**Small Business Employee Enrollment Form**  
**Blue Shield of California and Blue Shield of California Life & Health Insurance Company**  
**Effective January 1, 2015**

Please note: Missing information may delay processing.

### Reason for application  
- Please indicate the reason for your enrollment below:
  - ☐ New group enrollment  
    - Group effective date: ___ / ___ / ______  
  - ☐ Open enrollment  
    - Renewal date: ___ / ___ / ______  
  - ☐ New hire/rehire  
    - Date of hire/rehire: ___ / ___ / ______  
  - ☐ COBRA/Cal-COBRA enrollment  
  - ☐ New spouse/dependant  
    - Date of marriage/birth/adoption: ___ / ___ / ______
  - ☐ Other qualifying event (specify): ____________________  
    - Qualifying event date: ___ / ___ / ______

### Section 1a – Health plan selection  
Select one health plan from the package offered by your employer.

#### Blue Shield of California Off Exchange Package for Small Business
- ☐ Platinum Full PPO 0 OffEx  
- ☐ Platinum Full PPO 150 OffEx  
- ☐ Gold Full PPO 0 OffEx  
- ☐ Gold Full PPO 750 OffEx  
- ☐ Silver Full PPO 1250 OffEx  
- ☐ Silver Full PPO 1700 OffEx  
- ☐ Bronze Full PPO 4500 OffEx  
- ☐ Silver Full PPO HSA 2000 OffEx  
- ☐ Bronze Full PPO HSA 3500 OffEx  
- ☐ Bronze Full PPO HSA 5500 OffEx  
- ☐ Platinum Access+ HMO* $25 OffEx  
- ☐ Gold Access+ HMO* $30 OffEx  
- ☐ Silver Access+ HMO* $55 OffEx  
- ☐ Platinum Local Access+ HMO* $25 OffEx  
- ☐ Gold Local Access+ HMO* $30 OffEx  
- ☐ Silver Local Access+ HMO* $55 OffEx  
- **Trio ACO HMO Plans – Trio ACO HMO Network**  
  - ☐ Platinum Trio ACO HMO $25 OffEx  
  - ☐ Gold Trio ACO HMO $30 OffEx  
  - ☐ Silver Trio ACO HMO $55 OffEx

#### Blue Shield of California Mirror Package for Small Business
- ☐ Platinum 90 HMO Network 1 Mirror  
- ☐ Platinum 90 HMO Network 2 Mirror  
- ☐ Gold 80 HMO Network 1 Mirror  
- ☐ Gold 80 HMO Network 2 Mirror  
- ☐ Silver 70 HMO Network 1 Mirror  
- ☐ Silver 70 HMO Network 2 Mirror  
- ☐ Bronze 60 PPO Mirror  

#### Pediatric Dental plan* (required)
- ☐ Children’s Dental HMO Pediatric for Small Business  
- ☐ Children’s Dental PPO Pediatric for Small Business  
- ☐ Family Dental PPO Pediatric for Small Business  
- ☐ Family Dental HMO Pediatric for Small Business

* A Pediatric dental plan must be selected as it is provided with your medical plan coverage. Pursuant to state and federal law, pediatric dental coverage must be issued with health plan coverage for all enrollees (even for adults).

### Section 1b – Specialty Benefits – Dental, Vision, and Life Insurance plan selection
If your employer offers specialty benefits, please complete the attached Specialty Benefits Employee Benefit Selection Form to select specialty benefits coverage.

#### Section SB1 – Dental benefits

**Dental HMO Plans**
- ☐ DHMO Basic  
- ☐ DHMO Plus  
- ☐ DHMO Deluxe  
- ☐ DHMO Voluntary

**Dental PPO Plans**
- ☐ Ultimate Dental PPO for Small Business 50/2000  
- ☐ Ultimate Dental Plus PPO for Small Business 50/2000  
- ☐ SmileSM Deluxe 2000 50/2000/No Ortho/MAC  
- ☐ SmileSM Deluxe Plus 2000 50/2000/Ortho/MAC  
- ☐ SmileSM Deluxe 50/1500/Ortho/MAC  
- ☐ SmileSM Deluxe Gold 50/1500/Ortho/UBS

**Dental In-Network Only (INO) Plans**
- ☐ SmileSM INO Dental Plan 50/1500/Endo-Perio 80%/Ortho  
- ☐ SmileSM INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho  
- ☐ SmileSM INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/Ortho  
- ☐ SmileSM INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/No Ortho

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).
### Section SB2 – Vision coverage

**Vision coverage**

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<tbody>
<tr>
<td>Ultimate Vision Plus 0/0/150/120</td>
<td>Preferred Vision Plus 0/0/150/120</td>
<td>Enhanced Vision Plus 0/0/150/120</td>
</tr>
<tr>
<td>Ultimate Vision 0/0/150</td>
<td>Preferred Vision 0/0/150</td>
<td>Enhanced Vision 0/0/150</td>
</tr>
<tr>
<td>Ultimate Vision 15/25/150</td>
<td>Preferred Vision 15/25/150</td>
<td>Enhanced Vision 15/25/150</td>
</tr>
<tr>
<td>Ultimate Vision Voluntary 15/25/150</td>
<td>Preferred Vision Voluntary 15/25/150</td>
<td>Enhanced Vision Voluntary 15/25/150</td>
</tr>
<tr>
<td>Ultimate Vision 0/0/120</td>
<td>Preferred Vision 0/0/120</td>
<td>Enhanced Vision 0/0/120</td>
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<tr>
<td>Ultimate Vision 15/25/120</td>
<td>Preferred Vision 15/25/120</td>
<td>Enhanced Vision 15/25/120</td>
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</tbody>
</table>

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1 Voluntary vision plans require a minimum of three enrolling, eligible employees.

### Section SB3 – Life/AD&D insurance

**Group Term Life Insurance**

<table>
<thead>
<tr>
<th>Employee information</th>
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</thead>
<tbody>
<tr>
<td>Full-time employment date</td>
<td>Average hours worked per week</td>
</tr>
<tr>
<td>Earnings $ _________________ (excluding overtime, bonuses, etc.)</td>
<td>Hour</td>
</tr>
</tbody>
</table>

**Designation of beneficiary**

**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.

**Contingent beneficiary** – Proceeds will be paid to a contingent beneficiary only if no designated primary beneficiary survives the insured.

**Information on benefit amounts**

Please contact your benefits administrator for more information regarding your group life insurance coverage. Evidence of Insurability must be submitted for approval before an employee is eligible for coverage over a certain guaranteed amount or when enrolling outside of the initial eligibility period. 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.

<table>
<thead>
<tr>
<th>Social Security number</th>
<th>Relationship</th>
<th>Date of birth</th>
<th>% of benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>First name MI Last name</td>
<td>Social Security number</td>
<td>Relationship</td>
<td>Date of birth</td>
</tr>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
<td>ZIP code</td>
</tr>
</tbody>
</table>

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Please contact your benefits administrator for more information regarding your group life insurance coverage. Evidence of Insurability must be submitted for approval before an employee is eligible for coverage over a certain guaranteed amount or when enrolling outside of the initial eligibility period. 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.

<table>
<thead>
<tr>
<th>Number of eligible dependents:</th>
<th>Amount of coverage requested for dependent(s): $</th>
<th>Minimum amount of coverage is $1,000; maximum is $5,000</th>
</tr>
</thead>
</table>

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

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### Section 2 – Subscriber information

Note: Social Security numbers are required per CMS.

<table>
<thead>
<tr>
<th>Social Security number</th>
<th>Employer (group) name</th>
<th>Blue Shield Group ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last name MI First name</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Home (physical) address (no P.O. Box addresses)</th>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
</tr>
</thead>
</table>
Mailing address (if different from home address)  City  State  ZIP code

Work phone number:  Home phone number:  Language preference:
☐ English  ☐ Spanish  ☐ Chinese  ☐ Vietnamese  ☐ Other  

Email address (required)  How would you prefer we contact you? Blue Shield will use your preferred method when possible.
☐ Email  ☐ Standard mail  ☐ Telephone:  Work  Home

Date of birth:  Gender:  Marital Status:
☐ Male  ☐ Female  ☐ Single  ☐ Married  ☐ Domestic partner

Do you have any eligible dependent children under the age of 26?  ☐ Yes  ☐ No  How many?  How many are enrolling?

Employment status:
Do you actively work 30 hours or more per week for this employer? (full-time employee)  ☐ Yes  ☐ No
Do you actively work between 20 and 29 hours per week for this employer? (part-time employee)  ☐ Yes  ☐ No
If no to both of the above, are you an existing COBRA participant or enrolling due to a COBRA qualifying event?  ☐ Yes  ☐ No  If yes, proceed to Section 3.
If no, Date of hire (full time or part time if noted above)  (if orientation period is applied, the date of hire is the first day after completion of the orientation period)

Job title/classification

Section 3 – HMO Personal Physician/Dental HMO provider assignment
This section is only required if you selected an HMO plan. If you selected a PPO plan, please proceed to Section 4.

HMO plan Personal Physician selection
Would you like for Blue Shield to designate a Personal Physician for you and your dependents who is located near your home or work?
☐ Yes, I would like Blue Shield to designate a Personal Physician and/or Dental HMO provider for me and my dependents.
☐ No, I would like to request a specific Personal Physician and/or Dental HMO provider for myself and my dependents (please specify below).

* Please note: If Blue Shield is unable to assign the Personal Physician and/or Dental HMO provider you requested, Blue Shield will designate a provider. HMO Personal Physicians can be changed by visiting blueshieldca.com after enrollment.

HMO Personal Physician name  Provider number  IPA/MSG name  Existing patient?
☐ Yes  ☐ No

Dental HMO provider name  Provider number  Dental Group name  Existing patient?
☐ Yes  ☐ No

Section 4 – Dependent information
Please note: If the employee, spouse/domestic partner, or child dependent(s) are refusing coverage for any product offered by the group, the employee must complete and sign a Refusal of Personal Coverage form at the end of this application instead of completing the section below. Blue Shield will enroll dependents under all plans that the employee is also enrolled/enrolling in unless indicated otherwise.

Dependent type:  Gender:  Social Security number (required)  Enrolling in all products selected by subscriber?
☐ Spouse  ☐ Domestic partner  ☐ Male  ☐ Female  ☐ Yes  ☐ No
If no, Refusal of Coverage attached?  ☐ Yes  ☐ No

First name  MI  Last name  Suffix

Date of birth  Address (if different from employee)

HMO Personal Physician name  Provider number  IPA name  Existing patient?
☐ Yes  ☐ No

Dental HMO provider name  Provider number  Dental Group name  Existing patient?
☐ Yes  ☐ No

Dependent type:  Gender:  Social Security number (required)  Enrolling in all products selected by subscriber?
☐ Dependent child  ☐ Other dependent child: legal guardianship  ☐ Male  ☐ Female  ☐ Yes  ☐ No
If no, Refusal of Coverage attached?  ☐ Yes  ☐ No

First name  MI  Last name  Suffix

Date of birth  Address (if different from employee)

HMO Personal Physician name  Provider number  IPA name  Existing patient?
☐ Yes  ☐ No
<table>
<thead>
<tr>
<th>Subscriber's last name</th>
<th>First name</th>
<th>MI</th>
<th>Social Security number</th>
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Dental HMO provider name | Provider number | Dental Group name | Existing patient? | Yes | No |
|-------------------------|-----------------|-------------------|-------------------|-----|----|

### Dependent Information

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<thead>
<tr>
<th>Dependent type:</th>
<th>Gender:</th>
<th>Social Security number (required)</th>
<th>Enrolling in all products selected by subscriber?</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>[ ] Dependent child</td>
<td>[ ] Male</td>
<td>[ ] Female</td>
<td>[ ] Yes</td>
<td>[ ] No</td>
<td></td>
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<tr>
<td>[ ] Other dependent child: legal guardianship</td>
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<td>If no, Refusal of Coverage attached?</td>
<td>Yes</td>
<td>No</td>
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First name | MI | Last name | Suffix |
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Date of birth | Address (if different from employee) |
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HMO Personal Physician name | Provider number | IPA name | Existing patient? | Yes | No |
|---------------------------|-----------------|---------|-------------------|-----|----|

Dental HMO provider name | Provider number | Dental Group name | Existing patient? | Yes | No |
|-------------------------|-----------------|-------------------|-------------------|-----|----|

### Additional Dependent Information

<table>
<thead>
<tr>
<th>Dependent type:</th>
<th>Gender:</th>
<th>Social Security number (required)</th>
<th>Enrolling in all products selected by subscriber?</th>
<th>Yes</th>
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<td>Yes</td>
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HMO Personal Physician name | Provider number | IPA name | Existing patient? | Yes | No |
|---------------------------|-----------------|---------|-------------------|-----|----|

Dental HMO provider name | Provider number | Dental Group name | Existing patient? | Yes | No |
|-------------------------|-----------------|-------------------|-------------------|-----|----|

<table>
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<tr>
<th>Dependent type:</th>
<th>Gender:</th>
<th>Social Security number (required)</th>
<th>Enrolling in all products selected by subscriber?</th>
<th>Yes</th>
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<tbody>
<tr>
<td>[ ] Dependent child</td>
<td>[ ] Male</td>
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HMO Personal Physician name | Provider number | IPA name | Existing patient? | Yes | No |
|---------------------------|-----------------|---------|-------------------|-----|----|

Dental HMO provider name | Provider number | Dental Group name | Existing patient? | Yes | No |
|-------------------------|-----------------|-------------------|-------------------|-----|----|

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First name | MI | Last name | Suffix |
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Date of birth | Address (if different from employee) |
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<tr>
<td>Subscriber's last name</td>
<td>First name</td>
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<tr>
<th>HMO Personal Physician name</th>
<th>Provider number</th>
<th>IPA name</th>
<th>Existing patient?</th>
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<tr>
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<th>Dental Group name</th>
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**Section 5 – Other health plan information** — If enrolling due to a loss of coverage under a prior health plan and/or to receive credit toward any employer waiting period, documentation is required to verify the date of the qualifying event.

**Does any person applying for coverage currently have health coverage or previously had health coverage at any time in the past six (6) months?**

<table>
<thead>
<tr>
<th>Type of coverage:</th>
<th>Policy/ID No.</th>
<th>Date coverage began:</th>
<th>Date ended (if coverage is active, please leave blank):</th>
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<tbody>
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</table>

**Please list all subscriber and dependent member names currently or previously enrolled in the health coverage identified above:**

<table>
<thead>
<tr>
<th>Documentation attached?</th>
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Section 6 – COBRA Cal-COBRA group continuation coverage

Please complete this section only if enrolling for COBRA or Cal-COBRA group continuation coverage. Those individuals already enrolled in COBRA or Cal-COBRA coverage from a prior carrier are eligible to continue that coverage with Blue Shield for the remaining duration of time allowed through COBRA and/or Cal-COBRA (as applicable). Proof of enrollment as a COBRA/Cal-COBRA participant is required.

Please provide the name of the employee through whom group coverage was obtained prior to the qualifying event, in order to be eligible for COBRA/Cal-COBRA continuation coverage.

Employee's/subscriber's Blue Shield ID (if applicable)  Original qualifying event date _____ / _____ / ________

Qualifying event reason:

☐ Termination or reduction in hours (last day worked)
☐ Termination or reduction in hours due to disability
☐ Divorce or legal separation
☐ Entitlement to Medicare by covered employee
☐ Attainment of maximum age for a dependent child
☐ Death of covered employee
☐ Termination of domestic partnership

Section 7 - Disclosure of personal and health information

At Blue Shield of California, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously. Blue Shield protects the privacy and security of the personal information that we maintain, use, and disclose for purposes of administering your Blue Shield coverage.

Blue Shield obtains personal information about you and/or your covered dependents, including health and/or financial information, from you, at your direction, and/or with your permission. We are also permitted by federal and state law to obtain your personal information from other sources, including, for example, from your healthcare provider, insurer, insurance support organization, health plan, or insurance agent. We use and disclose your personal information to administer your Blue Shield coverage and as otherwise permitted or required by law. In doing so, we may disclose your personal information to others including, for example, a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Blue Shield will not disclose your personal information without your authorization except as permitted or required by law.

Blue Shield is required to provide you with a Notice of Privacy Practices ("Notice") that describes your privacy rights, our obligations to protect your privacy, and how we use and disclose your personal information with and without your specific authorization. When we use or disclose your personal information, we are bound by the terms of the Notice, which applies to all records that we create, obtain, and/or maintain that contain your personal information. You will receive our Notice when you enroll for Blue Shield 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 bluesshieldca.com/bsca/documents/about-blue-shield/privacy/.

Acknowledgement and signature

*I acknowledge and agree: All information I have provided on this enrollment 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 enrollment within 24 months of issuance, Blue Shield may pursue one of the following remedies: coverage may be cancelled, or the applicable premium may be adjusted, or, following notice, coverage may be rescinded. I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California.

Signature of employee  Date

Print employee name

All pages of this form are necessary to process your enrollment. Missing information may delay processing.

If submitting for an existing Blue Shield plan, go to blueshieldca.com.
Refusal of Coverage form

Complete this form if you, your spouse, domestic partner, or child dependent(s) are refusing this group health, dental, vision, and/or life insurance coverage offered through the employer. (The employer must retain a copy of this form to provide to Blue Shield upon request.) Please type or print. Use black ink. *Note: The employee's Social Security number is required for all eligible employees and dependents.

Employee name

Social Security number

Date of birth

Employer (Group) name

Hire date / / 

State of residence

Marital status Married No

Job title

Yes No

Is the employee a full-time employee, working at least 30 hours per week for this employer?

Yes No

Is the employee a part-time employee working at least 20 hours per week for this employer?

Declining coverage for:

If health plan offered, I decline health plan coverage for:

[ ] Myself and all dependents.

[ ] My spouse/domestic partner only

[ ] My children only

[ ] My spouse/domestic partner and children only

[ ] The following dependents only:

If dental plan offered, I decline dental plan coverage for:

[ ] Myself and all dependents.

[ ] My spouse/domestic partner

[ ] My children

[ ] My spouse/domestic partner and children

[ ] The following dependents only:

If vision plan offered, I decline vision plan coverage for:

[ ] Myself and all dependents.

[ ] My spouse/domestic partner

[ ] My children

[ ] My spouse/domestic partner and children

[ ] The following dependents only:

If life insurance plan offered, I decline life plan coverage for:

[ ] Myself and all dependents.

[ ] My spouse/domestic partner and children

Reason for declining coverage

OTHER EMPLOYER HEALTH COVERAGE

[ ] Enrolling as a dependent on this group health plan

[ ] Covered by another employer's health plan (through another carrier)

[ ] Covered by another employer's health plan (e.g., through your spouse/domestic partner)

Carrier name

ID number

[ ] Covered by TRICARE

OTHER NON-EMPLOYER HEALTH COVERAGE

[ ] Covered by another employer's vision plan (e.g., through your spouse/domestic partner)

[ ] Enrolling as a dependent on this group dental plan

[ ] Covered by another employer's dental plan (through another carrier)

[ ] Covered by another employer's dental plan (e.g., through your spouse/domestic partner)

[ ] Other

OTHER DENTAL COVERAGE

[ ] Covered California or other State Health Exchange

[ ] Medicare, Medi-Cal, Healthy Families Program

[ ] Other

OTHER VISION COVERAGE

[ ] Covered by an individual health plan.

[ ] Covered by TRICARE

[ ] Enrolling as a dependent on this group vision plan

[ ] Other

OTHER LIFE INSURANCE COVERAGE

[ ] Covered by another employer's life insurance coverage (e.g., through your spouse/domestic partner)

[ ] Covered by an individual health plan.

[ ] Covered by TRICARE

[ ] Enrolling as a dependent on this group dental plan

[ ] Other

[ ] Covered California or other State Health Exchange

[ ] Medicare, Medi-Cal, Healthy Families Program

[ ] Other

[ ] Covered by another employer's dental plan (e.g., through your spouse/domestic partner)

[ ] Enrolling as a dependent on this group vision plan

[ ] Other

[ ] Covered by another employer’s life insurance coverage (e.g., through your spouse/domestic partner)

[ ] Other

I acknowledge that the coverage available to me has been explained to me by my employer and I know that I have every right to enroll in this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I now decline to enroll myself, my spouse/domestic partner, and/or my child dependent(s) in my employer’s group health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

If I am declining enrollment for myself or my dependents because of other health coverage or because the employer stops contributing toward this coverage, I acknowledge that I may be able to enroll myself and my dependents in this plan if I request enrollment within 31 days (60 days if loss of Medi-Cal or Healthy Families coverage) after my or my dependents’ other coverage ends or after the employer stops contributing toward the other coverage.

In addition, if I acquire a new dependent as the result of marriage/domestic partnership, birth, adoption, or placement for adoption, I acknowledge that I, and my dependents, may request enrollment in my employer’s health plan by applying for that coverage within 31 days of the marriage/domestic partnership, birth, adoption, or placement for adoption. I also acknowledge that if I, or my dependents, become eligible for the Healthy Families or the Medi-Cal Premium Assistance programs, I or my dependents may request enrollment in my employer’s health plan by applying for coverage within 60 days of the notice of eligibility for these premium assistance programs.

If I have indicated above that the reason for declining coverage for myself or my dependent(s) is coverage under another employer health benefit plan, I acknowledge that if I or my dependent(s) involuntarily lose coverage under the other employer health benefit plan, I must request enrollment for myself and/or my dependent(s) in my employer health benefit plan within 31 days. Otherwise, I understand I may not enroll myself and/or my dependents in my employer’s health plan until the earlier of the end of my employer’s next open enrollment period or 12 months.

Signature of employee

Date

Print name

C12914 (1/15)