Employee Enrollment Form

Group Sales: Tel: 1-888-371-3060 I Fax: 1-415-955-8819

Balance by CCHP will provide translation or other language assistance free of charge in completing the application. The application, together with the Disclosure Form/Evidence of Coverage ("Agreement") constitutes the plan contract, and that applicants may request a copy of the Agreement prior to enrollment to learn the terms and conditions of the plan contract.

Employer Group Information

Employer (Group) Name:		Group Number:
Requested Effective Date (MM/DD/YY): / /	Date of Hire (MM/DD/YY): / /	Employment Status: ☐ Full-time ☐ Part-time

Reason for Application:

☐ New Group ☐ Open Enrollment ☐ New Hire ☐ Add Dependent(s)

☐ Employee Status Change, Reason _____ ☐ Other Enrollment, Reason _____

Employer Group Plan Coverage Selection

Medical Plans ☐ Ruby[10] HMO Platinum ☐ Ruby[20] HMO Platinum ☐ Ruby[40] HMO Platinum ☐ Opal[25] HMO Gold ☐ Opal[50] HMO Silver

☐ Platinum[90] HMO ☐ Gold[80] HMO ☐ Silver[70] HMO ☐ Bronze[60] HMO ☐ Bronze[60] HDHP HMO

Optional Riders (Applies to all Balance Enrollees) ☐ Adult Vision (VSP) ☐ Adult Dental (Delta) ☐ Other _____

Note(s) (Balance Use Only):

1. Employee Information

Last Name:	First Name:	M.I.:
Marital Status ☐ Single ☐ Married ☐ Domestic Partner	Date of Birth (MM/DD/YY):	SSN:
Email:	Cell Phone:	Home Telephone:

Home Address, City, State, ZIP (No P.O. Box):

Mailing Address, City, State, ZIP (if different than home address):

Primary Care Physician (PCP):	Medical Group: *(Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

One Medical ☐ YES, I want to JOIN One Medical. **If 'YES' we will assign you a PCP. You are free to change if you decide later.**

What is your race? (Check all that apply)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander
☐ White/Caucasian
☐ Other, please specify: _____
☐ Unknown
☐ Decline to state

What is your ethnicity? (Check all that apply)

☐ African American
☐ American
☐ Arab
☐ Asian Indian
☐ Black
☐ Chinese
☐ European
☐ Filipino
☐ Hispanic/Latino
☐ Iranian
☐ Korean
☐ Latin American
☐ Mexican
☐ Russian
☐ Vietnamese
☐ Other, please specify: _____
☐ Unknown
☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify:
☐	☐	Chinese (Written) / Cantonese (Spoken)	☐	☐	Polish			
☐	☐	Chinese (Written / Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Unknown
☐	☐	English	☐	☐	Russian	☐	☐	Decline to state
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your preferred pronoun?

☐ He/Him/His ☐ She/Her/Hers	☐ They/Them/Their ☐ Ze/Zir/Zirs	☐ No pronoun ☐ Other, please specify: _____	☐ Decline to state

What is your current gender identity?

☐ Female ☐ Male ☐ Transgender male/ trans man/ female-to-male (FTM) ☐ Transgender female/ trans woman/ male-to-female (MTF) ☐ Genderqueer (neither exclusively male nor female)	☐ Additional gender category or other, please specify: _____ ☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual	☐ Something else, please describe: _____ ☐ Do not know ☐ Decline to state

2. Dependent(s) to be covered or added

☐ **Spouse** ☐ **Domestic Partner**	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY):		SSN:	
Primary Care Physician (PCP) (*Required for HMO Plans Only*):		Medical Group: *(Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander	☐ White/Caucasian ☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your ethnicity? (Check all that apply)

☐ African American ☐ American ☐ Arab ☐ Asian Indian ☐ Black	☐ Chinese ☐ European ☐ Filipino ☐ Hispanic/Latino ☐ Iranian	☐ Korean ☐ Latin American ☐ Mexican ☐ Russian ☐ Vietnamese	☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify:
☐	☐	Chinese (Written)/Cantonese (Spoken)	☐	☐	Polish			
☐	☐	Chinese (Written /Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Unknown
☐	☐	English	☐	☐	Russian	☐	☐	Decline to state
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your preferred pronoun?

☐ He/Him/His ☐ She/Her/Hers	☐ They/Them/Their ☐ Ze/Zir/Zirs	☐ No pronoun ☐ Other, please specify: _____	☐ Decline to state

What is your current gender identity?

☐ Female ☐ Male ☐ Transgender male/ trans man/ female-to-male (FTM) ☐ Transgender female/ trans woman/ male-to-female (MTF) ☐ Genderqueer (neither exclusively male nor female)	☐ Additional gender category or other, please specify: _____ ☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual	☐ Something else, please describe: _____ ☐ Do not know ☐ Decline to state

Dependent # 1	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY):		SSN:	
Primary Care Physician (PCP):		Medical Group: *(Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander	☐ White/Caucasian ☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your ethnicity? (Check all that apply)

☐ African American ☐ American ☐ Arab ☐ Asian Indian ☐ Black	☐ Chinese ☐ European ☐ Filipino ☐ Hispanic/Latino ☐ Iranian	☐ Korean ☐ Latin American ☐ Mexican ☐ Russian ☐ Vietnamese	☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify:
☐	☐	Chinese (Written)/Cantonese (Spoken)	☐	☐	Polish			
☐	☐	Chinese (Written /Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Unknown
☐	☐	English	☐	☐	Russian	☐	☐	Decline to state
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your preferred pronoun?

☐ He/Him/His ☐ She/Her/Hers	☐ They/Them/Their ☐ Ze/Zir/Zirs	☐ No pronoun ☐ Other, please specify: _____	☐ Decline to state

What is your current gender identity?

☐ Female ☐ Male ☐ Transgender male/ trans man/ female-to-male (FTM) ☐ Transgender female/ trans woman/ male-to-female (MTF) ☐ Genderqueer (neither exclusively male nor female)	☐ Additional gender category or other, please specify: _____ ☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual	☐ Something else, please describe: _____ ☐ Do not know ☐ Decline to state

Dependent # 2	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY):		SSN:	
Primary Care Physician (PCP):		Medical Group: *(Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander	☐ White/Caucasian ☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your ethnicity? (Check all that apply)

☐ African American ☐ American ☐ Arab ☐ Asian Indian ☐ Black	☐ Chinese ☐ European ☐ Filipino ☐ Hispanic/Latino ☐ Iranian	☐ Korean ☐ Latin American ☐ Mexican ☐ Russian ☐ Vietnamese	☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify:
☐	☐	Chinese (Written)/Cantonese (Spoken)	☐	☐	Polish			_____
☐	☐	Chinese (Written /Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Unknown
☐	☐	English	☐	☐	Russian	☐	☐	Decline to state
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your preferred pronoun?

☐ He/Him/His ☐ She/Her/Hers	☐ They/Them/Their ☐ Ze/Zir/Zirs	☐ No pronoun ☐ Other, please specify: _____	☐ Decline to state

What is your current gender identity?

☐ Female
☐ Male
☐ Transgender male/ trans man/ female-to-male (FTM)
☐ Transgender female/ trans woman/ male-to-female (MTF)
☐ Genderqueer (neither exclusively male nor female)

☐ Additional gender category or other, please specify: _____
☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual
☐ Straight or heterosexual
☐ Bisexual

☐ Something else, please describe: _____
☐ Do not know
☐ Decline to state

Dependent # 3	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY):		SSN:	
Primary Care Physician (PCP):		Medical Group: *(Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander

☐ White/Caucasian
☐ Other, please specify: _____
☐ Unknown
☐ Decline to state

What is your ethnicity? (Check all that apply)

☐ African American
☐ American
☐ Arab
☐ Asian Indian
☐ Black

☐ Chinese
☐ European
☐ Filipino
☐ Hispanic/Latino
☐ Iranian

☐ Korean
☐ Latin American
☐ Mexican
☐ Russian
☐ Vietnamese

☐ Other, please specify: _____
☐ Unknown
☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)
☐	☐	Arabic
☐	☐	Bulgarian
☐	☐	Chinese (Written)/Cantonese (Spoken)
☐	☐	Chinese (Written /Mandarin (Spoken)
☐	☐	English
☐	☐	Korean

WRITTEN	SPOKEN	
☐	☐	Khmer
☐	☐	Laotian
☐	☐	Persian
☐	☐	Polish
☐	☐	Punjabi
☐	☐	Russian
☐	☐	Spanish

WRITTEN	SPOKEN	
☐	☐	Tagalog
☐	☐	Vietnamese
☐	☐	Other, please specify: _____
☐	☐	Unknown
☐	☐	Decline to state

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your preferred pronoun?

☐ He/Him/His
☐ She/Her/Hers

☐ They/Them/Their
☐ Ze/Zir/Zirs

☐ No pronoun
☐ Other, please specify: _____

☐ Decline to state

What is your current gender identity?

☐ Female
☐ Male
☐ Transgender male/ trans man/ female-to-male (FTM)
☐ Transgender female/ trans woman/ male-to-female (MTF)
☐ Genderqueer (neither exclusively male nor female)

☐ Additional gender category or other, please specify: _____
☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual	☐ Something else, please describe: _____ ☐ Do not know ☐ Decline to state

Dependent # 4	Last Name:	First Name:	M.I.:
Date of Birth (MM/DD/YY):		SSN:	
Primary Care Physician (PCP):		Medical Group: *(Leave blank if not known)*	Existing Patient? ☐ Yes ☐ No

What is your race? (Check all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Native Hawaiian or Other Pacific Islander	☐ White/Caucasian ☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your ethnicity? (Check all that apply)

☐ African American ☐ American ☐ Arab ☐ Asian Indian ☐ Black	☐ Chinese ☐ European ☐ Filipino ☐ Hispanic/Latino ☐ Iranian	☐ Korean ☐ Latin American ☐ Mexican ☐ Russian	☐ Vietnamese ☐ Other, please specify: _____ ☐ Unknown ☐ Decline to state

What is your preferred language for health care?

WRITTEN	SPOKEN		WRITTEN	SPOKEN		WRITTEN	SPOKEN	
	☐	American Sign Language (ASL)	☐	☐	Khmer	☐	☐	Tagalog
☐	☐	Arabic	☐	☐	Laotian	☐	☐	Vietnamese
☐	☐	Bulgarian	☐	☐	Persian	☐	☐	Other, please specify:
☐	☐	Chinese (Written)/Cantonese (Spoken)	☐	☐	Polish			_____
☐	☐	Chinese (Written /Mandarin (Spoken)	☐	☐	Punjabi	☐	☐	Unknown
☐	☐	English	☐	☐	Russian	☐	☐	Decline to state
☐	☐	Korean	☐	☐	Spanish			

What is your assigned sex at birth?

☐ Female ☐ Male ☐ Unknown ☐ Decline to state

What is your preferred pronoun?

☐ He/Him/His ☐ She/Her/Hers	☐ They/Them/Their ☐ Ze/Zir/Zirs	☐ No pronoun ☐ Other, please specify: _____	☐ Decline to state

What is your current gender identity?

☐ Female ☐ Male ☐ Transgender male/ trans man/ female-to-male (FTM) ☐ Transgender female/ trans woman/ male-to-female (MTF) ☐ Genderqueer (neither exclusively male nor female)	☐ Additional gender category or other, please specify: _____ ☐ Decline to state

What is your sexual orientation?

☐ Lesbian or gay or homosexual ☐ Straight or heterosexual ☐ Bisexual	☐ Something else, please describe: _____ ☐ Do not know ☐ Decline to state

3. Medicare Information

Is any person applying for coverage currently enrolled with Medicare?

☐ No ☐ Yes, please attach a copy of your Medicare card(s) & Name: _____

4. Disclosure of Personal and Health Information

Balance understands the importance of keeping your and your dependents' personal and health information private. Balance protects this information in electronic, written, and oral forms when used throughout our company. Balance will not disclose this information without your authorization except as permitted by law.
For the purpose of administering your Balance coverage, Balance is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, Balance is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.
A complete explanation of Balance policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing Balance's website.

5. Arbitration Agreement

I understand that (except for Small Claims cases) any and all disputes, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), which may arise under the agreement between me and Balance and any of this affiliates shall be determined by submission to binding arbitration as provided by California law. Any such dispute will not be resolved by a lawsuit or resort to court process except as applicable law provides for judicial review of arbitration proceedings. ALL PARTIES TO THIS CONTRACT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION. For more information regarding binding arbitration, please refer to your Evidence of Coverage.

Employee Signature X	Employee Name:	Date (MM/DD/YY):
Signature of Employer/Authorized Representative: X	Employer/Authorized Representative Name & Title:	Date (MM/DD/YY):

Privacy Protection of Data

CCHP and Balance by CCHP are required to comply with various State and Federal laws to protect, secure, retain, and maintain confidentiality of your sensitive and personal information. These laws include**, but not limited to**, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Centers for Medicare and Medicaid Services (CMS), and the California Consumer Privacy Act (CCPA). Balance has put in place policies and procedures to ensure that access to or use of your personal information is secure.

Policies and processes include standards on how Balance manages access to and the utilization of identified race, ethnicity, preferred language, gender identity and sexual orientation information collected for current or prospective health plan members. Balance discloses its procedures for managing access to and the use of collected race, ethnicity, preferred language, gender identity and sexual information at a minimum, at the time of data collection and on Balance's website Compliance Privacy page at balancebycchp.com/confidentiality-and-compliance-notice/. For questions on these policies, please call the Balance Compliant Hotline at 415-955-8810 or email to CCHPComplianceDept@cchphealthplan.com.