

Small Business Employee Enrollment Form

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

Effective October 1, 2015

Please note: Missing information may delay processing.

Reason for application – Please indicate the reason for your enrollment below:

<input type="checkbox"/> New group enrollment Group effective date: _____	<input type="checkbox"/> New hire/rehire Date of hire/rehire: _____
<input type="checkbox"/> Open enrollment Renewal date: _____	<input type="checkbox"/> COBRA/Cal-COBRA enrollment
<input type="checkbox"/> New spouse/dependant Date of marriage/birth/adoption: _____	<input type="checkbox"/> Other qualifying event (specify): _____ Qualifying event date: _____

Section 1a – Health plan selection – Select one health plan from the package offered by your employer.

Blue Shield of California Off Exchange Package for Small Business

<input type="checkbox"/> Platinum Full PPO 0 OffEx <input type="checkbox"/> Platinum Full PPO 150 OffEx <input type="checkbox"/> Gold Full PPO 0 OffEx <input type="checkbox"/> Gold Full PPO 750 OffEx <input type="checkbox"/> Gold Full PPO 1000 OffEx <input type="checkbox"/> Silver Full PPO 1250 OffEx <input type="checkbox"/> Silver Full PPO 1700 OffEx <input type="checkbox"/> Bronze Full PPO 3000 OffEx <input type="checkbox"/> Bronze Full PPO 4500 OffEx <input type="checkbox"/> Silver Full PPO HSA 2000 OffEx <input type="checkbox"/> Bronze Full PPO HSA 3500 OffEx <input type="checkbox"/> Bronze Full PPO HSA 5500 OffEx	<input type="checkbox"/> Platinum Access+ HMO® \$25 OffEx <input type="checkbox"/> Gold Access+ HMO® \$30 OffEx <input type="checkbox"/> Silver Access+ HMO® \$55 OffEx <input type="checkbox"/> Platinum Local Access+ HMO® \$25 OffEx <input type="checkbox"/> Gold Local Access+ HMO® \$30 OffEx <input type="checkbox"/> Silver Local Access+ HMO® \$55 OffEx Trio ACO HMO Plans – Trio ACO HMO Network <input type="checkbox"/> Platinum Trio ACO HMO \$25 OffEx <input type="checkbox"/> Gold Trio ACO HMO \$30 OffEx <input type="checkbox"/> Silver Trio ACO HMO \$55 OffEx
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Blue Shield of California Mirror Package for Small Business

<input type="checkbox"/> Platinum 90 HMO Network 1 Mirror <input type="checkbox"/> Platinum 90 HMO Network 2 Mirror <input type="checkbox"/> Gold 80 HMO Network 1 Mirror <input type="checkbox"/> Gold 80 HMO Network 2 Mirror	<input type="checkbox"/> Silver 70 HMO Network 1 Mirror <input type="checkbox"/> Silver 70 HMO Network 2 Mirror <input type="checkbox"/> Bronze 60 PPO Mirror
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Pediatric Dental plan* (required)

<input type="checkbox"/> Children's Dental HMO Pediatric for Small Business	<input type="checkbox"/> Children's Dental PPO Pediatric for Small Business
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* A Pediatric dental plan must be selected as it is provided with your medical plan coverage. Pursuant to state and federal law, pediatric dental coverage must be issued with health plan coverage for all enrollees (even for adults).

Section 1b – Specialty Benefits – Dental, Vision, and Life Insurance plan selection

If your employer offers specialty benefits, please complete the attached Specialty Benefits Employee Benefit Selection Form to select specialty benefits coverage.

Section SB1 – Dental benefits

Dental HMO Plans

<input type="checkbox"/> DHMO Basic	<input type="checkbox"/> DHMO Plus	<input type="checkbox"/> DHMO Deluxe	<input type="checkbox"/> DHMO Voluntary
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Dental PPO Plans

<input type="checkbox"/> Ultimate Dental PPO for Small Business 50/2000 <input type="checkbox"/> Ultimate Dental Plus PPO for Small Business 50/2000 <input type="checkbox"/> Smile SM Deluxe 2000 50/2000/No Ortho/MAC <input type="checkbox"/> Smile SM Deluxe Plus 2000 50/2000/Ortho/MAC <input type="checkbox"/> Smile SM Deluxe 50/1500/Ortho/MAC <input type="checkbox"/> Smile SM Deluxe Gold 50/1500/Ortho/U85	<input type="checkbox"/> Smile SM 50/1500/No Ortho/MAC <input type="checkbox"/> Smile SM Plus 50/1500/Ortho/MAC <input type="checkbox"/> Smile SM Value 50/1500/No Ortho/MAC <input type="checkbox"/> Smile SM Plus Gold 50/1500/Ortho/U85 <input type="checkbox"/> Smile SM Basic 75/1000/No Ortho/MAC <input type="checkbox"/> Smile SM Basic Voluntary 75/1000/No Ortho/MAC
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Dental In-Network Only (INO) Plans*

<input type="checkbox"/> Smile SM INO Dental Plan 50/1500/Endo-Perio 80%/Ortho <input type="checkbox"/> Smile SM INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho <input type="checkbox"/> Smile SM INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/Ortho <input type="checkbox"/> Smile SM INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/No Ortho	<input type="checkbox"/> Smile SM INO Dental Plan 50/2500/Endo-Perio 80%/Ortho <input type="checkbox"/> Smile SM INO Dental Plan 50/2500/Endo-Perio 80%/No Ortho <input type="checkbox"/> Smile SM INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/Ortho <input type="checkbox"/> Smile SM INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/No Ortho
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* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Subscriber's last name	First name	MI	Social Security number
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Section SB2 – Vision coverage

Vision coverage*

Ultimate Vision for Small Business (12-12-12)	Preferred Vision for Small Business (12-12-24)	Enhanced Vision for Small Business (12-24-24)
<input type="checkbox"/> Ultimate Vision Plus 0/0/150/120	<input type="checkbox"/> Preferred Vision Plus 0/0/150/120	<input type="checkbox"/> Enhanced Vision Plus 0/0/150/120
<input type="checkbox"/> Ultimate Vision 0/0/150	<input type="checkbox"/> Preferred Vision 0/0/150	<input type="checkbox"/> Enhanced Vision 0/0/150
<input type="checkbox"/> Ultimate Vision Plus 15/25/150/120	<input type="checkbox"/> Preferred Vision Plus 15/25/150/120	<input type="checkbox"/> Enhanced Vision Plus 15/25/150/120
<input type="checkbox"/> Ultimate Vision 15/25/150	<input type="checkbox"/> Preferred Vision 15/25/150	<input type="checkbox"/> Enhanced Vision 15/25/150
<input type="checkbox"/> Ultimate Vision Voluntary 15/25/150 ¹	<input type="checkbox"/> Preferred Vision 0/0/120	<input type="checkbox"/> Enhanced Vision 0/0/120
<input type="checkbox"/> Ultimate Vision 0/0/120	<input type="checkbox"/> Preferred Vision 15/25/120	<input type="checkbox"/> Enhanced Vision 15/25/120
<input type="checkbox"/> Ultimate Vision 15/25/120	<input type="checkbox"/> Preferred Vision Voluntary 15/25/120 ¹	<input type="checkbox"/> Enhanced Vision Voluntary 15/25/120 ¹

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

¹ Voluntary vision plans require a minimum of three enrolling, eligible employees.

Section SB3 – Life/AD&D insurance

Group Term Life Insurance*

Employee information

Full-time employment date	Average hours worked per week	Rehire date	Class/occupation	Earnings \$ _____ (excluding overtime, bonuses, etc.) <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year
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Designation of beneficiary

Primary beneficiary – Blue Shield Life will pay the life insurance benefits to the primary beneficiary/beneficiaries identified. An employee may designate more than one primary beneficiary. Please show percentages for each primary beneficiary in the “% of benefits” column to total 100% of benefits. If the percentage is not defined, the benefits will be distributed equally to those primary beneficiaries who survive the employee. To designate more than two primary beneficiaries, please provide on a separate sheet of paper, which is signed and dated by the employee, and attach to this form.

First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits
Address			City	State	ZIP code	
First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits
Address			City	State	ZIP code	

Contingent beneficiary – Proceeds will be paid to a contingent beneficiary only if no designated primary beneficiary survives the insured.

First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits
Address			City	State	ZIP code	

Information on benefit amounts

Please contact your benefits administrator for more information regarding your group life insurance coverage. Evidence of Insurability must be submitted for approval before an employee is eligible for coverage over a certain guaranteed amount or when enrolling outside of the initial eligibility period. Coverage granted to individuals listed in this enrollment form shall be subject to all provisions and limitations stated in the Blue Shield of California Life & Health Insurance Company group life insurance policy.

Employee Basic Life and AD&D Insurance amount: \$ _____	Basic Dependent Life Insurance: <input type="checkbox"/> Yes <input type="checkbox"/> No
Number of eligible dependents: _____	Amount of coverage requested for dependent(s): \$ _____ (Minimum amount of coverage is \$1,000; maximum is \$5,000)

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

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Section 2 – Subscriber information

Note: Social Security numbers are required per CMS.

Social Security number	Employer (group) name	Blue Shield Group ID
Last name	First name	MI
Home (physical) address (no P.O. Box addresses)	City	State
		ZIP code

Subscriber's last name		First name	MI	Social Security number
Mailing address (if different from home address)			City	State
Work phone number: ()	Home phone number: ()		Language preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____	
Email address (required)			How would you prefer we contact you? Blue Shield will use your preferred method when possible. <input type="checkbox"/> Email <input type="checkbox"/> Standard mail <input type="checkbox"/> Telephone: <input type="checkbox"/> Work <input type="checkbox"/> Home	
Date of birth: _____		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic partner
Do you have any eligible dependent children under the age of 26? <input type="checkbox"/> Yes <input type="checkbox"/> No How many? _____ How many are enrolling? _____				
Employment status:				
Do you actively work 30 hours or more per week for this employer? (full-time employee) <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you actively work between 20 and 29 hours per week for this employer? (part-time employee) <input type="checkbox"/> Yes <input type="checkbox"/> No				
If no to both of the above, are you an existing COBRA participant or enrolling due to a COBRA qualifying event? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, proceed to Section 3.				
If no, Date of hire (full time or part time if noted above) _____ (if orientation period is applied, the date of hire is the first day after completion of the orientation period)				
Job title/classification _____				

Section 3 – HMO Personal Physician/Dental HMO provider assignment

This section is only required if you selected an HMO plan. If you selected a PPO plan, please proceed to Section 4.

HMO plan Personal Physician selection

Would you like for Blue Shield to designate a Personal Physician for you and your dependents who is located near your home or work?

☐ Yes, I would like Blue Shield to designate a Personal Physician and/or Dental HMO provider for me and my dependents.

☐ No, I would like to request a specific Personal Physician and/or Dental HMO provider for myself and my dependents (please specify below).

* Please note: If Blue Shield is unable to assign the Personal Physician and/or Dental HMO provider you requested, Blue Shield will designate a provider. HMO Personal Physicians can be changed by visiting [blueshieldca.com](https://www.blueshieldca.com) after enrollment.

HMO Personal Physician name	Provider number	IPA/MG name	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dental HMO provider name	Provider number	Dental Group name	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4 – Dependent information

Please note: If the employee, spouse/domestic partner, or child dependent(s) are refusing coverage for any product offered by the group, the employee must complete and sign a Refusal of Personal Coverage form at the end of this application instead of completing the section below. Blue Shield will enroll dependents under all plans that the employee is also enrolled/enrolling in unless indicated otherwise.

Dependent type: <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security number (required)		Enrolling in all products selected by subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	
First name	MI	Last name			Suffix
Date of birth	Address (if different from employee)				
HMO Personal Physician name		Provider number		IPA name	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dental HMO provider name		Provider number		Dental Group name	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent type: <input type="checkbox"/> Dependent child <input type="checkbox"/> Other dependent child: legal guardianship	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security number (required)		Enrolling in all products selected by subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	
First name	MI	Last name			Suffix
Date of birth	Address (if different from employee)				
HMO Personal Physician name		Provider number		IPA name	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Subscriber's last name		First name		MI	Social Security number	
Dental HMO provider name				Provider number		Dental Group name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent type: <input type="checkbox"/> Dependent child <input type="checkbox"/> Other dependent child: legal guardianship		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (required)		Enrolling in all products selected by subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
First name			MI	Last name		Suffix
Date of birth		Address (if different from employee)				
HMO Personal Physician name				Provider number		IPA name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dental HMO provider name				Provider number		Dental Group name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent type: <input type="checkbox"/> Dependent child <input type="checkbox"/> Other dependent child: legal guardianship		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (required)		Enrolling in all products selected by subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
First name			MI	Last name		Suffix
Date of birth		Address (if different from employee)				
HMO Personal Physician name				Provider number		IPA name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dental HMO provider name				Provider number		Dental Group name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent type: <input type="checkbox"/> Dependent child <input type="checkbox"/> Other dependent child: legal guardianship		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (required)		Enrolling in all products selected by subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
First name			MI	Last name		Suffix
Date of birth		Address (if different from employee)				
HMO Personal Physician name				Provider number		IPA name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dental HMO provider name				Provider number		Dental Group name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent type: <input type="checkbox"/> Dependent child <input type="checkbox"/> Other dependent child: legal guardianship		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (required)		Enrolling in all products selected by subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
First name			MI	Last name		Suffix
Date of birth		Address (if different from employee)				
HMO Personal Physician name				Provider number		IPA name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dental HMO provider name				Provider number		Dental Group name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent type: <input type="checkbox"/> Dependent child <input type="checkbox"/> Other dependent child: legal guardianship		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (required)		Enrolling in all products selected by subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
First name			MI	Last name		Suffix
Date of birth		Address (if different from employee)				
HMO Personal Physician name				Provider number		IPA name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dental HMO provider name				Provider number		Dental Group name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Subscriber's last name		First name		MI	Social Security number	
Dependent type: <input type="checkbox"/> Dependent child <input type="checkbox"/> Other dependent child: legal guardianship		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (required)		Enrolling in all products selected by subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
First name		MI		Last name		Suffix
Date of birth		Address (if different from employee)				
HMO Personal Physician name				Provider number		IPA name
Dental HMO provider name				Provider number		Dental Group name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent type: <input type="checkbox"/> Dependent child <input type="checkbox"/> Other dependent child: legal guardianship		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (required)		Enrolling in all products selected by subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
First name		MI		Last name		Suffix
Date of birth		Address (if different from employee)				
HMO Personal Physician name				Provider number		IPA name
Dental HMO provider name				Provider number		Dental Group name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent type: <input type="checkbox"/> Dependent child <input type="checkbox"/> Other dependent child: legal guardianship		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security number (required)		Enrolling in all products selected by subscriber? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
First name		MI		Last name		Suffix
Date of birth		Address (if different from employee)				
HMO Personal Physician name				Provider number		IPA name
Dental HMO provider name				Provider number		Dental Group name
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
						Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 5 – Other health plan information – If enrolling due to a loss of coverage under a prior health plan and/or to receive credit toward any employer waiting period, documentation is required to verify the date of the qualifying event.

Does any person applying for coverage currently have health coverage or previously had health coverage at any time in the past six (6) months? ☐ Yes ☐ No

If yes, specify carrier: _____

Type of coverage: ☐ Group ☐ Individual ☐ Medicare ☐ Covered California/State Health Insurance Exchange ☐ Other (specify): _____

Policy/ID No. _____ Date coverage began: _____ Date ended (if coverage is active, please leave blank): _____

Please list all subscriber and dependent member names currently or previously enrolled in the health coverage identified above: _____ Documentation attached?
☐ Yes ☐ No

Subscriber's last name	First name	MI	Social Security number
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Section 6 – COBRA/Cal-COBRA group continuation coverage

Please complete this section only if enrolling for COBRA or Cal-COBRA group continuation coverage. Those individuals already enrolled in COBRA or Cal-COBRA coverage from a prior carrier are eligible to continue that coverage with Blue Shield for the remaining duration of time allowed through COBRA and/or Cal-COBRA (as applicable). Proof of enrollment as a COBRA/Cal-COBRA participant is required.

Please provide the name of the employee through whom group coverage was obtained prior to the qualifying event, in order to be eligible for COBRA/Cal-COBRA continuation coverage.

Employee last name	Employee first name	MI
Employee's/subscriber's Blue Shield ID (if applicable)	Original qualifying event date	

Qualifying event reason:

- | | |
|--|--|
| <input type="checkbox"/> Termination or reduction in hours (last day worked) | <input type="checkbox"/> Attainment of maximum age for a dependent child |
| <input type="checkbox"/> Termination or reduction in hours due to disability | <input type="checkbox"/> Death of covered employee |
| <input type="checkbox"/> Divorce or legal separation | <input type="checkbox"/> Termination of domestic partnership |
| <input type="checkbox"/> Entitlement to Medicare by covered employee | |

Section 7 - Disclosure of personal and health information

At Blue Shield of California, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously. Blue Shield protects the privacy and security of the personal information that we maintain, use, and disclose for purposes of administering your Blue Shield coverage.

Blue Shield obtains personal information about you and/or your covered dependents, including health and/or financial information, from you, at your direction, and/or with your permission. We are also permitted by federal and state law to obtain your personal information from other sources, including, for example, from your healthcare provider, insurer, insurance support organization, health plan, or insurance agent. We use and disclose your personal information to administer your Blue Shield coverage and as otherwise permitted or required by law. In doing so, we may disclose your personal information to others including, for example, a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Blue Shield will not disclose your personal information without your authorization except as permitted or required by law.

Blue Shield is required to provide you with a Notice of Privacy Practices ("Notice") that describes your privacy rights, our obligations to protect your privacy, and how we use and disclose your personal information with and without your specific authorization. When we use or disclose your personal information, we are bound by the terms of the Notice, which applies to all records that we create, obtain, and/or maintain that contain your personal information. You will receive our Notice when you enroll for Blue Shield coverage.

You may also obtain a copy of our Notice by calling the customer service number on your Blue Shield member ID card or by visiting our website at [blueshieldca.com/bsca/documents/about-blue-shield/privacy](https://www.blueshieldca.com/bsca/documents/about-blue-shield/privacy).

Acknowledgement and signature

I acknowledge and agree: All information I have provided on this enrollment 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 committed fraud or made an intentional misrepresentation of any material fact in conjunction with this enrollment within 24 months of issuance, Blue Shield may pursue one of the following remedies: coverage may be cancelled, or the applicable premium may be adjusted, or, following notice, coverage may be 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 of California.

Signature of employee

Date

Print employee name

**All pages of this form are necessary to process your enrollment.
Missing information may delay processing.
If submitting for an existing Blue Shield plan, go to [blueshieldca.com](https://www.blueshieldca.com).**

Refusal of Coverage form

Complete this form if you, your spouse, domestic partner, or child dependent(s) are refusing this group health, dental, vision, and/or life insurance coverage offered through the employer. (The employer must retain a copy of this form to provide to Blue Shield upon request.) Please type or print. Use black ink. ***Note: The employee's Social Security number is required for all eligible employees and dependents.**

Employee name	Social Security number	Date of birth
Employer (Group) name	Hire date	State of residence
Marital status Married <input type="checkbox"/> Yes <input type="checkbox"/> No Domestic partnership <input type="checkbox"/> Yes <input type="checkbox"/> No	Job title	
Is the employee a full-time employee, working at least 30 hours per week for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No Is the employee a part-time employee working at least 20 hours per week for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Declining coverage for:

I decline health plan coverage for:

- ☐ Myself and all dependents.
- ☐ My spouse/domestic partner only
- ☐ My children only
- ☐ My spouse/domestic partner and children only
- ☐ The following dependents only:
- _____

If dental plan offered, I decline dental plan coverage for:

- ☐ Myself and all dependents.
- ☐ My spouse/domestic partner
- ☐ My children
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:
- _____

If vision plan offered, I decline vision plan coverage for:

- ☐ Myself and all dependents
- ☐ My spouse/domestic partner
- ☐ My children
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:
- _____

If life insurance plan offered, I decline life plan coverage for:

- ☐ Myself and all dependents
- ☐ My spouse/domestic partner and children

Reason for declining coverage

OTHER EMPLOYER HEALTH COVERAGE

- ☐ Enrolling as a dependent on this group health plan
- ☐ Covered by this employer's other health plan (through another carrier)
- ☐ Covered by another employer's health plan (e.g., through your spouse/domestic partner)
- Carrier name _____
- ID number _____
- ☐ Covered by TRICARE

OTHER NON-EMPLOYER HEALTH COVERAGE

- ☐ Covered by an individual health plan.
- Carrier name _____
- ID number _____
- ☐ Covered California or other State Health Exchange
- ☐ Medicare, Medi-Cal, Healthy Families Program
- ☐ Other _____

OTHER DENTAL COVERAGE

- ☐ Enrolling as a dependent on this group dental plan
- ☐ Covered by another employer's dental plan (e.g., through your spouse/domestic partner)
- Carrier name _____
- ID number _____
- ☐ Other _____

OTHER VISION COVERAGE

- ☐ Enrolling as a dependent on this group vision plan
- ☐ Covered by another employer's vision plan (e.g., through your spouse/domestic partner)
- Carrier name _____
- ID number _____
- ☐ Other _____

OTHER LIFE INSURANCE COVERAGE

- ☐ Covered by another employer's life insurance coverage (e.g., through your spouse/domestic partner)
- Carrier name _____
- ID number _____
- ☐ Other _____

I acknowledge that the coverage available to me has been explained to me by my employer and I know that I have every right to enroll in this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I now decline to enroll myself, my spouse/domestic partner, and/or my child dependent(s) in my employer's group health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

If I am declining enrollment for myself or my dependents because of other health coverage or because the employer stops contributing toward this coverage, I acknowledge that I may be able to enroll myself and my dependents in this plan if I request enrollment within 31 days (60 days if loss of Medi-Cal or Healthy Families coverage) after my or my dependents' other coverage ends or after the employer stops contributing toward the other coverage.

In addition, if I acquire a new dependent as the result of marriage/domestic partnership, birth, adoption or placement for adoption, I acknowledge that I, and my dependents, may request enrollment in my employer's health plan by applying for that coverage within 31 days of the marriage/domestic partnership, birth, adoption, or placement for adoption. I also acknowledge that if I, or my dependents, become eligible for the Healthy Families or the Medi-Cal Premium Assistance programs, I or my dependents may request enrollment in my employer's health plan by applying for coverage within 60 days of the notice of eligibility for these premium assistance programs.

If I have indicated above that the reason for declining coverage for myself or my dependent(s) is coverage under another employer health benefit plan, I acknowledge that if I or my dependent(s) involuntarily lose coverage under the other employer health benefit plan, I must request enrollment for myself and/or my dependent(s) in my employer health benefit plan within 31 days. Otherwise, I understand I may not enroll myself and/or my dependents in my employer's health plan until the earlier of the end of my employer's next open enrollment period or 12 months.

Signature of employee

Date

Print name