



Blue Cross Enrollment Form

INSTRUCTIONS

Please read carefully and provide all applicable information. Your signature is required.
Return the completed form to your employer.

Blue Cross of California (Blue Cross) and BC Life & Health Insurance Company (BC Life) are Independent Licensees of the Blue Cross Association.
Medical and Dental coverage provided by Blue Cross of California and/or BC Life & Health Insurance Company.
Vision and Life Insurance coverage offered by BC Life & Health Insurance Company.

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www.bluecrossca.com

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

GC4099 7/07

Blue Cross Enrollment Form

Effective Date				

Group No.									

PERSONAL INFORMATION

Last Name (Print)										First Name (Print)										M.I.		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address										City										State		ZIP Code	
Telephone No. () -					Employer					Job Title													
Date of Hire			Part-time to Full-time Effective Date			Class		Dept. No.		E-mail Address													

LANGUAGE PREFERENCE

When information is sent to you, we may be able to send it to you in a language other than English. What language would you prefer? (Optional)

English Spanish Chinese Korean Japanese Tagalog Vietnamese Khmer Hmong Farsi
 Arabic Armenian Russian Other _____

EMPLOYEE & FAMILY INFORMATION – Please list yourself and all eligible family members to be enrolled. (Attach ac

	Last Name	First Name	M.I.	Sex	Birthdate Mo/Day/Yr	Age	Social Security No.
Self	Same as above	Same as above					
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner				<input type="checkbox"/> M <input type="checkbox"/> F			
Child				<input type="checkbox"/> M <input type="checkbox"/> F			
Child				<input type="checkbox"/> M <input type="checkbox"/> F			
Child				<input type="checkbox"/> M <input type="checkbox"/> F			
Child				<input type="checkbox"/> M <input type="checkbox"/> F			

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the Family Code.

DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE? If yes, please complete this section including

	Name	Name and Address of Other Insurance Carrier	Effective Date Mo/Day/Yr	Group Number
Self				
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner				
Dependent No. 1 Above				
Dependent No. 2 Above				
Dependent No. 3 Above				
Dependent No. 4 Above				

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

Medical

HMO (CaliforniaCare)* EPO (Prudent Buyer Exclusive)

Preferred HMO (CaliforniaCare PLUS)* POS (Blue Cross Plus)*

Power Advantage HMO* BC PPO (non-California resident)

Select HMO* BC Exclusive (non-California resident)

PPO (Prudent Buyer) BC Power CareAdvocate PPO (non-California resident)

Power CareAdvocate PPO Medicare

Power Select PPO Other _____

Lumenos® (select one of the following)

H.S.A.** H.R.A. H.I.A. H.I.A. Plus

Dental

Dental Blue (select one of the following)

100 200 300 Complete

PPO Dental National Dental PPO

Voluntary PPO National Voluntary PPO

Dental Net*

Choice Dental (select one of the following)

Dental Net* PPO Dental

Other _____

* Indicate Medical Group/IPA No. in the *Employee & Family Information* section below.

** Blue Cross will facilitate the opening of a Health Savings Account in your name, if directed by your employer.

* Indicate Dental Office No. in the *Employee & Family* section

Vision Blue View Vision

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.

Additional sheets if necessary.)

If children are age 19 or over you must check the appropriate boxes below		Totally Disabled	Coverage	Medical Group/IPA No.	Blue Cross HMO IPA Primary Care Physician Code	Is this your current MD?	Dental Office No.
		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Qualifies as IRS Dependent	Full-time Student	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision			<input type="checkbox"/> Yes <input type="checkbox"/> No	

ant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

ing Medicare (if applicable)

MEDICARE SECTION

Is this yours or your dependent's primary coverage?	Does it cover?	Are you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	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).
<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Health: <input type="checkbox"/> Yes <input type="checkbox"/> No Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes Part A... <input type="checkbox"/> Yes <input type="checkbox"/> No Part B... <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Health: <input type="checkbox"/> Yes <input type="checkbox"/> No Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you or your Dependents have Medicare?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Health: <input type="checkbox"/> Yes <input type="checkbox"/> No Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes for your dependent Part A... <input type="checkbox"/> Yes <input type="checkbox"/> No Part B... <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Health: <input type="checkbox"/> Yes <input type="checkbox"/> No Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No	Name(s) of Medicare Dependents:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental Health: <input type="checkbox"/> Yes <input type="checkbox"/> No Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No		

PRIOR COVERAGE FOR PPO 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					
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner					
Child					
Child					
Child					

PLEASE READ CAREFULLY – SIGNATURE REQUIRED

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.

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

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

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.

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

REQUIREMENT FOR BINDING ARBITRATION: I understand that if my coverage is provided pursuant to an employer-sponsored benefit plan that is exempt from ERISA or if I have a dispute that is not governed by ERISA that I will be subject to the following binding arbitration provision:

I UNDERSTAND THAT BLUE CROSS AND BC LIFE REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO CLAIMS OF MEDICAL MALPRACTICE IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. This means that Blue Cross/BC Life and I are waiving our rights to a jury trial for both medical malpractice claims and any other disputes. California Health & Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: **“It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.”** Blue Cross/BC Life and I are also giving up our right to pursue on a class basis any claim or controversy against each other.

NOTICE: EXCEPT AS NOTED ABOVE, BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ALL DISPUTES AGAINST BLUE CROSS/BC LIFE WHERE THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS AND ANY OTHER DISPUTES.

Employee Signature: **X** _____

Date: _____