



2-50 Existing Small Group Employee Addition Application

For Adding New Employees and Their Eligible Dependents to Existing Coverage



Blue Cross Dental Net and Blue Cross Dental SelectHMO, and all medical products except Blue Cross Basic PPO, Blue Cross Saver PPO and Advantage PPO offered by Blue Cross of California. Blue Cross PPO and FFS Dental, Blue Cross Basic PPO, Blue Cross Saver PPO, Advantage PPO, Life and AD&D products offered by BC Life & Health Insurance Company.

Small Group Services
Blue Cross of California
P.O. Box 9062
Oxnard, CA 93031-9062
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 and 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.
246576

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

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

- Basic PPO PPO \$40 Copay Premier PPO \$20 Copay Saver HMO
 Saver PPO PPO \$30 Copay Premier PPO \$10 Copay HMO 100%
 Advantage PPO \$25 Copay 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:

- High Option PPO* Dental Net – You must select a Dental Office No. _____
 Standard Option PPO* Blue Cross Dental SelectHMO – You must select a Dental Office No. _____
 Basic Option PPO* Other _____

* 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.

- Family addition New hire COBRA COBRA/Cal-COBRA Effective Date: _____
 Late enrollment Other Cal-COBRA*

* 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 Aquatic Farms Ltd.			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			Ethnic Origin (Optional) <input type="checkbox"/> Caucasian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hispanic <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Native American <input type="checkbox"/> Other					

* 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.

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.

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 TWELVE (12) MONTHS FROM THE DATE OF ANY FUTURE APPLICATION 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.



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 Medical Savings Account (MSA) 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 MSA. To do so, I must contact a qualified financial institution. Also, I understand that I should consult my tax advisor.

Continued on next page



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 X	Date (MM/DD/YY)	Signature of Employee's Spouse (If applying for coverage) X	Date (MM/DD/YY)
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AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional to give Blue Cross of California or Affiliate ("Blue Cross") its agents, employees, designees, or representatives, including my Blue Cross agent or broker any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related Complex), except the results of HIV testing, to me, or any of my dependents applying for or having Blue Cross coverage. I understand that this information may be collected in connection with the review, investigation or evaluation of any application for coverage or of any claim for benefits.

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.

I also authorize Blue Cross to disclose all such medical or personal information related to myself or any covered dependent, to a health care provider, a health care service plan, a self-insurer, or any insurance company for the purposes of investigating or evaluating any claim for benefits.

This authorization is effective immediately and shall remain in effect for a period of thirty (30) months, except that it shall remain effective for use in connection with any claim for benefits for as long as any Blue Cross coverage may be in effect. A photo copy of this authorization is as valid as the original, and I, and my Blue Cross agent or broker, am entitled to receive a copy of this form.

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

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

