BLUE CROSS ENROLLMENT FORM

(SHADED SECTIONS I, II AND III ARE REQUIRED)

EFFECTIVE DATE

GROUP NO.

I: PERSONAL INFORMATION

LAST NAME (Print)	FIRST NAME (Print)	M.I.	1 ☐ MALE 2 ☐ FEMALE
STREET ADDRESS	CITY	STATE	ZIP
TELEPHONE NO. ( ) -	EMPLOYER	JOB TITLE	
DATE OF HIRE	CLASS	DEPT. NO.	E-MAIL ADDRESS

III: EMPLOYEE & FAMILY INFORMATION Please list yourself and all eligible family members to be enrolled. (Attach additional sheets if necessary.)

	LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH
SELF				MO DAY YR
SPOUSE				MO DAY YR
☐ SON ☐ DAUGHTER				MO DAY YR
☐ SON ☐ DAUGHTER				MO DAY YR
☐ SON ☐ DAUGHTER				MO DAY YR
☐ SON ☐ DAUGHTER				MO DAY YR

IV: DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? IF YES, PLEASE COMPLETE THIS SE

	NAME	NAME AND ADDRESS OF OTHER INSURANCE CARRIER	EFFECTIVE DATE
SELF			MO DAY YR
SPOUSE			MO DAY YR
DEPENDENT #1 ABOVE			MO DAY YR
DEPENDENT #2 ABOVE			MO DAY YR
DEPENDENT #3 ABOVE			MO DAY YR
DEPENDENT #4 ABOVE			MO DAY YR

V: PRIOR COVERAGE FOR PPO (Prudent Buyer or BlueCard) PLANS ONLY

Please fill out the following information to receive proper credit for **PREVIOUS COVERAGE**, if immediately prior to becoming eligible for this plan, you or your dependents were covered under any public or private health care coverage (including MediCal or individual coverage). According to federal law your employer or FORMER CARRIER must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.

	Name	Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage
SELF					
SPOUSE					
☐ SON ☐ DAUGHTER					
☐ SON ☐ DAUGHTER					

II: SELECTED COVERAGE

TYPE OF COVERAGE: ☐ New Enrollment ☐ Re-Hire ☐ Part-time to Full-time ☐ Open-enrollment

MEDICAL

☐ Blue Cross HMO℠ (CaliforniaCare)*
☐ Blue Cross Preferred HMO℠ (CaliforniaCare PLUS)*
☐ Blue Cross PowerSelect HMO℠ (Select Network)
☐ Blue Cross PPO℠ (Prudent Buyer)
☐ Blue Cross EPO℠ (Prudent Buyer Exclusive)
☐ Blue Cross POS℠ (Blue Cross Plus)*
☐ BlueCard® PPO ☐ BlueCard® EPO ☐ Medicare
☐ Other ____________________
* indicate Medical Group/IPA# in Section III

DENTAL

☐ Choice Dental (Select One of the Following)
☐ Dental Net* ☐ Prudent Buyer
☐ Dental Net*
☐ Blue Cross Dental SelectHMO*
☐ Fee-For-Service Dental
☐ National Dental PPO
☐ Prudent Buyer Dental PPO
☐ PPO Dental Exclusive
☐ Other ____________________
* indicate Dental Office # in Section III

☐ UNIACCOUNT
(Flexible Spending Account)*
(Indicate Payroll Deductions)

I authorize payroll deductions on the following:

☐ Health Care Account $ __________

☐ Dependent Care $ __________

*Blue Cross or BC Life & Health PPO, Drug and Dental plan enrollees, will have out-of-pocket expenses, automatically deducted from their Health Care FSA account. Automatic FSA processing is not possible for HMO enrollees and those with coverage through another Health Plan. Reminder Automatic FSA processing is the equivalent of signing and submitting an FSA claim form, which states that you are eligible for FSA reimbursement and that you will not claim FSA reimbursed expenses on your income tax return.

AGE	SOCIAL SECURITY NUMBER	If Children are age 19 or over, you must check the appropriate boxes below		TOTALLY DISABLED	MEDICAL GROUP/IPA#	Blue Cross HMO IPA Primary Care Physician Code	Is This Your Current MD?	DENTAL OFFICE #
				☐ YES ☐ NO			☐ YES ☐ NO	
		Qualifies as IRS Dependent	Full-Time Student	☐ YES ☐ NO			☐ YES ☐ NO	
		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	
		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	
		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	
		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	

S SECTION INCLUDING MEDICARE (if applicable)

GROUP NUMBER	Is this yours or your dependents' primary coverage?	DOES IT COVER?
	☐ YES ☐ NO	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
	☐ YES ☐ NO	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
	☐ YES ☐ NO	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
	☐ YES ☐ NO	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
	☐ YES ☐ NO	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No
	☐ YES ☐ NO	Mental Health: ☐ Yes ☐ No Medical: ☐ Yes ☐ No Dental: ☐ Yes ☐ No

MEDICARE SECTION

Are you retired? .... ☐ YES ☐ NO

If yes.. Part A ☐ YES ☐ NO
.... Part B ☐ YES ☐ NO

Do any of your Dependents have Medicare? .... ☐ YES ☐ NO

If yes for your dependent.................. Part A ☐ YES ☐ NO
.... Part B ☐ YES ☐ NO

Name(s) of Medicare Dependent(s):

____

____

If yes for Medicare for you and/or your Dependent(s), please provide your and/or their HIB number and indicate the entitlement reason and Medicare eligibility date for yourself and/or your Dependent(s).

HIB # __________
Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD
Effective Date of Medicare ____/____/____
Name __________

HIB # __________
Entitlement Reason: ☐ Over 65 ☐ Disabled ☐ ESRD
Effective Date of Medicare ____/____/____
Name __________

VI - X: PLEASE READ CAREFULLY – SIGNATURE REQUIRED

VI. DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required dues.

VII. NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

VIII. HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

IX. EFFECTIVE DATE: The effective date of coverage is subject to Blue Cross of California approval.

X. ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employment Retirement Income Security Act of 1974), certain disputes may not be subject to the following arbitration provisions: I understand that any and all disputes between myself (and/or any enrolled family member) and Blue Cross of California/ BC Life & Health, including claims for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and Blue Cross/BC Life & Health are giving up the right to have any dispute decided in a court of law before a jury. Blue Cross/BC Life & Health and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Evidence of Coverage/Certificate.

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

X ____________________
Employee Signature Date

BlueCross of California | BC Life & Health Insurance Company

Medical and Dental coverage provided by Blue Cross of California and/or BC Life & Health Insurance Company.

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