U90	<input type="checkbox"/> Diamond DPPO/\$5000/U95/Adult+Child Ortho

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

<input type="checkbox"/> Smile SM Value 50/1500/No Ortho/MAC/NR	<input type="checkbox"/> Smile SM Plus Gold 50/1500/Ortho/U80
<input type="checkbox"/> Smile SM 50/1500/No Ortho/MAC/NR	<input type="checkbox"/> Smile SM Plus Gold 50/2500/Ortho/U90/ADV
<input type="checkbox"/> Smile SM Plus 50/1500/Ortho/MAC/NR	<input type="checkbox"/> Smile SM Plus Gold 50/2500/No Ortho/U90/ADV
<input type="checkbox"/> Smile SM Basic 75/1000/No Ortho/MAC/NR	<input type="checkbox"/> Ultimate Dental PPO for Small Business 50/2000/No Ortho/U90
<input type="checkbox"/> Smile SM Basic 50/1000/No Ortho/MAC	
<input type="checkbox"/> Smile SM Plus 50/1500/No Ortho/MAC/WP	
<input type="checkbox"/> Smile SM Deluxe 50/1500/Ortho/MAC/NR	

Voluntary Dental PPO plans**

<input type="checkbox"/> Bronze Voluntary DPPO/\$1000/MAC	<input type="checkbox"/> Bronze Voluntary DPPO/\$1000/MAC/Child Only Ortho
<input type="checkbox"/> Bronze Voluntary DPPO/\$1500/MAC	<input type="checkbox"/> Bronze Voluntary DPPO/\$1500/MAC/Child Only Ortho

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

<input type="checkbox"/> Smile SM Basic Voluntary 75/1000/No Ortho/MAC/NR	<input type="checkbox"/> Smile SM Basic Voluntary 50/1500/Ortho/U80
<input type="checkbox"/> Smile SM Basic Voluntary 50/1000/No Ortho/MAC	<input type="checkbox"/> Smile SM 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)

☐ SmileSM INO Dental Plan 50/1500/Endo-Perio 80%/Ortho
☐ SmileSM INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho

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

<input type="checkbox"/> Smile SM Deluxe Gold 50/1500/Ortho/U85	<input type="checkbox"/> Smile SM Value 50/1500/No Ortho/MAC
<input type="checkbox"/> Smile SM Plus 50/1500/Ortho/MAC	<input type="checkbox"/> Smile SM Basic 75/1000/No Ortho/MAC
	<input type="checkbox"/> Smile SM Basic Voluntary 75/1000/No Ortho/MAC**

† 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.

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

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

All voluntary dental plans require a minimum of one (1) enrolling, eligible employee.

Subscriber name	Subscriber ID number	Group/employer name
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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 10/25/150¹

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 10/25/120¹

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 10/25/120¹

☐ 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*

Employee information

Full-time employment date	Average hours worked per week	Earnings \$ _____ (excluding overtime, bonuses, etc.)
Rehire date	Class/occupation**	<input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year

**Job classification is required when your employer offers life insurance that is based on job classifications.

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
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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.

First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits
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Address	City	State	ZIP code
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First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits
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Address	City	State	ZIP code
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Subscriber name		Subscriber ID number	Group/employer name		
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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
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Address	City	State	ZIP code
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Employee and dependent 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): \$ _____
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Number of eligible dependents: _____	Basic Dependent Life Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No
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* Underwritten by Blue Shield of California Life & Health Insurance Company.

If transferring to medical HMO and/or dental HMO plan(s), provide primary care physician/dental provider information below.*

Please complete this section for the subscriber and all of their dependents if they have a preferred provider. If no provider is received, a provider will be assigned for each member enrolled.

Last name	MI	First name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth
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HMO provider name	HMO provider number	Independent Practice Association/medical group	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Dental HMO provider name	Dental HMO provider number	Dental group name	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Last name	MI	First name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth
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HMO provider name	HMO provider number	Independent Practice Association/medical group	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Dental HMO provider name	Dental HMO provider number	Dental group name	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Last name	MI	First name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth
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HMO provider name	HMO provider number	Independent Practice Association/medical group	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Dental HMO provider name	Dental HMO provider number	Dental group name	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Last name	MI	First name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth
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HMO provider name	HMO provider number	Independent Practice Association/medical group	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Dental HMO provider name	Dental HMO provider number	Dental group name	Current patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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* 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 at random. HMO primary care physicians can be changed by visiting [blueshieldca.com](https://www.blueshieldca.com) after enrollment.

Subscriber name

Subscriber ID number

Group/employer name

Acknowledgement and signature

I acknowledge and agree: All information I have provided on this form is accurate and complete to the best of my knowledge and belief. I understand that this form, along with any prior enrollment form, the *Evidence of Coverage (EOC)/Certificate of Insurance* and Health Service Agreement/Policy, and any endorsements and attachments thereto, collectively constitutes the entire agreement for coverage.

If you are enrolling yourself or dependents or making coverage changes during a Special Enrollment Period, you are attesting that you and/or the dependent enrolling has experienced one of the triggering events in the *Evidence of Coverage (EOC)* and that proof of this event is available upon request.

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.

Signature of employee _____ Date _____

Print employee name _____

Keep a copy of this document for your files.

Blue Shield of California protects the privacy of your personal information, including your individually identifiable health information. We will not disclose your personal information without your authorization, except as permitted or required by law.

To obtain a copy of Blue Shield's Notice of Privacy Practices, call the customer service number on your Blue Shield member ID card or visit our website at blueshieldca.com/privacy.

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