blue california

Life Insurance Plan
Employee Enrollment Application

Blue Shield plans for 101+ employees

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

Please note: Failure to complete this enrollment application legibly and completely may result in a delay in the enrollment process.

Reason for application:

☐ New hire	☐ Loss of coverage date _____	☐ Late enrollment
☐ Rehire date _____	☐ Open enrollment	☐ Other qualifying event type _____
		Date above event occurred _____

Section 1 – Important enrollment guidelines for Specialty Benefits coverage

Life insurance enrollment is subject to the following rules:

1. All Basic Term Life insurance amounts for employees who enroll when first eligible for benefits are fully Guarantee Issued (no Evidence of Insurability required). Evidence of Insurability is required for late enrollees.
2. For Supplemental Life, Evidence of Insurability is required for all amounts over the Guarantee Issue.
3. An employee must be enrolled in Supplemental Life/AD&D coverage for their spouse/domestic partner or dependent children to be eligible for Supplemental Life coverage. Spouse/Domestic Partner and/or dependent children do not have to be covered under the Basic Dependent Life coverage to be eligible for Supplemental Life coverage.

Section 2 – Plan(s) Select plan(s) as appropriate.

☐ Basic Group Term Employee Life/AD&D insurance ☐ Basic Dependent Life insurance ☐ Supplemental Term Life insurance
☐ Supplemental Term AD&D insurance

Internal use only. Do not write in this section and skip to Section 3.

Department code	Group ID	Subgroup ID	Class ID	Effective date

Section 3 – Employee information

Social Security number	**Employer (group) name**	
Last name	**First name**	**MI**
Employment status: ☐ Full time ☐ Part time ☐ Retiree	**Date of hire:** _____	Job title/classification
Home address (street, city, state, ZIP code)		Basic group term life/AD&D insurance amount:
		Basic Dependent Life amount: (all eligible dependents will be covered)
Mailing address (if different from home address)		Supplemental Life insurance amount (subject to approval):
		Supplemental AD&D insurance amount (subject to approval):
Cell phone number	Landline phone number	**Email address (Required for electronic communications)**

I agree that Blue Shield and its affiliated entities and agents may communicate with me about my account and various health and wellness programs available to me, and other promotional information that may benefit me and my dependents, including by phone or text to the numbers I have listed on this form, using an auto-dialer or artificial or prerecorded voice; standard data rates apply. ☐ Yes ☐ No
Participation is voluntary, and you can opt out any time; for more information, visit **blueshieldca.com/terms**.

Communication preference: ☐ Electronic ☐ Paper

Date of birth ____________ | **Gender** ☐ Male ☐ Female | **Marital status** ☐ Single ☐ Married ☐ Domestic partner

Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Persian ☐ Other ____________

Are you enrolling your spouse/domestic partner and/or child dependents ☐ **Yes** ☐ **No If "yes," complete Section 4 of application.**

Section 4 – Dependent spouse/domestic partner/children information If you, your spouse/domestic partner, or your dependents are refusing coverage, please complete and sign the Refusal of Coverage form.

Dependent's address, if different from employee's address – Please indicate which dependent(s) this applies to:

Enrolling spouse/domestic partner information

☐ Spouse ☐ Domestic partner Gender: ☐ Male ☐ Female	First name:		MI	Last name:
	Communication preference: ☐ Electronic ☐ Paper		**Email address (Required for electronic communications)**	
	Social Security number:	Date of birth (mm/dd/yyyy)	Supplemental Life insurance amount (subject to approval):	Supplemental AD&D insurance amount (subject to approval):

Enrolling dependent child(ren) information

Gender: ☐ Male ☐ Female	First name:		MI	Last name:
	Communication preference (if 12+ years of age): ☐ Electronic ☐ Paper		**Email address (Required for electronic communications)**	
	Social Security number:	Date of birth (mm/dd/yyyy)	Supplemental Life insurance amount (subject to approval):	Supplemental AD&D insurance amount (subject to approval):
Gender: ☐ Male ☐ Female	First name:		MI	Last name:
	Communication preference (if 12+ years of age): ☐ Electronic ☐ Paper		**Email address (Required for electronic communications)**	
	Social Security number:	Date of birth (mm/dd/yyyy)	Supplemental Life insurance amount (subject to approval):	Supplemental AD&D insurance amount (subject to approval):
Gender: ☐ Male ☐ Female	First name:		MI	Last name:
	Communication preference (if 12+ years of age): ☐ Electronic ☐ Paper		**Email address (Required for electronic communications)**	
	Social Security number:	Date of birth (mm/dd/yyyy)	Supplemental Life insurance amount (subject to approval):	Supplemental AD&D insurance amount (subject to approval):

Section 5 – Life insurance beneficiary

Primary beneficiary – Blue Shield Life will pay the proceeds to the primary beneficiary. If more than one person is named as primary beneficiary, the proceeds will be distributed equally to those who survive the insured, unless otherwise specified in the % of benefits field.

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

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

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

If beneficiary is a trust or corporation, please provide name and date of trust agreement and state of incorporation.

Name of trust/corporation	Date of trust	State of incorporation

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 above-stated beneficiary designation(s).

Print spouse/domestic partner name:_____

Spouse/domestic partner signature:_____ Date:_____

Section 6 – Authorization

The following authorization section is to be signed by **all** employees applying for coverage with Blue Shield of California Life & Health Insurance Company ("Blue Shield Life").

This enrollment cannot be processed without your signed authorization.

I agree: All information on this 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 application. Blue Shield of California/Blue Shield Life may pursue one of the following remedies within the first 24 months of coverage: my coverage may be canceled, or rescinded. I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California/Blue Shield Life.

Signature of employee_____ Date _____

Print employee name _____

I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

Signature of employee _____ Date _____

Print employee name _____

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Disclosure of personal and health information

At Blue Shield Life, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously. We are required to maintain the privacy and security of your personal information in whatever format it is held – paper, electronic, or oral. This statement applies to personal information about you and your covered dependents that Blue Shield obtains, creates, and/or maintains.

In the course of administering your Blue Shield Life insurance coverage, we collect, use, and disclose information about you and your covered dependents, and we create records about you and the services we provide to you. The information in these records includes individually identifiable personal information such as your name, address, telephone number, and Social Security number, as well as your health information, such as healthcare diagnosis or claim information.

We obtain personal information about you and/or your covered dependents from you, at your direction, and/or with your permission. We also obtain this information from other sources as permitted by law, 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 Life insurance 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 Life maintains a GLBA Notice of Privacy Practices ("GLBA Notice") describing your privacy rights, our obligations to protect your privacy, and how we use 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 GLBA Notice, which applies to all records that we create, obtain, and/or maintain that contain your personal information. Our GLBA Notice will be made available to you when you enroll for Blue Shield Life insurance coverage. You may also obtain a copy of our GLBA Notice by calling the customer service number on your Blue Shield member ID card or by visiting our website at: **blueshieldca.com/bsca/about-blue-shield/privacy/GLBA_Notice_of_privacy_practices.sp**.

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)**。