



2-50 Small Group Employee Application

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 or the application may be returned to you resulting in a delay in processing.
- 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 (5033) | <input type="checkbox"/> PPO \$40 Copay (5032) | <input type="checkbox"/> Premier PPO \$20 Copay (5030) | <input type="checkbox"/> High Deductible EPO (8978) |
| <input type="checkbox"/> Saver PPO (NM01) | <input type="checkbox"/> PPO \$30 Copay (5031) | <input type="checkbox"/> Premier PPO \$10 Copay (8982) | <input type="checkbox"/> Saver HMO (8980) |
| | <input type="checkbox"/> Advantage PPO \$25 Copay (PE24) | | <input type="checkbox"/> HMO 100% (5036) |

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"/> High Option PPO* | <input type="checkbox"/> Dental Net – You must select a Dental Office No. <input type="text"/> |
| <input type="checkbox"/> Standard Option PPO* | <input type="checkbox"/> Blue Cross Dental SelectHMO – You must select a Dental Office No. <input type="text"/> |
| <input type="checkbox"/> Basic Option PPO* | |

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

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

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

An eligible “dependent” is an employee’s lawful spouse or domestic partner (if employer has elected to cover domestic partners); 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: _____

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 HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 1–10 EMPLOYEES AND LATE ENROLLEES:
GROUPS WITH 11-50 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.

		Yes	No			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?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Ulcer, colitis, gall stone, hernia or any other disorder of the stomach, intestines, rectum, gall bladder, or liver?	<input type="checkbox"/>	<input type="checkbox"/>	10.	Within the last five years, had an x-ray, electrocardiogram, cardiovascular exam, or any laboratory test or study?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Cancer, cyst, or tumor?	<input type="checkbox"/>	<input type="checkbox"/>	11.	Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	12.	Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Tuberculosis, asthma, hay fever, adenoids, pleurisy or any other disorder of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>	13a.	Is any female to be covered currently pregnant? If yes, Due Date (Month): _____	<input type="checkbox"/>	<input type="checkbox"/>
6.	Epilepsy, fainting spells, mental or nervous condition, paralysis or any disorder of the brain or nervous system? If epileptic, date of last seizure: _____	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles, or bones?	<input type="checkbox"/>	<input type="checkbox"/>	14.	Any history of complication of pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Any physical deformity or defect? Any serious bodily injury, fracture, concussion, burn, and/or congenital problems?	<input type="checkbox"/>	<input type="checkbox"/>	15.	Does anyone listed on this application use tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/> Still under treatment		Date of Onset/Treatment (Mo/Yr)	Date Ended	<input type="checkbox"/> 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	<input type="checkbox"/> Still under treatment		Date of Onset/Treatment (Mo/Yr)	Date Ended	<input type="checkbox"/> 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.



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 **will not** duplicate Medicare Benefits **whether or not** you actually enroll.

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.

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.

ARBITRATION AGREEMENT: I understand that any dispute between myself (and/or any enrolled family member) and Blue Cross of California/ BC Life & Health 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, Blue Cross/BC Life & Health and the member are giving up the right to have any dispute decided in a court of law before a jury. Blue Cross and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other.

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 (Month/Day/year)
Signature of Employee's Spouse (If applying for coverage)	Date (Month/Day/year)

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.

Signature of Employee	Date (Month/Day/year)
Signature of Employee's Spouse (If applying for coverage)	Date (Month/Day/year)

After completion, sign Authorization, 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.



Blue Cross of California and BC Life & Health Insurance Company
are Independent Licensees of the Blue Cross Association.
® Registered Mark of the Blue Cross Association.