Blue Cross of California

11-50 Small Group Employee Application

Medical and Dental Coverage underwritten by Blue Cross of California and BC Life & Health Insurance Company

Life Insurance underwritten by BC Life & Health.

INSTRUCTIONS – DO NOT TYPE

1. **You, the employee, must complete this application.** You are solely responsible for its accuracy and completeness.
2. All questions must be answered in full or the application may be returned to you resulting in a delay in processing.
3. **Print clearly using black ink.**

GROUP NO.

1 BENEFITS

A. MEDICAL – *Check only one Medical Plan:*

☐ Premier $10 Co-Pay ☐ Basic Hospital
☐ Classic $15 Co-Pay ☐ CaliforniaCare 100
☐ Classic $25 Co-Pay ☐ CaliforniaCare 80
☐ Classic $35 Co-Pay ☐ CaliforniaCare Saver

If selecting CaliforniaCare, you must select a Primary Medical Group (PMG) or an Independent Practice Association (IPA).

CaliforniaCare PMG or IPA Medical Office Number:

If you are selecting an IPA, please select a Primary Care Physician for each enrolling family member and list them by number below in Section 3A.

Are you currently a patient at the above PMG facility? ☐ Yes ☐ No

B. DENTAL (If Group has elected Dental Coverage) –
Check only one Dental Plan:

☐ Basic Option PPO*
☐ Standard Option PPO*
☐ High Option PPO*
☐ Dental Net – You must select a Dental Net Office No:

* *Fee-for-service dental coverage is substituted if the member is outside of BCC's dental service area.*

C. OPTIONAL DEPENDENT LIFE INSURANCE:

☐ Yes ☐ No

Dependent Life Insurance is only $2.00 per month.
(Available only if offered by employer.)

2 EMPLOYEE INFORMATION

Must be completed by employee.

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

LAST NAME	FIRST NAME	M.I.	MARITAL STATUS ☐ Single ☐ Married	# of Dependents including Spouse	SOCIAL SECURITY NO.

HOME ADDRESS (P.O. Box not acceptable unless rural P.O. Box)	Apt. No.	# of Hours Worked per Week	HOME PHONE NO. ( )

CITY	STATE	ZIP CODE	SPOUSE'S SOCIAL SECURITY NO.

EMPLOYER NAME	OCCUPATION / JOB TITLE	HIRE DATE (MM/DD/YY)	☐ Part Time ☐ Full Time

BUSINESS PHONE NO. ( )	SALARY $ ☐ Hourly ☐ Weekly ☐ Monthly	LIFE INSURANCE BENEFICIARY – Last Name, First Name, Middle Initial	RELATIONSHIP

3 EMPLOYEE / DEPENDENT INFORMATION – *List yourself and only those eligible dependents who are enrolling.*

An eligible "dependent" is an employee's lawful spouse; the unmarried children of the employee or of the employee's spouse who are under age 19; or the unmarried child of the employee or enrolled spouse, who is between the age of 19-24, who is a full-time student and is fully dependent on the employee for support.

If spouse's last name is different from yours, please explain: ____

FAMILY ADDITION: Date of marriage: **Date of adoption:**

3A. CaliforniaCare enrollees only – If you select an IPA you must choose a primary care physician for each member of your family.

SEX	LAST NAME	FIRST NAME	M.I.	HEIGHT	WEIGHT	DISABLED?	BIRTHDATE Month Day Year	PRIMARY CARE PHYSICIAN NO.
10 ☐ Male 20 ☐ Female	EMPLOYEE					☐ Yes ☐ No		
30 ☐ Male 40 ☐ Female	SPOUSE *					☐ Yes ☐ No		
50 ☐ Male 70 ☐ Female						☐ Yes ☐ No		
51 ☐ Male 71 ☐ Female						☐ Yes ☐ No		
52 ☐ Male 72 ☐ Female						☐ Yes ☐ No		

4 COVERAGE DECLINATION – *To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependent(s)*

A. Health Plan coverage declined for:
☐ Myself ☐ Spouse*
☐ Dependent(s)

B. Dental coverage declined for:
☐ Myself ☐ Spouse*
☐ Dependent(s)

C. Life Insurance declined for:
☐ Myself ☐ Spouse
☐ Dependent(s)

Reason for declining coverage: *(Check one)*
☐ Covered by spouse's group coverage – Carrier name and I.D. number: ____
☐ Covered by Blue Cross Individual Policy
☐ Spouse covered by employer's group medical coverage – Carrier name: ____
☐ Covered by Champus or Champva
☐ Enrolled in any other insurance carrier plan – Carrier name: ____
☐ Medicare
☐ Other *(Explain)*: ____

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 TWELVE (12) MONTHS FROM THE DATE OF ANY FUTURE APPLICATION TO BE ENROLLED IN THIS GROUP MEDICAL AND/OR GROUP LIFE INSURANCE PLAN. PRE-EXISTING CONDITIONS, WHEN ENROLLED IN THIS GROUP MEDICAL PLAN, MAY NOT BE COVERED FOR SIX (6) MONTHS.**

X ____
Signature if declining coverage for employee/dependent(s)
Date (Month / Day / Year)

** Spouse includes domestic partner ONLY if your employer has elected that coverage.*
If coverage is available, domestic partner enrollment requires completion of the Domestic Partner Affidavit.

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

We know you want to keep the following information confidential, and we've designed this form to help you do that.

5 HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 11-50 EMPLOYEES:

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, oiiiii0---or AIDS-related complex? ☐ 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
3. Is any female to be covered currently pregnant? ☐ Yes ☐ No If yes, due date (month): ______
   If you are a male, are you expecting a child with anyone? ☐ Yes ☐ No

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

Name of patient: ______
Date of first treatment: ______
Date(s) of following treatment(s): ______
Degree of recovery: ______
Condition treated: ______
Medication and dosage taken: ______
Date – From: ______ Through: ______

Name of patient: ______
Date of first treatment: ______
Date(s) of following treatment(s): ______
Degree of recovery: ______
Condition treated: ______
Medication and dosage taken: ______
Date – From: ______ Through: ______

ALL EMPLOYEES MUST COMPLETE THE FOLLOWING

6 OTHER COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS: *All questions must be answered.*

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
   (Any Individual Blue Cross of California coverage must be terminated if and when accepted by this Group Medical Plan.)
   If yes, applicant/family member(s) name: ______ Type of continuous coverage: ☐ Group ☐ Individual ☐ Other
   Insurance Company: ______ Date coverage began: ______ Date ended: ______

Fold

Fold

C. Does any persons applying for coverage currently have Dental Insurance Coverage? ☐ Yes ☐ No Type of coverage: ☐ Group ☐ Individual ☐ Other
   If yes, applicant/family member name(s): ______
   Insurance company: ______ Date coverage began: ______ Date ended: ______

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

SUBMIT PROOF OF COVERAGE – Proof of this coverage must accompany this application. Acceptable forms of proof are: certificate of coverage from prior carrier, ***or***, copy of I.D. card and copy of payroll stub showing medical coverage deduction, ***or***, copy of most recent medical premium bill. ***Failure to advise and provide proof of prior coverage may subject you or a family member to a six-month pre-existing conditions clause.***

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

I AGREE: All information on this form is correct and true. I understand that this 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 may be 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.

I AM APPLYING FOR PRUDENT BUYER PLAN COVERAGE: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider. If Prudent Buyer Co-Pay 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 CALIFORNIACARE COVERAGE: I understand that I am responsible for paying for services rendered that are not authorized by my primary medical group.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: I authorize any insurance company, physician, hospital, clinic, health care provider or other organization, institution or person having records or knowledge of anyone listed on this application to give Blue Cross of California and BC Life & Health Insurance Company or its designated agent any and all records pertaining to any medical history, services or treatment provided to anyone listed on this application for purposes of review, investigation or evaluation. This authorization becomes immediately effective and shall remain in effect as long as necessary to permit evaluation of this application or to process claims. A photocopy of this authorization is as valid as the original.

I understand that California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

I understand that my employer's application will determine the coverages in force and that coverage is not in force if an application for that coverage has not been made by my employer and approved by Blue Cross of California or BC Life & Health Insurance Company.

I understand that I am entitled to a copy of this signed Authorization if I request it.

I, the applicant, acknowledge that I have read and understand this Application in its entirety.

ARBITRATION AGREEMENT: We understand that any dispute between us and Blue Cross of California/BC Life & Health must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, not by lawsuit or resort to court process, except as California provides for judicial review of arbitration proceedings. Under this coverage, Blue Cross/BC Life & Health and we are giving up the right to have any dispute decided in a court of law before a jury.

X ______ ______
Signature of Employee *Date (Month / Day / Year)*

X ______ ______
Signature of Employee's Spouse *(If applying for coverage)* *Date (Month / Day / Year)*

Blue Cross of California and BC Life & Health are Independent Licensees of the Blue Cross Association
® is a Registered Mark of the Blue Cross Association

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