BeneFits from Blue Cross

Small business solutions.
A package that fits.

Employee Application

www.bluecrossca.com

Group No.

Please complete using black ink/type, seal the inside pages for privacy and return to your Group Administrator. To avoid the possibility of delay, please answer all questions and be sure to sign and date this application.

1. Please ask your employer which BeneFits plans are offered, and check your selection:

From BCL&H:

☐ *Hospital BeneFits*	Hospitalization only benefits
☐ *Hospital BeneFits Plus*	Hospitalization plus limited doctor visit benefits
☐ *Hospital BeneFits Preferred*	Hospitalization and limited doctor visit, dental & vision benefits
☐ *PPO $35 Copay GenRx*	Comprehensive PPO coverage with generic-only drug benefits

From BCC:

☐ *Power Select HMO*	Comprehensive HMO coverage in selected zip codes

Please select an IPA for Select HMO:

2. Please ask your employer if other coverage is offered …

Dental: (Skip this section if you checked the *Hospital BeneFits Preferred* plan in Section 1.) Ask your employer if the following dental coverage options are available. If so, please check one if you would like to enroll:

From BCL&H:
☐ Dental BeneFits

From BCC:
☐ Dental Net – please select a Dental Office number:

Life: Ask your employer if Life coverage from BCL&H is offered. If not, please disregard questions in this application that pertain to Life coverage.

3. Please provide the following enrollment information (must be completed by the employee):

☐ New group enrollment	☐ New hire	☐ COBRA	COBRA/Cal-COBRA
☐ Family addition	☐ Change of coverage	☐ Cal-COBRA	Effective Date:
☐ Late enrollment	☐ Other	*(Cal-COBRA applicants must submit first month's premium)*	

Last Name	First Name	M.I.	Social Security or ID No.
Home Address *(P.O. Box not acceptable unless rural P.O. Box)* Apt No.		Marital Status ☐ Single ☐ Married	Spouse's Social Security or ID No.
City	State / ZIP Code	# of Dependents including Spouse	Home Phone No. ( )
Employer Name	Occupation/Job Title		Business Phone No. ( )
Hire Date ☐ Part time ☐ Full time	Salary *(Required)* $	☐ Hourly ☐ Weekly ☐ Monthly	# of Hours Worked per Week
Life Insurance Beneficiary – *Last Name*	*First*	*M.I.*	Relationship

Language Choice *(Optional)* ☐ English ☐ Spanish ☐ Chinese ☐ Korean

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Social Security or ID No.

4. Please tell us about yourself and your eligible enrolling dependents …

Eligible dependent is an employee's lawful spouse or domestic partner; a child of an employee who is the permanent legal guardian of that child and for which a valid court order establishing guardianship has been submitted; the unmarried child(ren) of the employee or, of the employee's spouse who are under age 19, or, the unmarried child(ren) of the employee or enrolled spouse from the nineteenth (19th) to the twenty-fourth (24) birthday who qualify as dependents for federal income tax purposes and are full time students. Blue Cross requires written proof of student status annually.

If spouse's last name is different from yours, is he/she a domestic partner? ☐ Yes ☐ No

FAMILY ADDITION: Date of marriage: ______ Date of adoption: ______

Sex	Last Name	First Name	MI	Height	Weight	Disabled?	Birthdate Mo. Day Year	HMO BeneFits only: Primary Care Physician No.
☐ Male ☐ Female	Employee					☐ Yes ☐ No		
☐ Male ☐ Female	Spouse or Domestic Partner					☐ Yes ☐ No		
☐ Son ☐ Daughter						☐ Yes ☐ No		
☐ Son ☐ Daughter						☐ Yes ☐ No		
☐ Son ☐ Daughter						☐ Yes ☐ No		
☐ Son ☐ Daughter						☐ Yes ☐ No		

5. Please complete if you want to decline coverage for yourself and/or any eligible dependents:

Type of Coverage:	Declined for:	Because: *(proof of coverage may be required)*
BeneFits package health plan	☐ Self ☐ Spouse ☐ Child(ren)	☐ Covered by another employer-sponsored group plan; carrier & ID number are: ______ ☐ Covered by Blue Cross Individual Policy
Dental plan (if offered)	☐ Self ☐ Spouse ☐ Child(ren)	☐ Covered by Tricare ☐ Covered by Medicare ☐ Enrolled in any other insurance carrier plan; name: ______
Life coverage (if offered)	☐ Self	☐ Other: ______

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. **BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN. PREEXISTING CONDITIONS, WHEN ENROLLED IN THIS GROUP MEDICAL PLAN, MAY NOT BE COVERED FOR SIX (6) MONTHS.**

X ______ ______

Signature if declining coverage for self/dependents *Date (Month/Day/Year)*

Social Security or ID No.

6. Health Questionnaire – *this confidential information will not be seen or given to your employer*

Have you, your spouse or any of your dependents:

1. Ever had, consulted for, had treatment rendered, been advised to have treatment, or received treatment or been hospitalized for any of the following conditions:

   Cardiovascular disease or heart attack; stroke; disorder of the kidney, stomach, intestines or liver; musculoskeletal conditions; mental or nervous condition; central nervous system disorders; diabetes; any disorder of the lungs or respiratory system; cancer or immune deficiency disorder, AIDS, or AIDS-related complex, not including the results of HIV testing? ☐ Yes ☐ No

2. During the last 24 months, had surgery or been confined in any hospital, sanitarium, convalescent facility or specialized care facility or had medical expenses more than $5,000? ☐ Yes ☐ No

3a. Is any female to be covered currently pregnant? ☐ Yes ☐ No

b. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application? ☐ Yes ☐ No

4. Does anyone listed on this application use tobacco products? ☐ Yes ☐ No

5. Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner? ☐ Yes ☐ No

If you answer "Yes" to all or part of the above questions, please complete the following:

Name of patient ______________________

Condition treated ______________________

Dates of treatment: Start __________ End __________

check here if still under treatment ☐

Treatment rendered ______________________

Medication and dosage taken ______________________

Dates taken: Start __________ End __________

check here if still taking ☐

Name of patient ______________________

Condition treated ______________________

Dates of treatment: Start __________ End __________

check here if still under treatment ☐

Treatment rendered ______________________

Medication and dosage taken ______________________

Dates taken: Start __________ End __________

check here if still taking ☐

After completion, please remove tape and fold closed to seal.

Social Security or ID No.

7. Other Coverage – *please be sure to complete this important information:*

A. Do any persons on this application intend to continue other Group coverage if this application is accepted? ☐ Yes ☐ No

If yes:
Name of person: ______________________________

Insurance Company: ______________________________

B. Does any person applying for coverage currently have health insurance coverage? ☐ Yes ☐ No

Has any person applying for coverage had health insurance coverage at any time in the past six months? ☐ Yes ☐ No

If yes:
Applicant/family member name(s): ______________________________

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: ______________

Insurance Company: ______________________________

Date coverage began: ______________ Dated ended: ______________

C. Does any person applying for coverage currently have Dental Insurance Coverage? ☐ Yes ☐ No

If yes:
Applicant/family member name(s): ______________________________

Type of continuous coverage: ☐ Group ☐ Individual ☐ Other: ______________

Insurance Company: ______________________________

Date coverage began: ______________ Dated ended: ______________

D. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits? ☐ Yes ☐ No

NOTE: If you are eligible for Medicare, Blue Cross **may not** duplicate Medicare benefits.

SUBMIT PROOF OF COVERAGE
To comply with federal and state laws, proof of this coverage must accompany this application.

Acceptable forms of proof are:

1. Certificate of coverage from prior carrier, ***or***
2. Copy of ID card ***and*** copy of payroll stub showing medical coverage deduction, ***or***
3. Copy of most recent medical premium bill or certificate of coverage from prior carrier.

Please note that if you do not advise and provide proof of prior coverage, you or a family member may be subject to a six-month preexisting conditions exclusion.

After completion, remove tape on inside pages, fold closed to seal, and submit application to your employer.

Social Security or ID No.

8. Authorization – *The following Authorization is to be signed by ALL EMPLOYEES applying for coverage.*

I AGREE: To the best of my knowledge and belief, all information on this form is correct and true. I understand that his application and any information Blue Cross of California and/or BC Life & Health Insurance Company obtains prior to the effective date of coverage is the basis on which coverage maybe issued under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by BLUE CROSS and BC LIFE & HEALTH INSURANCE COMPANY. Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded.

RESCISSION OF MEMBERSHIP: I have provided a complete history of material information that will be considered in the acceptance or denial of this application. I understand that if I intentionally provided incomplete or false material information Blue Cross may revoke my coverage. This means Blue Cross will cancel membership as if it never existed. Also, after approval for membership, if material information is discovered by Blue Cross that was not provided to the Plan prior to the effective date of the policy, Blue Cross may deny coverage.

All of my dependents listed on this application who are over the age of 18 years have read this application and have provided complete and accurate Information for this application. Also, to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about any children under the age of 18 listed on this application is true and complete. I understand and agree that I alone am responsible for the accuracy and completeness of this application. I understand and agree that no one listed on this application will be eligible for coverage if they provide false or incomplete information and that Blue Cross may revoke coverage if it discovers that in applying for coverage I intentionally provided incomplete or false material information to Blue Cross.

I AM APPLYING FOR PPO COVERAGE: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider. If a PPO Plan is selected and a non-participating provider is used, medical payments will be based upon the lesser percentage of the negotiated fee rate and I will be responsible for any amount over that payment.

I AM APPLYING FOR HMO COVERAGE: I understand that I am responsible for paying for services rendered that are not authorized by my primary medical group.

Initials:

I AM APPLYING FOR TERM LIFE COVERAGE: I understand that I am submitting this application to the life insurance department of BC Life & Health Insurance Company (BCL&H) and that if one or more of the following circumstances apply, then the medical information on this application will be used in the life department of BCL&H to determine whether or not life insurance will be offered to me: 1) my employer has 2-10 enrolled employees; 2) the date of this application is more than thirty (30) days after my eligibility date for coverage; 3) the amount of term life insurance coverage I am applying for is over $50,000.

I understand that if my coverage is revoked I will be sent written notice that will explain the basis for the decision and my appeal rights. I have the option to submit a new application in the future to be underwritten and considered for enrollment. I also understand that I will be required to pay for any services that were covered while a member and that Blue Cross will refund all amounts paid by me except amounts owed to Blue Cross.

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:

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employment 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 UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND BC LIFE & HEALTH 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 BC LIFE & HEALTH ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. 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 CERTIFICATE.

I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND BLUE CROSS OF CALIFORNIA OR ITS AFFILIATES, 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 OF CALIFORNIA OR ITS AFFILIATES ARE GIVING UP THE RIGHT TO HAVE ANY DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY. BLUE CROSS OF CALIFORNIA OR ITS AFFILIATES 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.

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.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

Signature of Employee	Date *(MM/DD/YY)*	Signature of Employee's Spouse *(If applying for coverage)*	Date *(MM/DD/YY)*
X		X	

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.

After completion, remove tape on inside pages, fold closed to seal, and submit application to your employer. Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

Blue Cross of California and BC Life & Health Insurance Company are Independent Licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.

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