blue shield of california

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® 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 _____ ☐ Virtual Blue℠ _____ ☐ Tandem PPO Savings† _____
☐ Tandem EPO _____ ☐ Blue Shield 65 Plus℠ (HMO) _____

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

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
Virtual Blue℠: ☐ 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 _____ ☐ 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 _____

Section 3 – Employee information

Social Security number or Taxpayer Identification 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 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.

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:

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**
☐ Spouse ☐ Domestic partner ☐ Male ☐ Female First MI Last **Social Security number or Taxpayer Identification 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)**		

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
☐ Male ☐ Female First MI Last **Social Security number or Taxpayer Identification 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
☐ Male ☐ Female First MI Last **Social Security number or Taxpayer Identification 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
☐ Male ☐ Female First MI Last **Social Security number or Taxpayer Identification 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 – 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.