



NEW ENROLLMENT RE-HIRE

DO NOT WRITE IN SHADED AREAS

EMPLOYEE INFORMATION (Please type or print clearly. Use black ink.)

SELEF	1 SOCIAL SECURITY #		EMPLOYER (GROUP) NAME		DEPT. CODE	GROUP NUMBER	B/U	
	LAST NAME			FIRST NAME		M.I.	OED	RSN
	MAILING ADDRESS			CITY	STATE	ZIP	S TOC	NP PKG
	HOME PHYSICAL ADDRESS			CITY	STATE	ZIP	BLUE SHIELD LIFE/AD&D AMOUNT	
	BUSINESS PHONE () ()		HOME PHONE () ()		E-MAIL ADDRESS		FULL-TIME-HIRE DATE	JOB TITLE
HOW WOULD YOU LIKE US TO CONTACT YOU? SELECT ONE OF THE FOLLOWING OPTIONS AS YOUR PREFERENCE FOR COMMUNICATION: <input type="checkbox"/> Electronic Mail <input type="checkbox"/> Standard Mail Telephone: <input type="checkbox"/> Home <input type="checkbox"/> Work Blue Shield/Blue Shield Life will use your preferred method when possible.						Are you a full-time employee, actively working for this employer at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many hours per week?		
DATE OF BIRTH MO DAY YEAR			SEX M F	MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		LANGUAGE PREFERENCE <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Other		Check yes if additional sheet(s) is attached to this Application <input type="checkbox"/> YES
ACCESS+ HMO & ADDED ADVANTAGE POS - NAME OF PRIMARY CARE PHYSICIAN:				Prov. #	Existing Patient? Y / N	DENTAL HMO ONLY - NAME OF DENTAL CENTER:		DENTAL CENTER #

IF YOU, YOUR SPOUSE OR YOUR DEPENDENT(S) ARE REFUSING COVERAGE, PLEASE COMPLETE AND SIGN THE REVERSE SIDE.

2 **CHECK PLAN(S):** (See Important Guidelines on Page 2) ACCESS+ HMO SHIELD SPECTRUM PPO
 100/50 PPO PLAN A OR B ADDED ADVANTAGE POS ACCESS BAJA HMO DENTAL HMO DENTAL PPO BLUE SHIELD LIFE ONLY* ACTIVE CHOICE PLANS*

3 **DEPENDENT INFORMATION:**
ACCESS+ HMO AND ADDED ADVANTAGE POS APPLICANTS MUST SELECT A PRIMARY CARE PHYSICIAN IN THE BLUE SHIELD ACCESS+ HMO PHYSICIAN AND HOSPITAL DIRECTORY. DENTAL HMO APPLICANTS MUST SELECT A DENTAL CENTER LISTED IN THE DENTAL HMO DENTAL CENTER DIRECTORY. YOU MAY CHOOSE A DIFFERENT ACCESS+ HMO PRIMARY CARE PHYSICIAN FOR EACH FAMILY MEMBER. BE SURE TO INCLUDE EACH PRIMARY CARE PHYSICIAN'S PROVIDER NUMBER AND THEIR IPA NUMBER AS WELL AS EACH DENTAL CENTER NUMBER. FOR ACCESS BAJA HMO, PLEASE SEE PAGE 2. DOMESTIC PARTNER ENROLLMENT IS ONLY AVAILABLE IF YOUR EMPLOYER HAS ELECTED TO OFFER THIS OPTION.
 DEPENDENT'S ADDRESS IF DIFFERENT FROM EMPLOYEE

DO YOU HAVE ELIGIBLE DEPENDENTS? <input type="checkbox"/> YES <input type="checkbox"/> NO ARE THEY ENROLLING? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, PLEASE COMPLETE REFUSAL OF COVERAGE		Enroll In	HMO and ADDED ADVANTAGE POS ONLY - NAME OF PRIMARY CARE PHYSICIAN	Existing Patient?	DENTAL HMO ONLY - DENTAL CENTER
<input type="checkbox"/> SPOUSE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> M <input type="checkbox"/> F	LAST NAME	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Dr's Name: Prov. # IPA/MG#	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Center Name: Dental Center #
FIRST NAME	DATE OF BIRTH				
SOCIAL SECURITY #					
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	LAST NAME	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Dr's Name: Prov. # IPA/MG#	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Center Name: Dental Center #
FIRST NAME	DATE OF BIRTH				
SOCIAL SECURITY #					
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	LAST NAME	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Dr's Name: Prov. # IPA/MG#	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Center Name: Dental Center #
FIRST NAME	DATE OF BIRTH				
SOCIAL SECURITY #					
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	LAST NAME	<input type="checkbox"/> Medical <input type="checkbox"/> Dental	Dr's Name: Prov. # IPA/MG#	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dental Center Name: Dental Center #
FIRST NAME	DATE OF BIRTH				
SOCIAL SECURITY #					

4 **COORDINATION OF BENEFITS:**
 DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH PLAN OR HEALTH INSURANCE (INCLUDING MEDICARE) IN ADDITION TO THIS BLUE SHIELD/BLEU SHIELD LIFE COVERAGE? Yes No
 WILL THIS COVERAGE REMAIN IN EFFECT AFTER THE BLUE SHIELD LIFE COVERAGE BEGINS? Yes No

5 **CERTIFICATION FOR STUDENTS OVER AGE 18:** I HEREBY CERTIFY THAT MY DEPENDENT(S) IS/ARE CURRENTLY ENROLLED AS A FULL TIME STUDENT(S) AT THE SCHOOL(S) LISTED BELOW.
 NAME: _____ # OF HOURS: _____ NAME: _____ # OF HOURS: _____
 SCHOOL: _____ STATE: _____ # OF UNITS: _____ SCHOOL: _____ STATE: _____ # OF UNITS: _____

6 **LIFE INSURANCE BENEFICIARY**
 NAME _____ RELATIONSHIP TO APPLICANT _____
 STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____

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 to the best of my knowledge and belief. I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have misrepresented or omitted any material fact that my coverage may be cancelled or my employer's contract rescinded. I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.
 I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield/Blue Shield Life.
 Authorization for Disclosure of Personal Information: I authorize any "provider of care," insurer, health plan, or my Blue Shield agent or broker, to disclose to Blue Shield of California or Blue Shield of California Life & Health Insurance Company (individually or collectively referred to as "Blue Shield"), or its representatives, and vice versa, all "medical information" (as those terms are defined in the California Civil Code) regarding me and my applying family members, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for the purposes of evaluating this application, determining eligibility and claims for benefits, quality assurance, peer review, or administrative functions reasonably related to executing and managing this Agreement/Policy. In addition, I authorize Blue Shield to obtain personal and medical record information (as those terms are defined in the California Insurance Code) from an institutional source or an insurance support organization that gathers this type of information, for the purposes of determining eligibility for coverage. This authorization will remain valid as follows: (1) for 30 months from the date of authorization for the purposes of processing the application, a policy reinstatement, or a request for change in policy benefits; and (2) for all other activities under the policy, for the term of the coverage or for as long as may be necessary for processing of claims incurred during the term of coverage. I understand that I am entitled to a copy of this form and that a photocopy is as valid as the original.
I, the applicant, acknowledge that I have read and understood this Application in its entirety.
 Signature of Employee X _____ Date X _____