

(15+ Employees) EMPLOYEE APPLICATION



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DIS NAME: Prov. # PROM BENEFITS: DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH PLAN OR HEALTH INSURANCE IN ADDITION TO THIS INSURANCE? NAME OF INSURED LAST PRIST NAME OF OTHER INSURANCE CARRIER NAME OF OTHER INSURANCE CARRIER NAME: # OF HOURS: SCHOOL: # OF UNITS: STREET ADDRESS CITY RELATIONSHIP TO APPLICANT STREET ADDRESS CITY STATE 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 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 it is and my employer's application have been approved by Blue Shield and CPIC. 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 coverage of the Blue Shield health service contract/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. Even if this application is approved, any misstatements or omissions may result in the future claims being denied and the policy rescinded. I, the applicant, acknowledge that I have read and understand this Application in its entirety.									PCD#			
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