Small Group Change of Coverage Application *(For Existing Enrollments Only)*

www.bluecrossca.com

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.

INSTRUCTIONS- Before requesting a different plan, please read the Blue Cross brochure describing the plan you are thinking of choosing. **Be sure you are acquainted with the benefits, copayments, annual deductibles and the limitations and exclusions of the plan you choose.** The plan you choose must be part of your employer's Small Group benefit coverage.

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 and all signatures and dates must be included where noted; otherwise, the 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. CHOICE OF COVERAGE – *Please change my coverage to:*

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
- ☐ Power HealthFund 750
- ☐ Power HealthFund 500
- ☐ Saver HMO
- ☐ Classic HMO
- ☐ HMO 100%
- ☐ Power Select HMO
- ☐ High Deductible EPO
- ☐ Other:

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

2. SUBSCRIBER INFORMATION: *Complete address portion ONLY if a recent change.*

Last Name	First Name	M.I.	Marital Status ☐ Single ☐ Married	Social Security or ID No.
Street Address (P.O. Box not acceptable)			# of Dependents including Spouse	Spouse's Social Security or ID No.
City	State	ZIP Code	Home Phone No. ( )	Business Phone No. ( )
Occupation	Employer Name			No. of Hours Worked Per Week

3. SUBSCRIBER / FAMILY INFORMATION – *List yourself and all eligible family members requesting a change in coverage.* ***If spouse's last name is different from yours, is he/she a domestic partner?*** **☐ Yes ☐ No**

3A. HMO only – IPA

If you select an IPA you must choose a Primary Care Physician for each member of your family.

	Last Name	First Name	M.I.	Height	Weight	Birthdate Mo Day Yr	Provider Number of Primary Care Physician
10 ☐ Male 20 ☐ Female	Subscriber						
30 ☐ Male 40 ☐ Female	Spouse*						
☐ Son ☐ Daughter							
☐ Son ☐ Daughter							
☐ Son ☐ Daughter							

** 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.*

4. HEALTH HISTORY OF MEMBERS CURRENTLY ENROLLED:

Social Security or ID No.

Your claims history with Blue Cross will also be used in addition to the history listed on this application.

Has any enrolled family member been hospitalized, seen a physician or other health care provider or taken prescription medication within the last 6 months? ☐ Yes ☐ No *If yes, provide the required medical information below:*

Member Name	Hospital / Provider Name and Address	Condition/Illness Treated	Medication (If applicable)

5. 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 HSA compatible 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.

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 *(Mo/Day/Yr)*	Signature of Employee's Spouse *(If applying for coverage)*	Date *(Mo/Day/Yr)*
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.

Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.