



# 2-50 Existing Small Group Employee Addition Application

## For Adding New Employees and Their Eligible Dependents to Existing Coverage

Blue Cross of California offers: Premier PPO plans, PPO Copay plans, High Deductible EPO, Saver HMO, Classic HMO, HMO 100%, Power Select HMO, Dental Net and Dental SelectHMO.

BC Life & Health Insurance Company offers: Basic PPO, Saver PPO, PPO \$35 Copay GenRx, Power HealthFund plans, Advantage PPO; all dental products except Dental Net and Dental SelectHMO; Life and AD&D plans.

Small Group Services  
Blue Cross of California  
P.O. Box 9062  
Oxnard, CA 93031-9062  
[www.bluecrossca.com](http://www.bluecrossca.com)



### INSTRUCTIONS

- You, the employee, must complete this application.** You are solely responsible for its accuracy and completeness.
- All questions must be answered in full; all signatures and dates must be included where noted; otherwise, the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
- Type or print clearly using blue or black ink.**

Group No.

### 1 COVERAGE – Please verify with your employer which plans are available.

#### A. MEDICAL COVERAGE SELECTION – Check only one Medical Plan:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Basic PPO            | <input type="checkbox"/> Advantage PPO \$25 Copay | <input type="checkbox"/> Power HealthFund 750 | <input type="checkbox"/> Saver HMO        |
| <input type="checkbox"/> Saver PPO            | <input type="checkbox"/> Premier PPO \$20 Copay   | <input type="checkbox"/> Power HealthFund 500 | <input type="checkbox"/> Classic HMO      |
| <input type="checkbox"/> PPO \$35 Copay GenRx | <input type="checkbox"/> Premier PPO \$10 Copay   | <input type="checkbox"/> High Deductible EPO  | <input type="checkbox"/> HMO 100%         |
| <input type="checkbox"/> PPO \$40 Copay       | <input type="checkbox"/> Other _____              |   | <input type="checkbox"/> Power Select HMO |
| <input type="checkbox"/> PPO \$30 Copay       |   |   |   |

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

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.

HMO plan PMG or IPA Medical Office Number:  Are you currently a patient of this facility?  Yes  No

#### B. DENTAL COVERAGE SELECTION – (If group has elected Dental Coverage) – Check only one Dental Plan:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Platinum Preferred 2000 | <input type="checkbox"/> High Option PPO*     | <u>You must select a Dental Office No. for the following plans:</u> |
| <input type="checkbox"/> Platinum 2000           | <input type="checkbox"/> Standard Option PPO* | <input type="checkbox"/> Dental Net                                 |
| <input type="checkbox"/> Gold Preferred 1500     | <input type="checkbox"/> Basic Option PPO*    | <input type="checkbox"/> Blue Cross Dental SelectHMO                |
| <input type="checkbox"/> Gold 1500               | <input type="checkbox"/> Other _____          | <input type="text"/>  |
| <input type="checkbox"/> Silver 1000             |   | Dental Office No.   |

\* Fee-for-service dental coverage is substituted if the member is outside of PPO dental service area.

#### C. OPTIONAL DEPENDENT LIFE INSURANCE (Available only if offered by employer.) Yes No

#### D. SUPPLEMENTAL LIFE INSURANCE (Available only if offered by employer.)

- Yes  No Amount:  \$15,000  \$25,000  \$50,000  \$100,000

### 2 EMPLOYEE INFORMATION – Must be completed by employee.

- |  |                                   |                                     |                                 |
|--|-----------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> Family addition | <input type="checkbox"/> New hire | <input type="checkbox"/> COBRA      | COBRA/Cal-COBRA Effective Date: |
| <input type="checkbox"/> Late enrollment | <input type="checkbox"/> Other    | <input type="checkbox"/> Cal-COBRA* | <input type="text"/>            |

\* Cal-COBRA applicants must submit first month's premium.

Last Name		First Name		M.I.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Social Security or ID No.	
Home Address (P.O. Box not acceptable unless rural P.O. Box)				Apt No.	# of Dependents including Spouse*	Spouse's Social Security or ID No.	
City			State	ZIP Code	Home Phone No. ( )		
Hire Date (MM/DD/YY)	Employer Name			Occupation/Job Title	<input type="checkbox"/> Part time <input type="checkbox"/> Full time	# of Hours Worked per Week	
Business Phone No. ( )	Salary (Required) \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	Life Insurance Beneficiary – Last Name, First, M.I.			Relationship	
Language Choice (Optional) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Korean							

\* Spouse includes domestic partner ONLY if your employer has elected that coverage. If coverage is available, domestic partner enrollment requires submission of a signed and notarized Domestic Partner Affidavit or, if applicable, a copy of a valid Declaration of Domestic Partnership filed with and stamped by the Secretary of State of California.



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

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An eligible "dependent" is an employee's lawful spouse or domestic partner (if employer has elected to cover domestic partners); a child (except a newborn) 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.

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

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	Primary Care Physician No.
<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee					<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse *					<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Son <input type="checkbox"/> Daughter						<input type="checkbox"/> Yes <input type="checkbox"/> No		

**4 COVERAGE DECLINATION** – To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependents. Proof of coverage may be required.

**A. Health Plan coverage declined for:**

- Myself  Spouse\*  
 Child(ren)

**B. Dental coverage declined for:**

- Myself  Spouse\*  
 Child(ren)

**C. Life Insurance declined for:**

- Myself  Spouse\*  
 Child(ren)

**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 Tricare
- 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 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 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 submission of a signed and notarized Domestic Partner Affidavit or, if applicable, a copy of a valid Declaration of Domestic Partnership filed with and stamped by the Secretary of State of California.



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**5 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  
 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  
 Type of continuous coverage:  Group  Individual  Other: \_\_\_\_\_  
 If yes, Applicant/family member name(s): \_\_\_\_\_  
 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 I.D. 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.

**Failure to advise and provide proof of prior coverage may subject you or a family member to a six-month pre-existing conditions clause.**

**6 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 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 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.

**I AM APPLYING FOR a Health Savings Account (HSA) compatible EPO PLAN:** I understand that the High Deductible Plans are designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. I understand that having this coverage does not establish an HSA. To do so, I must contact a qualified financial institution. Also, I understand that I should consult my tax advisor.

*Continued on next page*



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**6 AUTHORIZATION – Continued**

**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.

**All signatures and dates below are required if applying for coverage.**

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

**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, sign Authorization 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.

