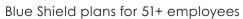
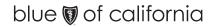
Employee Enrollment Application





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

*Please note: Failure to legibly fill out enrollment application completely may result in a delay in the enrollment process.

Reason for application:					
☐ New hire	Loss of coverage date/	/	enrollment		
Re-hire date// Dpen enrollment		☐ Othe	r qualifying event type		
		Date	above event occurred//		
Section 1 – Important en	rollment guidelines fo	or Specialty Benefits	s coverage		
dependent to enroll in a dental or vis All of an employee's dependents enr dependent life insurance coverage. An employee must enroll in basic life domestic partner and child(ren) in sup	sion plan, the employee must be olled in the health plan will auto insurance to be eligible to enroll plemental life insurance — only in all life insurance coverage, if ar	enrolled in the same dental omatically be enrolled in the in supplemental life insuran f supplemental dependent life employer contributes 100%	plan without enrolling in a health plan. In or vision plan. Dependent Life Insurance plan if the empose coverage. The employee may also enroll e insurance is offered by the employer. Covof the premium, then 100% of eligible empose.	oloyer offers I their spouse/ verage may be	
Plans for 51+ employees		Specialty Benefits			
Access+ HMO SaveNet Local Access+ HMO Added Advantage POS Access Baja HMO Active Choice¹		☐ Dependent Basic Li ☐ Supplemental Life a ☐ Dental PPO ☐ Dental INO¹²² ☐ Dental HMO ☐ Vision ☐ Other 1 Underwritten by Blue Shield 2 Pending regulatory approval 3 Shield PPO Savings Plus an	ID insurance¹ fe insurance¹ and AD&D Insurance¹ and AD&D Insurance¹ I of California Life & Health Insurance Company te HSA-eligible high-deductible health plans. fer tax advice, but we do offer HSAs, HRAs, HI.	y (Blue Shield Life).	
Section 3 – Employee inf	ormation	·	Internal use only. Do not write in shaded area.		
Social Security number	Employer (group) name	Department code	Group number	BU	
Last name	First name	MI	Effective date		
Employment status:			Job title/classification		
Full Time Part Time	Retiree Date of Hire: _				
Home address – (street, city, state,	, ZIP)		Basic Life/AD&D insurance a	Basic Life/AD&D insurance amount:	
Mailing address (if different than ho	me address)		Supp. Life/AD&D insurance a	Supp. Life/AD&D insurance amount:	
(Home phone number)	E-mail address	,	How would you prefer we contact you? E-mail Standard mail Telephone		
Date of birth//	Gender Ma	ale Female Marital	status Single Married Do	mestic partner	
Language preference: English	`	tnamese Other			
Are you enrolling your spouse/do		donondonto Voc	No Idamo accomplate Continuo af a		
			No If yes, complete Section 3 of a	pplication.	
HMO Provider Information: Blue S				pplication.	
	Shield of California directory we			pplication.	
HMO Provider Information: Blue S	Shield of California directory we): IPA/			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 Personal Coverage Form.

Dependent's address, if different from employee – please indicate which dependent(s) this applies to:

Enrolling Spouse/Domestic Partner information	Enroll in (please check all that apply)	Access+ HMO and Added Advantage POS only – name of Personal Physician	Dental HMO only – dental provider	
Spouse Domestic partner		Doctor's name	Dental provider name	
Male Female		(First)	First	
First (MI)	☐ Medical	Last	Last	
Last	☐ Dental☐ Vision	Provider number	Dental provider number	
Social Security number		IPA/MG number		
Date of birth (mm/dd/yyyy)		Existing patient?	Existing patient?	
Enrolling Dependent Child(ren) information	Enroll in (please check all that apply)	Access+ HMO and Added Advantage POS only – name of Personal Physician	Dental HMO only – dental provider	
Male Female		Doctor's name	Dental provider name	
First MI	Medical Dental Vision	(First)	First	
Last		Last	Last	
Social Security number		Provider number	Dental provider number	
Date of birth (mm/dd/yyyy)		IPA/MG number		
Disabled? Yes No		Existing patient?	Existing patient? Yes No	
☐ Male ☐ Female		Doctor's name	Dental provider name	
First MI		First	First	
Last	☐ Medical	Last	Last	
Social Security number	☐ Dental ☐ Vision	Provider number	Dental provider number	
Date of birth (mm/dd/yyyy)		IPA/MG number		
Disabled? Yes No		Existing patient? Yes No	Existing patient? Yes No	
☐ Male ☐ Female		Doctor's name	Dental provider name	
First MI		First	First	
Last	☐ Medical	Last	Last	
Social Security number	Dental Vision	Provider number	Dental provider number	
Date of birth (mm/dd/yyyy)		IPA/MG number		
Disabled? Yes No		Existing patient? Yes No	Existing patient? Yes No	

Primary beneficiary – Blue Shield Life will the proceeds will be distributed equally to the					
First name		MI	Last name		
Social Security number	Relationship		% of	benefits	Date of birth
Address	<u> </u>		<u>i</u>		
City				State	ZIP code
First name		MI	Last name	:	,
Social Security number	Relationship		% of	benefits	Date of birth
Address	<u>-</u>		<u>-</u>		
City				State	ZIP code
Contingent beneficiary – Proceeds will be p	aid to a contingent benef	iciary c	only if no primary	beneficiary sur	rvives the insured.
First name		MI	Last name		
Social Security number	Relationship		% of	benefits	Date of birth
Address	<u>.</u>		<u>i</u>		2
City				State	ZIP code
Are you or any of your dependents currently coverage here: Part A: Effective date: Is Medicare eligibility due to End Stage Renal If yes, please answer the following questions: a) What was the first date of dialysis treatmonth Date Type: [b] b) If you have had a kidney transplant, what	(mm/dd/yy Disease (ESRD)? ☐ Yes nent, and what type of dia ☐ Hemo ☐ Self-dia	ryy) Par Dalysis a alysis (p	rt B: Effective No re you receiving? peritoneal)	date:/_	(mm/dd/yyyy)
Section 7 – Authorization The following authorization section is to or Blue Shield of California Life & Heal your signed authorization.	o be signed by all er	mploy	rees applying t	for coverage	e with Blue Shield of California
l agree: All information on this form is correct be issued under the plan. I understand that if I application within the first 24 months of cover the contribution (if any) required toward the coll understand that coverage does not become eff	have committed fraud or lage, my coverage may be last of this plan.	made a	n intentional mis lled, or rescinded.	representation I further autho	of any material fact in conjunction with this orize my employer to deduct from my earnings
Signature of employee					Date
Print employee name					

Section 5 – Life insurance beneficiary

Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, "Blue Shield") understand the importance of keeping your and your dependents' personal and health information private. Blue Shield protects this information in electronic, written, and oral forms when used throughout our company.

Blue Shield will not disclose this information without your authorization except as permitted by law.

For the purpose of administering your Blue Shield coverage, Blue Shield 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, Blue Shield 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 Blue Shield's 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 Blue Shield's web site.