



# 2-50 Small Group Employee Application

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



## INSTRUCTIONS

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 or the application may be returned to you resulting in a delay in processing.
3. Type or print clearly using blue or black ink.

GROUP NO. \_\_\_\_\_

### 1 COVERAGE

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

##### High Options:

- Premier PPO \$10 Copay       HMO 100%  
 Premier PPO \$20 Copay

##### Medium Options:

- PPO \$30 Copay  
 PPO \$40 Copay

##### Low Options:

- Saver HMO       High Deductible EPO  
 Saver PPO       Basic PPO

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 at this facility?  Yes  No

#### B. DENTAL COVERAGE SELECTION (If Group has elected Dental Coverage) – Check only one Dental Plan:

##### High Option:

- High Option PPO\*

##### Low Options:

- Basic Option PPO\*  
 DentalNet – You must select a Dental Office No. \_\_\_\_\_

##### Medium Option:

- Standard Option PPO\*

- Blue Cross Dental SelectHMO – You must select a 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:

- Yes       No

Dependent Life Insurance is only \$2.00 per month for \$5,000 option or \$4.00 per month for \$10,000 option. (Available only if offered by employer.)

### 2 EMPLOYEE INFORMATION

Must be completed by employee.

- New group enrollment       New hire       COBRA       Cal-COBRA\*  
 Family addition       Change of coverage      \*Cal-COBRA applicants must submit first month's premium.  
 Late enrollment       Other

COBRA / Cal-COBRA Effective Date: \_\_\_\_\_

LAST NAME	FIRST NAME	M.I.	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married	# of Dependents including Spouse	SOCIAL SECURITY NO.
HOME ADDRESS (P.O. Box not acceptable unless rural P.O. Box)			Apt. No.	# of Hours Worked per Week	HOME PHONE NO. ( ) ( ) ( )
CITY	STATE	ZIP CODE	SPOUSE'S SOCIAL SECURITY NO.		
EMPLOYER NAME	OCCUPATION / JOB TITLE			HIRE DATE (MM/DD/YY)	<input type="checkbox"/> Part time <input type="checkbox"/> Full time
BUSINESS PHONE NO. ( ) ( ) ( )	SALARY (Required) \$ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly	LIFE INSURANCE BENEFICIARY – Last Name, First Name, Middle Initial			RELATIONSHIP

### 3 EMPLOYEE / DEPENDENT INFORMATION – List yourself and only those eligible dependents who are enrolling.

An eligible "dependent" is an employee's lawful spouse/domestic partner; the unmarried children of the employee or of the employee's spouse who are under age 19; or the unmarried child of the employee or enrolled spouse, who is between the age of 19-24, is a full-time student, and is fully dependent on the employee for support.

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: \_\_\_\_\_

#### 3A. HMO only – IPA

If you select an IPA you must choose a primary care physician for each member of your family.

SEX	LAST NAME	FIRST NAME	M.I.	HEIGHT	WEIGHT	DISABLED?	BIRTHDATE Month Day Year	PRIMARY CARE PHYSICIAN NO.
10 <input type="checkbox"/> Male 20 <input type="checkbox"/> Female	EMPLOYEE					<input type="checkbox"/> Yes <input type="checkbox"/> No		
30 <input type="checkbox"/> Male 40 <input type="checkbox"/> Female	SPOUSE *					<input type="checkbox"/> Yes <input type="checkbox"/> No		
50 <input type="checkbox"/> Male 60 <input type="checkbox"/> Female						<input type="checkbox"/> Yes <input type="checkbox"/> No		
70 <input type="checkbox"/> Male 80 <input type="checkbox"/> Female						<input type="checkbox"/> Yes <input type="checkbox"/> No		
90 <input type="checkbox"/> Male 00 <input type="checkbox"/> Female						<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 dependent(s).

#### A. Health Plan coverage declined for:

- Myself       Spouse\*  
 Dependent(s)

#### 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 Champus or Champva  
 Enrolled in any other insurance carrier plan – Carrier name: \_\_\_\_\_  
 Medicare  
 Other (Explain): \_\_\_\_\_

#### B. Dental coverage declined for:

- Myself       Spouse\*  
 Dependent(s)

#### C. Life Insurance declined for:

- Myself       Spouse  
 Dependent(s)

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 completion of the Domestic Partner Affidavit.

After completion, remove tape on inside pages, fold closed to seal, and submit application to your employer.

**HEALTH QUESTIONNAIRE – The following information is confidential and will not be seen or given to your employer.**

**5 HEALTH QUESTIONNAIRE FOR GROUPS ENROLLING 1-10 EMPLOYEES AND LATE ENROLLEES:**

**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"/>	8. Any physical deformity or defect? Any serious bodily injury, fracture, concussion, burn, and/or congenital problems? .....	<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"/>	9. Has any person to be covered had or been told that they had an immune deficiency disorder, AIDS, or AIDS-related complex? .....	<input type="checkbox"/>	<input type="checkbox"/>
3. Cancer, cyst, or tumor? .....	<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"/>
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"/>	11. Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner? .....	<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"/>	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"/>
6. Epilepsy, fainting spells, mental or nervous condition, paralysis or any disorder of the brain or nervous system? .....	<input type="checkbox"/>	<input type="checkbox"/>	13a. Is any female to be covered currently pregnant? .....	<input type="checkbox"/>	<input type="checkbox"/>
If epileptic, date of last seizure: _____			If yes, Due Date (Month): _____		
7. Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles, or bones? .....	<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"/>
			14. Any history of complication of pregnancy? .....	<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.)

<b>QUESTION #</b>	<b>NAME OF FAMILY MEMBER (As identified on physician's record)</b>			<b>QUESTION #</b>	<b>NAME OF FAMILY MEMBER (As identified on physician's record)</b>		
DATE OF ONSET / TREATMENT (Month/Year)	DATE ENDED	<input type="checkbox"/> Still under treatment		DATE OF ONSET / TREATMENT (Month/Year)	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
<b>QUESTION #</b>	<b>NAME OF FAMILY MEMBER (As identified on physician's record)</b>			<b>QUESTION #</b>	<b>NAME OF FAMILY MEMBER (As identified on physician's record)</b>		
DATE OF ONSET / TREATMENT (Month/Year)	DATE ENDED	<input type="checkbox"/> Still under treatment		DATE OF ONSET / TREATMENT (Month/Year)	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
<b>QUESTION #</b>	<b>NAME OF FAMILY MEMBER (As identified on physician's record)</b>			<b>QUESTION #</b>	<b>NAME OF FAMILY MEMBER (As identified on physician's record)</b>		
DATE OF ONSET / TREATMENT (Month/Year)	DATE ENDED	<input type="checkbox"/> Still under treatment		DATE OF ONSET / TREATMENT (Month/Year)	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
<b>QUESTION #</b>	<b>NAME OF FAMILY MEMBER (As identified on physician's record)</b>			<b>QUESTION #</b>	<b>NAME OF FAMILY MEMBER (As identified on physician's record)</b>		
DATE OF ONSET / TREATMENT (Month/Year)	DATE ENDED	<input type="checkbox"/> Still under treatment		DATE OF ONSET / TREATMENT (Month/Year)	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?
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?
3a. Is any female to be covered currently pregnant?
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?
4. Does anyone listed on this application use tobacco products?

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?
If yes, Name of person: \_\_\_\_\_
Insurance Company: \_\_\_\_\_
B. Does any person applying for coverage currently have health insurance coverage?
Has any person applying for coverage had health insurance coverage at any time in the past six months?
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?
If yes, Applicant/family member name(s): \_\_\_\_\_
Type of coverage: Group Individual Other: \_\_\_\_\_
Insurance Company: \_\_\_\_\_ Date coverage began: \_\_\_\_\_ Dated ended: \_\_\_\_\_
D. Is any person applying for coverage eligible for Medicare or currently receiving 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 preexisting conditions clause.

Continued on the following page

After completion, remove tape on inside pages, fold closed to seal, and submit application to your employer.

**7 AUTHORIZATION – The following Authorization is to be signed by ALL EMPLOYEES applying for coverage.**

**I AGREE:** 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 No Deductible 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 THE HIGH DEDUCTIBLE EPO (Medical Savings Account (MSA) compatible) 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 confirm that it is true and accurate with no omissions or misstatements.

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
Signature of Employee Date (Month / Day / Year) Signature of Employee's Spouse Date (Month / Day / Year)  
(If applying for coverage)

**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, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related Complex) of 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.

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
Signature of Employee Date (Month / Day / Year) Signature of Employee's Spouse Date (Month / Day / Year)  
(If applying for coverage)

**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.**