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

II: SELECTED COVERAGE

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

MEDICAL

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

DENTAL

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

☐ 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.

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	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 #
							Qualifies as IRS Dependent	Full-Time Student					
SELF				MO DAY YR					☐ YES ☐ NO			☐ YES ☐ NO	
SPOUSE				MO DAY YR					☐ YES ☐ NO			☐ YES ☐ NO	
☐ SON ☐ DAUGHTER				MO DAY YR			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	
☐ SON ☐ DAUGHTER				MO DAY YR			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	
☐ SON ☐ DAUGHTER				MO DAY YR			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	
☐ SON ☐ DAUGHTER				MO DAY YR			☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO			☐ YES ☐ NO	

IV: DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? IF YES, PLEASE COMPLETE THIS SECTION INCLUDING MEDICARE (if applicable)

	NAME	NAME AND ADDRESS OF OTHER INSURANCE CARRIER	EFFECTIVE DATE	GROUP NUMBER	Is this yours or your dependents' primary coverage?	DOES IT COVER?
SELF			MO DAY YR		☐ YES ☐ NO	Mental Health: ☐ Yes ☐ No; Medical: ☐ Yes ☐ No; Dental: ☐ Yes ☐ No
SPOUSE			MO DAY YR		☐ YES ☐ NO	Mental Health: ☐ Yes ☐ No; Medical: ☐ Yes ☐ No; Dental: ☐ Yes ☐ No
DEPENDENT #1 ABOVE			MO DAY YR		☐ YES ☐ NO	Mental Health: ☐ Yes ☐ No; Medical: ☐ Yes ☐ No; Dental: ☐ Yes ☐ No
DEPENDENT #2 ABOVE			MO DAY YR		☐ YES ☐ NO	Mental Health: ☐ Yes ☐ No; Medical: ☐ Yes ☐ No; Dental: ☐ Yes ☐ No
DEPENDENT #3 ABOVE			MO DAY YR		☐ YES ☐ NO	Mental Health: ☐ Yes ☐ No; Medical: ☐ Yes ☐ No; Dental: ☐ Yes ☐ No
DEPENDENT #4 ABOVE			MO DAY YR		☐ 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 ______

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					

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 provided under an employer-sponsored plan subject to ERISA, certain disputes may not be subject to the Binding Arbitration provision.

Any dispute connected with a Blue Cross *plan or an affiliate ("Blue Cross")*, whether related to the agreement of or cancellation of care, or the relation to care or its delivery, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. By agreeing to arbitration, the *member* and Blue Cross acknowledge that they surrender their right to a court trial by jury and also agree to relinquish their right for class arbitration against each other. Arbitration findings will be final and binding unless California or Federal Law provides for the judicial review of the arbitration proceedings.

I have read and understood the provisions set out on this form. All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. Any misstatements or omissions may result in future claims being denied and/or my coverage being rescinded.

X ______

Employee Signature Date

BlueCross of California | BC Life & Health Insurance Company

Blue Cross of California is an Independent Licensee of the Blue Cross Association.
The Blue Cross name and symbol are registered service marks of the Blue Cross Association.
Medical and Dental coverage provided by Blue Cross of California and/or BC Life & Health Insurance Company.

www.bluecrossca.com GC4099 Effective 9/03; Printed 9/03

DISTRIBUTION: WHITE – Blue Cross of California Membership; **CANARY** – Blue Cross of California Marketing; **PINK** – Employee; **GOLDENROD** – Employer

BLUE CROSS ENROLLMENT FORM

WORKSHEET INSTRUCTIONS

SECTION I: PERSONAL INFORMATION

Requested information is required.

SECTION II: SELECTED COVERAGE

Check the appropriate boxes. Requested information is required.

SECTION III: EMPLOYEE & FAMILY INFORMATION

Requested information is required.

Please check the Totally Disabled box only if the condition prohibits you/your dependent from working or performing daily activities.

For Blue Cross HMO/Blue Cross POS/Blue Cross Preferred HMO members only: Each person listed must receive all medical care through the Medical Group or Independent Practice Association he or she has selected in order to receive the HMO benefit, and must live or work within the service area of the group selected. Select a Primary Care Physician from the listing in your Provider Directory. You must indicate the Primary Care Physician number which is listed below the physician's name or after the address. (If you select an IPA, you must select a Primary Care Physician from within the IPA.)

For Dental Net and Blue Cross Dental SelectHMO only: Each family member needs to select a dental office.

SECTION IV: DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE?

Please fill in requested information if applicable.

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

Please fill in requested information if applicable.

SECTIONS VI - X: PLEASE READ CAREFULLY – SIGNATURE IS REQUIRED

Non-Participating Provider Agreement, Arbitration Agreement, please read.

EMPLOYEE COPY - Retain the pink copy of this form for your records.

GC4099 Effective 9/03; Printed 9/03