2-50 Small Group Employee Application

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

INSTRUCTIONS

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; 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.
3. **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:*

- ☐ Basic PPO
- ☐ Saver PPO
- ☐ PPO $35 Copay GenRx
- ☐ PPO $40 Copay
- ☐ PPO $30 Copay
- ☐ Advantage PPO $25 Copay
- ☐ Premier PPO $20 Copay
- ☐ Premier PPO $10 Copay
- ☐ Other _____
- ☐ Power HealthFund 750
- ☐ Power HealthFund 500
- ☐ High Deductible EPO
- ☐ Saver HMO
- ☐ Classic HMO
- ☐ HMO 100%
- ☐ Power Select HMO

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:*

- ☐ Platinum Preferred 2000
- ☐ Platinum 2000
- ☐ Gold Preferred 1500
- ☐ Gold 1500
- ☐ Silver 1000
- ☐ High Option PPO*
- ☐ Standard Option PPO*
- ☐ Basic Option PPO*
- ☐ Other _____

You must select a Dental Office No. for the following plans:

- ☐ Dental Net
- ☐ Blue Cross Dental SelectHMO

☐☐☐☐☐☐ 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.*

- ☐ New group enrollment
- ☐ Family addition
- ☐ Late enrollment
- ☐ New hire
- ☐ Change of coverage
- ☐ Other
- ☐ COBRA
- ☐ Cal-COBRA*

COBRA/Cal-COBRA Effective Date: ☐☐☐☐☐☐

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

Last Name	First Name	M.I.	Marital Status ☐ Single ☐ Married	Social Security or I.D. No.

Home Address *(P.O. Box not acceptable unless rural P.O. Box)*	Apt No.	# of Dependents including Spouse*	Spouse's Social Security or I.D. No.

City	State	ZIP Code	Home Phone No.
			( )

Hire Date *(MM/DD/YY)*	Employer Name	Occupation/Job Title	☐ Part time ☐ Full time	# of Hours Worked per Week

Business Phone No.	Salary *(Required)*	☐ Hourly ☐ Weekly ☐ Monthly	Life Insurance Beneficiary – *Last Name, First, M.I.*	Relationship
( )	$			

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

For Office Use Only Please

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

Social Security or I.D. No.

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.

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:** ____

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

Sex	Last Name	First Name	MI	Height	Weight	Disabled?	Birthdate Mo. Day Year	Primary Care Physician No.
☐ Male ☐ Female	Employee					☐ Yes ☐ No		
☐ Male ☐ Female	Spouse *					☐ Yes ☐ No		
☐ Son ☐ Daughter						☐ Yes ☐ No		
☐ Son ☐ Daughter						☐ Yes ☐ No		
☐ Son ☐ Daughter						☐ Yes ☐ No		
☐ Son ☐ Daughter						☐ Yes ☐ 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.*

HEALTH QUESTIONNAIRE – ***The following information is confidential and will not be seen or given to your employer.***

Social Security or I.D. No.

5 HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 1–10 EMPLOYEES AND LATE ENROLLEES:

GROUPS WITH 11-50 ENROLLING EMPLOYEES: DO NOT COMPLETE THIS SECTION. PLEASE SKIP TO SECTION 5A.

HEALTH HISTORY OF YOU AND YOUR FAMILY ***(Include information on all family members you wish to cover.)***

Has any person listed on this application ever had, consulted for, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions?

All questions must be answered "Yes" or "No".
INCOMPLETE APPLICATIONS WILL BE RETURNED TO YOU FOR COMPLETION WHICH MAY DELAY THE EFFECTIVE DATE OF YOUR COVERAGE.

Question	Yes	No
1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins, or any other disorder of the heart, blood, blood vessels, hyperlipemia or arteriosclerosis?	☐	☐
2. Ulcer, colitis, gall stone, hernia or any other disorder of the stomach, intestines, rectum, gall bladder, or liver?	☐	☐
3. Cancer, cyst, or tumor?	☐	☐
4. Disorder of the kidneys, blood or albumin, thyroid glands, diabetes, venereal disease or any related eye disorders, urinary systems, male or female organs, or menstrual dysfunction?	☐	☐
5. Tuberculosis, asthma, hay fever, adenoids, pleurisy or any other disorder of the lungs or respiratory system?	☐	☐
6. Epilepsy, fainting spells, mental or nervous condition, paralysis or any disorder of the brain or nervous system?	☐	☐
If epileptic, date of last seizure: ________________		
7. Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles, or bones?	☐	☐
8. Any physical deformity or defect? Any serious bodily injury, fracture, concussion, burn, and/or congenital problems?	☐	☐
9. Has any person to be covered had or been told that they had an immune deficiency disorder, AIDS, or AIDS-related complex, not including the results of HIV testing?	☐	☐
10. Within the last five years, had an x-ray, electrocardiogram, cardiovascular exam, or any laboratory test or study?	☐	☐
11. Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner?	☐	☐
12. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same?	☐	☐
13a. Is any female to be covered currently pregnant?	☐	☐
If yes, Due Date (Month): ________________		
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?	☐	☐
14. Any history of complication of pregnancy?	☐	☐
15. Does anyone listed on this application use tobacco products?	☐	☐

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE THE FOLLOWING.

Please explain and provide us with **FULL DETAILS** for each "Yes" answer to any condition(s) checked in all the preceding boxes. In addition, **please give details below of last doctor visit and/or physical examination for ALL family members listed regardless of the date or reason.** *(Insert additional sheets, if necessary.)*

Question #	Name of Family Member *(As identified on physician's record)*		Question #	Name of Family Member *(As identified on physician's record)*	
Date of Onset/Treatment *(Mo/Yr)*	Date Ended	☐ Still under treatment	Date of Onset/Treatment *(Mo/Yr)*	Date Ended	☐ Still under treatment
Name of Condition(s)/Illness(es) Treated			Name of Condition(s)/Illness(es) Treated		
Treatment Rendered			Treatment Rendered		
Medication (if taken)	Date Prescribed	Dosage	Medication (if taken)	Date Prescribed	Dosage
Question #	Name of Family Member *(As identified on physician's record)*		Question #	Name of Family Member *(As identified on physician's record)*	
Date of Onset/Treatment *(Mo/Yr)*	Date Ended	☐ Still under treatment	Date of Onset/Treatment *(Mo/Yr)*	Date Ended	☐ Still under treatment
Name of Condition(s)/Illness(es) Treated			Name of Condition(s)/Illness(es) Treated		
Treatment Rendered			Treatment Rendered		
Medication (if taken)	Date Prescribed	Dosage	Medication (if taken)	Date Prescribed	Dosage

Insert additional sheets before sealing, if necessary.

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

Social Security or I.D. No.

5A 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, 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

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

Name of patient: _____ Name of patient: _____

Date of first treatment: _____ Date of first treatment: _____

Date(s) of following treatment(s): _____ Date(s) of following treatment(s): _____

Degree of recovery: _____ Degree of recovery: _____

Condition treated: _____ Condition treated: _____

Medication and dosage taken: _____ Medication and dosage taken: _____

Date – From: _____ Through: _____ 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

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 preexisting conditions clause.

Continued on the following page ➥

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

Social Security or I.D. No.

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.

I AM APPLYING FOR TERM LIFE COVERAGE: I understand that

Initials:

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; 4) I am applying for supplemental life coverage.

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.

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.

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

3345 5/04