Small Business Subscriber Change Request

Effective January 1, 2023

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

All change requests must be received within 31 days of the effective date of the change. This form is used to request changes in personal information, add/cancel dependent coverage, or change plans during open enrollment. For employees requesting a new primary care physician (HMO plans), visit **blueshieldca.com** or call Blue Shield at the number on the back of your Blue Shield member ID card.

WHICH CHANGES ARE YOU MAKING? (select all that apply)

- ☐ Subscriber address
- ☐ Phone/Email address change
- ☐ Subscriber name change
- ☐ Date of birth
- ☐ Social Security Number
- ☐ Dependent name change
- ☐ Dependent address change
- ☐ Dependent addition coverage
- ☐ Effective date update
- ☐ Date of hire
- ☐ Waiving coverage
- ☐ Plan change

SUBSCRIBER INFORMATION – All information requested in this section is required for all changes.

Enrolled employee (subscriber) name

Blue Shield subscriber ID number

Social Security number (required per CMS)

Employment status ☐ Full time (30 hrs) ☐ Part time (20-29 hrs) ☐ COBRA/Cal-COBRA beneficiary

Group/employer name

Blue Shield Group ID (from ID card)

Requested effective date

Please tell us about yourself. How would you describe your race or ethnicity? These race and ethnicity questions are optional and are only used to help ensure all members have the same access to the highest quality of care.

Reset

1. Are you of Hispanic or Latino origin?
   - ☐ Yes
   - ☐ No
   - ☐ Unknown
   - ☐ Declined
2. If yes, please select one:
   - ☐ Cuban
   - ☐ Guatemalan
   - ☐ Mexican, Mexican American, Chicano
   - ☐ Puerto Rican
   - ☐ Salvadoran
   - ☐ 2 or more Ethnicities
   - ☐ Other Hispanic, Latino, Spanish
3. Which race(s) do you identify with? (select one)
   - ☐ American Indian or Alaska Native
   - ☐ Asian Indian
   - ☐ Black or African American
   - ☐ Cambodian
   - ☐ Chinese
   - ☐ Filipino
   - ☐ Guamanian or Chamorro
   - ☐ Hmong
   - ☐ Japanese
   - ☐ Korean
   - ☐ Laotian
   - ☐ Native Hawaiian
   - ☐ Samoan
   - ☐ Vietnamese
   - ☐ White
   - ☐ 2 or more Races
   - ☐ Other
   - ☐ Unknown
   - ☐ Declined

MEMBER INFORMATION UPDATE

Address change

Please complete this section to update your address. Include both your full previous and full new address. HMO plans: If you have moved outside your primary care physician's service area, you will need to change your primary care physician. Visit **blueshieldca.com**, or call Blue Shield at the number on your ID card for more information.

Old address | City | State | ZIP code | County

New address | City | State | ZIP code | County

Dependent name (if address change is applicable for dependent only):

Phone/email address change

Please complete this section to update your phone or email address information with Blue Shield.

Old phone number ☐ Cell ☐ Landline | Old email address

New phone number ☐ Cell ☐ Landline | New email address

Subscriber name | Subscriber ID number | Employer name

Employee name change – documentation may be required
Note: A copy of court order, marriage license, driver's license, or ID card are examples of required documentation.

Prior name (first name, last name) | New name (first name, last name)

Reason for change: ☐ Marriage ☐ Divorce ☐ Other (please specify):

Documentation attached? ☐ Yes ☐ No

Date of birth correction – documentation required
Note: A copy of the driver's license, ID card, or birth certificate are examples of required documentation.

Member's name | Date of birth | Documentation attached? ☐ Yes ☐ No

Social Security number correction/change – documentation required
A copy of the Social Security card, letter of verification from the Social Security Office, and a written statement explaining the reason for the change are examples of required documentation.

Old Social Security number | New Social Security number | Documentation attached? ☐ Yes ☐ No

MEMBER ELIGIBILITY CHANGES

Dependent addition of coverage
Please complete this section to add a spouse, domestic partner, or dependent child to the employee's coverage. Please copy and attach additional pages as needed if adding multiple dependents. The request must be received within the time frame allowed per the qualifying event, or during the group's open enrollment period. Documentation is required to verify the date of the qualifying event, including for loss of coverage, adoption, or court-ordered coverage. A completed **Refusal of Coverage (C19927)** is required for any dependent that is refusing coverage under the plan.
Note: Social Security number is required per CMS.

Dependent 1

Relationship to employee
☐ Dependent child
☐ Spouse/domestic partner
☐ Dependent child: legal guardianship

Reason for addition
☐ Newborn
☐ Adoption*
☐ Court order*
☐ Marriage
☐ Domestic partnership
☐ Loss of coverage†
☐ Open enrollment

Event date

* Court order required. † Documentation required.

Social Security number | Date of birth | Gender: ☐ Male ☐ Female

Which Race does this dependent identify with?

Which Ethnicity does this dependent identify with?

First name | MI | Last name | Suffix

Address (if different from employee) | City | State | ZIP code

Was the dependent covered under another health insurance plan within the past 12 months? ☐ Yes ☐ No
If yes, please specify carrier and plan name, start and end dates of coverage:

Carrier and plan name: _____ _____ to _____

HMO provider name | HMO provider number | IPA/MG name | Current patient? ☐ Yes ☐ No

Dental HMO provider name | Dental HMO provider number | Current patient? ☐ Yes ☐ No

Enrolling in same products selected by subscriber? ☐ Yes ☐ No | If no, please attach completed Refusal of Coverage form.

Subscriber name | Subscriber ID number | Employer name

Dependent 2

Relationship to employee
- ☐ Dependent child
- ☐ Spouse/domestic partner
- ☐ Dependent child: legal guardianship

Reason for addition
- ☐ Newborn
- ☐ Adoption*
- ☐ Court order*
- ☐ Marriage
- ☐ Domestic partnership
- ☐ Loss of coverage†
- ☐ Open enrollment

Event date

* Court order required. † Documentation required.

Social Security number | Date of birth | Gender: ☐ Male ☐ Female

Which Race does this dependent identify with?

Which Ethnicity does this dependent identify with?

First name | MI | Last name | Suffix

Address (if different from employee) | City | State | ZIP code

Was the dependent covered under another health insurance plan within the past 12 months? ☐ Yes ☐ No
If yes, please specify carrier and plan name, start and end dates of coverage:

Carrier and plan name: _____ _____ to _____

HMO provider name | HMO provider number | IPA/MG name | Current patient? ☐ Yes ☐ No

Dental HMO provider name | Dental HMO provider number | Current patient? ☐ Yes ☐ No

Enrolling in same products selected by subscriber? ☐ Yes ☐ No If no, please attach completed Refusal of Coverage form.

Dependent cancellation of coverage

Please complete this section to cancel all Blue Shield coverage for a dependent spouse, domestic partner, or child due to loss of eligibility. If any dependents being cancelled remain eligible for coverage, or if coverage is being partially cancelled (not all plans), a completed Refusal of Coverage form is required for those plans being declined/cancelled.

Relationship to employee
- ☐ Dependent child
- ☐ Spouse/domestic partner

Reason for cancellation
- ☐ Divorce ☐ Death
- ☐ Military deployment
- ☐ Other insurance coverage
- ☐ Termination of domestic partnership

Event date

Social Security number | Date of birth | Gender: ☐ Male ☐ Female

First name | MI | Last name | Suffix

Address (if different from employee) | City | State | ZIP code

Cancel coverage for all Blue Shield plans? ☐ Yes ☐ No If no, please attach completed Refusal of Coverage form.

Relationship to employee
- ☐ Dependent child
- ☐ Spouse/domestic partner

Reason for cancellation
- ☐ Divorce ☐ Death
- ☐ Military deployment
- ☐ Other insurance coverage
- ☐ Termination of domestic partnership

Event date

Social Security number | Date of birth | Gender: ☐ Male ☐ Female

First name | MI | Last name | Suffix

Address (if different from employee) | City | State | ZIP code

Subscriber name	Subscriber ID number	Employer name

Cancel coverage for all Blue Shield plans? ☐ Yes ☐ No — If no, please attach completed Refusal of Coverage form.

Relationship to employee
☐ Dependent child
☐ Spouse/domestic partner

Reason for cancellation
☐ Divorce ☐ Death
☐ Military deployment
☐ Other insurance coverage
☐ Termination of domestic partnership

Event date

Social Security number	Date of birth	Gender: ☐ Male ☐ Female

First name	MI	Last name	Suffix

Address (if different from employee)	City	State	ZIP code

Cancel coverage for all Blue Shield plans? ☐ Yes ☐ No — If no, please attach completed Refusal of Coverage form.

PLAN CHANGES

Plan change request

Please indicate the requested changes to coverage through an annual or special open enrollment period by completing all sections below for medical plan and specialty plan options.

Medical benefit plans: Please check with your employer to determine the benefit plans available to you.

☐ **No change to medical benefits.**

Blue Shield of California Off-Exchange Package Plans

PPO plans – Full PPO Network
☐ Platinum Full PPO 0/0 OffEx
☐ Platinum Full PPO 0/10 OffEx
☐ Platinum Full PPO 250/10 OffEx
☐ Platinum Full PPO 250/15 OffEx
☐ Gold Full PPO 0/25 OffEx
☐ Gold Full PPO 500/30 OffEx
☐ Gold Full PPO 750/30 OffEx
☐ Gold Full PPO 1000/35 OffEx
☐ Silver Full PPO 2000/60 OffEx
☐ Silver Full PPO 2350/65 OffEx*
☐ Silver Full PPO 2550/70 OffEx
☐ Bronze Full PPO 5500/65 OffEx
☐ Bronze Full PPO 6250/65 OffEx
☐ Bronze Full PPO 6500/70 OffEx
☐ Bronze Full PPO 6850/55 OffEx
☐ Bronze Full PPO 7500/65 OffEx

Access+ HMO plans – Access+ HMO Network
☐ Platinum Access+ HMO® 0/20 OffEx
☐ Platinum Access+ HMO® 0/25 OffEx
☐ Platinum Access+ HMO® 0/30 OffEx
☐ Gold Access+ HMO® 0/30 OffEx
☐ Gold Access+ HMO® 500/35 OffEx
☐ Gold Access+ HMO® 1000/35 OffEx
☐ Gold Access+ HMO® 1500/35 OffEx
☐ Silver Access+ HMO® 2300/70 OffEx
☐ Silver Access+ HMO® 2750/70 OffEx
☐ Bronze Access+ HMO® 7000/70 OffEx

HSA-compatible HDHP plans – Full PPO Network
☐ Gold Full PPO Savings 1750/15% HDHP PrevRx OffEx
☐ Silver Full PPO Savings 2300/25% OffEx
☐ Silver Full PPO Savings 2600/35% HDHP PrevRx OffEx
☐ Bronze Full PPO Savings 5700/40% OffEx
☐ Bronze Full PPO Savings 7000 OffEx

Local Access+ HMO plans – Local Access+ HMO Network
☐ Platinum Local Access+ HMO® 0/20 OffEx
☐ Platinum Local Access+ HMO® 0/25 OffEx
☐ Platinum Local Access+ HMO® 0/30 OffEx
☐ Gold Local Access+ HMO® 0/30 OffEx
☐ Gold Local Access+ HMO® 500/35 OffEx
☐ Gold Local Access+ HMO® 1000/35 OffEx
☐ Gold Local Access+ HMO® 1500/35 OffEx
☐ Silver Local Access+ HMO® 2300/70 OffEx
☐ Silver Local Access+ HMO® 2750/70 OffEx
☐ Bronze Local Access+ HMO® 7000/70 OffEx

HSA-compatible HDHP plans – Tandem PPO Network
☐ Gold Tandem PPO Savings 1750/15% HDHP PrevRx OffEx
☐ Silver Tandem PPO Savings 2300/25% OffEx
☐ Silver Tandem PPO Savings 2600/35% HDHP PrevRx OffEx
☐ Bronze Tandem PPO Savings 5700/40% OffEx
☐ Bronze Tandem PPO Savings 7000 OffEx

Trio HMO plans – Trio ACO HMO Network
☐ Platinum Trio HMO 0/20 OffEx
☐ Platinum Trio HMO 0/25 OffEx
☐ Platinum Trio HMO 0/30 OffEx
☐ Gold Trio HMO 0/30 OffEx
☐ Gold Trio HMO 500/35 OffEx
☐ Gold Trio HMO 1000/35 OffEx
☐ Gold Trio HMO 1500/35 OffEx
☐ Silver Trio HMO 2300/70 OffEx
☐ Silver Trio HMO 2750/70 OffEx
☐ Bronze Trio HMO 7000/70 OffEx

Tandem PPO plans – Tandem PPO Network
☐ Platinum Tandem PPO 0/0 OffEx
☐ Platinum Tandem PPO 0/10 OffEx
☐ Platinum Tandem PPO 250/10 OffEx
☐ Platinum Tandem PPO 250/15 OffEx
☐ Gold Tandem PPO 0/25 OffEx
☐ Gold Tandem PPO 500/30 OffEx
☐ Gold Tandem PPO 750/30 OffEx
☐ Gold Tandem PPO 1000/35 OffEx
☐ Virtual Blue℠ Gold Tandem PPO 1500/45 OffEx
☐ Silver Tandem PPO 2000/60 OffEx
☐ Silver Tandem PPO 2350/65 OffEx*
☐ Silver Tandem PPO 2550/70 OffEx
☐ Bronze Tandem PPO 5500/65 OffEx
☐ Bronze Tandem PPO 6250/65 OffEx
☐ Bronze Tandem PPO 6500/70 OffEx
☐ Bronze Tandem PPO 6850/55 OffEx
☐ Bronze Tandem PPO 7500/65 OffEx
☐ Virtual Blue℠ Bronze Tandem PPO 7500/75 OffEx

Blue Shield of California Mirror Package Plans
☐ Blue Shield Platinum 90 PPO 0/15 + Child Dental
☐ Blue Shield Gold 80 PPO 350/25 + Child Dental
☐ Blue Shield Silver 70 PPO 2500/55 + Child Dental
☐ Blue Shield Bronze 60 PPO 6300/65 + Child Dental
☐ Blue Shield Trio Platinum 90 HMO 0/20 + Child Dental
☐ Blue Shield Trio Gold 80 HMO 250/35 + Child Dental
☐ Blue Shield Trio Silver 70 HMO 2500/55 + Child Dental

* The Silver Full PPO 2350/65 OffEx and Silver Tandem PPO 2350/65 OffEx offer enhanced coverage for members diagnosed with diabetes, asthma, COPD, and CAD.

Subscriber name | Subscriber ID number | Employer name

SPECIALTY BENEFIT PLANS – dental,* vision,* and life insurance* plan selection

* Only benefits your employer group offers are available for selection. Any benefits selected that are not offered by your employer group will be omitted from your enrollment.

Section SB1 – Dental coverage

Dental HMO plans

☐ DHMO Basic ☐ DHMO Standard ☐ DHMO Plus ☐ DHMO Deluxe ☐ DHMO Voluntary

Dental PPO plans

☐ Bronze DPPO/$1000/MAC
☐ Bronze DPPO/$1000/MAC/Child Only Ortho
☐ Bronze DPPO/$1500/MAC
☐ Bronze DPPO/$1500/MAC/Child Only Ortho
☐ Silver DPPO/$1500/MAC
☐ Silver DPPO/$1500/MAC/Adult+Child Ortho
☐ Silver DPPO/$1500/U90
☐ Silver DPPO/$1500/U90/Adult+Child Ortho
☐ Gold DPPO/$1500/MAC
☐ Gold DPPO/$1500/MAC/Adult+Child Ortho
☐ Gold DPPO/$2000/MAC
☐ Gold DPPO/$2000/MAC/Adult+Child Ortho
☐ Gold DPPO/$1500/U90
☐ Gold DPPO/$1500/U90/Adult+Child Ortho
☐ Gold DPPO/$2000/U90
☐ Gold DPPO/$2000/U90/Adult+Child Ortho
☐ Platinum DPPO/$2500/U90
☐ Platinum DPPO/$2500/U90/Adult+Child Ortho
☐ Platinum DPPO/$3000/U90
☐ Platinum DPPO/$3000/U90/Adult+Child Ortho
☐ Platinum DPPO/$5000/U90
☐ Platinum DPPO/$5000/U90/Adult+Child Ortho
☐ Diamond DPPO/$3000/U95
☐ Diamond DPPO/$3000/U95/Adult+Child Ortho
☐ Diamond DPPO/$5000/U95
☐ Diamond DPPO/$5000/U95/Adult+Child Ortho

Dental PPO plans (only available for groups enrolled in these plans prior to 12/31/2021)

☐ Smile℠ Value 50/1500/No Ortho/MAC/NR
☐ Smile℠ 50/1500/No Ortho/MAC/NR
☐ Smile℠ Plus 50/1500/Ortho/MAC/NR
☐ Smile℠ Basic 75/1000/No Ortho/MAC/NR
☐ Smile℠ Basic 50/1000/No Ortho/MAC
☐ Smile℠ Basic 50/1000/Ortho/U85
☐ Smile℠ Plus 50/1500/No Ortho/MAC
☐ Smile℠ Plus 50/1500/No Ortho/MAC/WP
☐ Smile℠ Deluxe 50/1500/Ortho/MAC/NR
☐ Smile℠ Deluxe 2000 50/2000/No Ortho/MAC/NR
☐ Smile℠ Deluxe Plus 2000 50/2000/Ortho/MAC/NR
☐ Smile℠ Deluxe Gold 50/1500/Ortho/U85/NR
☐ Smile℠ Plus Gold 50/1500/Ortho/U85/NR
☐ Smile℠ Plus Gold 50/1500/Ortho/U80
☐ Smile℠ Plus Gold 50/1500/No Ortho/U80
☐ Smile℠ Plus Gold 50/1500/Ortho/U80/ADV
☐ Smile℠ Plus Gold 50/1500/Ortho/U90/ADV
☐ Smile℠ Plus Gold 50/1500/No Ortho/U90/ADV
☐ Smile℠ Plus Gold 50/2500/Ortho/U90/ADV
☐ Smile℠ Plus Gold 50/2500/No Ortho/U90/ADV
☐ Ultimate Dental Plus PPO for Small Business 50/2000/Ortho/MAC/NR
☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/MAC/NR
☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/U80
☐ Ultimate Dental PPO for Small Business 50/2000/Lifetime Ortho/U90
☐ Ultimate Dental PPO for Small Business 50/2000/No Ortho/U90

Voluntary Dental PPO plans**

☐ Bronze Voluntary DPPO/$1000/MAC
☐ Bronze Voluntary DPPO/$1500/MAC
☐ Bronze Voluntary DPPO/$1000/MAC/Child Only Ortho
☐ Bronze Voluntary DPPO/$1500/MAC/Child Only Ortho

Voluntary Dental PPO Plans* (only available for groups enrolled in these plans prior to 12/31/2021)

☐ Smile℠ Basic Voluntary 75/1000/No Ortho/MAC/NR
☐ Smile℠ Basic Voluntary 50/1000/No Ortho/MAC
☐ Smile℠ Basic Voluntary 50/1500/Ortho/U80
☐ Smile℠ Basic Voluntary 50/1000/No Ortho/U80 (No Wait)†

Dental In-Network Only (INO) plans (only available for groups enrolled in these plans prior to 12/31/2018)

☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/Ortho
☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho
☐ Smile℠ INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/Ortho*

Dental PPO plans (only available for groups enrolled in these plans prior to 12/31/2018)

☐ Smile℠ Deluxe 50/1500/Ortho/MAC
☐ Smile℠ Deluxe Gold 50/1500/Ortho/U85
☐ Smile℠ 50/1500/No Ortho/MAC
☐ Smile℠ Plus 50/1500/Ortho/MAC
☐ Smile℠ Value 50/1500/No Ortho/MAC
☐ Smile℠ Basic 75/1000/No Ortho/MAC
☐ Smile℠ Basic Voluntary 75/1000/No Ortho/MAC

* Voluntary dental plans require a minimum of one (1) enrolling, eligible employee.

† This Voluntary plan does not include Waiting Periods and submission of proof of any prior coverage is not required.

** The voluntary plans include a 12-month waiting period on major services and orthodontic services (ortho plan).

ADV stands for Advantage. ADV plans incentivize members to use in-network providers. NR stands for No Rollover.

Subscriber name | Subscriber ID number | Employer name

Section SB2 – Vision coverage*

Ultimate Vision for Small Business (12-12-12)
- ☐ Ultimate Vision Plus 0/0/150/150
- ☐ Ultimate Vision 0/0/150
- ☐ Ultimate Vision Plus 10/25/150/150
- ☐ Ultimate Vision 10/25/150
- ☐ Ultimate Vision 0/0/120
- ☐ Ultimate Vision 10/25/120
- ☐ Ultimate Vision Voluntary 10/25/150[1]

Preferred Vision for Small Business (12-12-24)
- ☐ Preferred Vision Plus 0/0/150/150
- ☐ Preferred Vision 0/0/150
- ☐ Preferred Vision Plus 10/25/150/150
- ☐ Preferred Vision 10/25/150
- ☐ Preferred Vision 0/0/120
- ☐ Preferred Vision 10/25/120
- ☐ Preferred Vision Voluntary 10/25/120[1]

Basic Vision for Small Business (12-24-24)
- ☐ Basic Vision Plus 0/0/150/150
- ☐ Basic Vision 0/0/150
- ☐ Basic Vision Plus 10/25/150/150
- ☐ Basic Vision 10/25/150
- ☐ Basic Vision 0/0/120
- ☐ Basic Vision 10/25/120
- ☐ Basic Vision Voluntary 10/25/120[1]

☐ Other (please specify) _____

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

1 Voluntary vision plans require a minimum of one (1) enrolling, eligible employee.

Section SB3 – Life/AD&D insurance

Group term life insurance*

Employee information

Full-time employment date | Average hours worked per week | Earnings $ _____ (excluding overtime, bonuses, etc.)

Rehire date | Class/occupation | ☐ Hour ☐ Week ☐ Month ☐ Year

Designation of beneficiary

Community property laws – If you are married or in a domestic partnership, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin) and name someone other than your spouse/domestic partner as beneficiary, it is possible that payment of benefits will be delayed or disputed unless your spouse/domestic partner also signs the beneficiary designation.

I agree to the stated beneficiary designation(s).

Spouse/domestic partner signature | Date

Spouse/domestic partner name (please print)

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

Subscriber name	Subscriber ID number	Employer name

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	

Employee and dependent benefit amounts

Please contact your benefits administrator for more information regarding your group life insurance coverage. 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: $ ___________ Amount of coverage requested for dependent(s): $ ___________

Number of eligible dependents: ___________ Basic Dependent Life Insurance: ☐ Yes ☐ No

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

If transferring to medical HMO and/or dental HMO plan(s), provide primary care physician/dental provider information below.*

Please complete this section for the subscriber and all of their dependents if they have a preferred provider. If no provider is received, a provider will be assigned for each member enrolled.

Last name		MI	First name	Sex ☐ Male ☐ Female	Date of birth
HMO provider name	HMO provider number		Independent Practice Association/medical group		Current patient? ☐ Yes ☐ No
Dental HMO provider name		Dental HMO provider number	Dental group name		Current patient? ☐ Yes ☐ No
Last name		MI	First name	Sex ☐ Male ☐ Female	Date of birth
HMO provider name	HMO provider number		Independent Practice Association/medical group		Current patient? ☐ Yes ☐ No
Dental HMO provider name		Dental HMO provider number	Dental group name		Current patient? ☐ Yes ☐ No
Last name		MI	First name	Sex ☐ Male ☐ Female	Date of birth
HMO provider name	HMO provider number		Independent Practice Association/medical group		Current patient? ☐ Yes ☐ No
Dental HMO provider name		Dental HMO provider number	Dental group name		Current patient? ☐ Yes ☐ No
Last name		MI	First name	Sex ☐ Male ☐ Female	Date of birth
HMO provider name	HMO provider number		Independent Practice Association/medical group		Current patient? ☐ Yes ☐ No
Dental HMO provider name		Dental HMO provider number	Dental group name		Current patient? ☐ Yes ☐ No

* Please note: If Blue Shield is unable to assign the primary care physician and/or dental HMO provider you requested, Blue Shield will designate a provider at random. HMO primary care physicians can be changed by visiting **blueshieldca.com** after enrollment.

Subscriber name	Subscriber ID number	Employer name

ACKNOWLEDGEMENT AND SIGNATURE

I acknowledge and agree: All information I have provided on this form is accurate and complete to the best of my knowledge and belief. I understand that this form, along with any prior enrollment form, the *Evidence of Coverage/Certificate of Insurance* and Health Service Agreement/Policy, and any endorsements and attachments thereto, collectively constitutes the entire agreement for coverage.

Signature of employee _____ **Date** _____

Print employee name _____

Keep a copy of this document for your files.

Blue Shield of California protects the privacy of your personal information, including your individually identifiable health information. We will not disclose your personal information without your authorization, except as permitted or required by law.
To obtain a copy of Blue Shield's Notice of Privacy Practices, call the customer service number on your Blue Shield member ID card or visit our website at **blueshieldca.com/privacy**.

PLEASE BE SURE TO RETURN ALL PAGES OF THIS FORM. Missing information or pages may delay processing.
Complete your Subscriber Change Request form at blueshieldca.com.

NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: **blueshieldca.com/notices**. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en **blueshieldca.com/notices**. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 **blueshieldca.com/notices**。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。