Blue Shield of California
An Independent Member of the Blue Shield Association

(300+ Employees) EMPLOYEE APPLICATION

CPIC Life
A Blue Shield of California Subsidiary

❑ NEW ENROLLMENT ❑ RE-HIRE

DO NOT WRITE IN SHADED AREAS

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

1 SELF

SOCIAL SECURITY #	EMPLOYER (GROUP) NAME	DEPT. CODE	GROUP NUMBER	B/U
	Cal/Nev Annual Conferene		W 0 0 1 4 0	2 9

LAST NAME	FIRST NAME	M.I.	OED	RSN

MAILING ADDRESS	CITY	STATE	ZIP	S	TOC	NP	PKG

HOME PHYSICAL ADDRESS	CITY	STATE	ZIP	CPIC 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: ❑ Electronic Mail ❑ Standard Mail Telephone: ❑ Home ❑ Work
Blue Shield/CPIC *Life* will use your preferred method when possible

Are you a full-time employee, actively working for this employer at this time? ❑ Yes ❑ No If no, please explain.
If yes, how many hours per week?

DATE OF BIRTH (MO / DAY / YEAR)	SEX (M / F)	MARITAL STATUS: ❑ Single ❑ Married ❑ Domestic Partner	LANGUAGE PREFERENCE ❑ English ❑ Spanish ❑ Chinese ❑ Other	Check yes if additional sheet(s) is attached to this Application ❑ YES

ACCESS+ HMO & ADDED ADVANTAGE POS – NAME OF PRIMARY CARE PHYSICIAN:	Prov. # / IPA/MG #	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 ❑ CPIC LIFE ONLY ❑ ACTIVE CHOICE*

3 **DEPENDENT INFORMATION:**
ACCESS+ HMO AND ADDED ADVANTAGE POS APPLICANTS MUST SELECT A PRIMARY CARE PHYSICIAN IN THE BLUE SHIELD/CPIC *LIFE* 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? ❑ YES ❑ NO
ARE THEY ENROLLING? ❑ YES ❑ NO
IF NO, PLEASE COMPLETE REFUSAL OF COVERAGE

Dependent		Enroll In	HMO and ADDED ADVANTAGE POS ONLY – NAME OF PRIMARY CARE PHYSICIAN	Existing Patient?	DENTAL HMO ONLY – DENTAL CENTER
❑ SPOUSE ❑ DOMESTIC PARTNER ❑ M ❑ F FIRST NAME SOCIAL SECURITY #	LAST NAME DATE OF BIRTH	❑ Medical ❑ Dental	Dr's Name: Prov. # IPA/MG#	❑ Yes ❑ No	Dental Center Name: Dental Center #
❑ SON ❑ DAUGHTER FIRST NAME SOCIAL SECURITY #	LAST NAME DATE OF BIRTH	❑ Medical ❑ Dental	Dr's Name: Prov. # IPA/MG#	❑ Yes ❑ No	Dental Center Name: Dental Center #
❑ SON ❑ DAUGHTER FIRST NAME SOCIAL SECURITY #	LAST NAME DATE OF BIRTH	❑ Medical ❑ Dental	Dr's Name: Prov. # IPA/MG#	❑ Yes ❑ No	Dental Center Name: Dental Center #
❑ SON ❑ DAUGHTER FIRST NAME SOCIAL SECURITY #	LAST NAME DATE OF BIRTH	❑ Medical ❑ Dental	Dr's Name: Prov. # IPA/MG#	❑ Yes ❑ No	Dental Center Name: Dental Center #

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/CPIC *LIFE* COVERAGE? ❑ Yes ❑ No
WILL THIS COVERAGE REMAIN IN EFFECT AFTER THE BLUE SHIELD/CPIC *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. 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/CPIC *Life*.

I authorize any "provider of care", insurer or health plan to disclose to Blue Shield of California/CPIC *Life*, or their representatives, all "medical information" (as those terms are defined in the California Civil Code), including any medical information regarding substance abuse, or mental or emotional conditions, regarding me, my spouse or my children. This medical information is collected for the purpose of evaluating my employer's application, determining claims for benefits, or for quality assurance and peer review. This authorization will remain valid for the term of the coverage of the Blue Shield/CPIC *Life* health service contract and CPIC *Life* policy. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization.

I, the applicant, acknowledge that I have read and understood this Application in its entirety.

Signature of Employee X ____________________ **Date X** ________

C-14958 (7/03) *Underwritten by CPIC *Life* REV1 (7/03)