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

(15+ Employees) EMPLOYEE APPLICATION

CPIC Life
A Blue Shield of California Subsidiary

DO NOT WRITE IN SHADED AREAS

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

1

SOCIAL SECURITY NUMBER		EMPLOYER (GROUP) NAME		GR	B/U
LAST NAME	FIRST NAME		MI.	OED	RSN
MAILING ADDRESS	CITY	STATE	ZIP	S / TOC / NP	PKG
JOB TITLE	ARE YOU ACTIVELY WORKING FULL TIME, AT LEAST 30 HOURS PER WEEK? ❑ YES ❑ NO PLEASE EXPLAIN:			CPIC LIFE/AD&D AMOUNT	
DATE OF BIRTH MO DAY YR	SEX M F	MARRIED YES NO	DATE OF FULL TIME HIRE MO DAY YR	EMPLOYEE'S PHONE NUMBER WORK ( )	HOME ( )

IF YOU, YOUR SPOUSE OR YOUR DEPENDENT(S) ARE REFUSING COVERAGE, PLEASE COMPLETE AND SIGN THE REVERSE SIDE.

2 **CHECK ONE:**

❑ ACCESS+HMO ❑ SHIELD SELECT ❑ BLUE SHIELD POS ❑ PREFERRED SAVINGS ❑ PPO ❑ CPIC LIFE ONLY

3 **EMPLOYEE/DEPENDENT INFORMATION:**

ACCESS+ HMO AND POS APPLICANTS MUST SELECT A PRIMARY CARE PHYSICIAN IN THE BLUE SHIELD ACCESS+ HMO PHYSICIAN AND HOSPITAL DIRECTORY. D/HMO APPLICANTS MUST SELECT A PRIMARY CARE DENTIST IN THE **DIRECTORY OF PARTICIPATING DENTIST.** YOU MAY CHOOSE THE SAME OR A DIFFERENT BLUE SHIELD ACCESS+ HMO PRIMARY CARE PHYSICIAN FOR EACH FAMILY MEMBER. *BE SURE TO INCLUDE EACH PRIMARY CARE PHYSICIAN'S PROVIDER NUMBER AND THEIR IPA NUMBER, AND, EACH DENTIST'S PCD NUMBER.*

SELF

HMO and POS ONLY NAME OF PRIMARY CARE PHYSICIAN	Prov. # IPA/MG #	Existing Patient? Y / N	D/HMO ONLY NAME OF PRIMARY CARE DENTIST	PCD #

ARE YOU ENROLLING ELIGIBLE DEPENDENTS? ❑ **YES** ❑ **NO** **IF NO, PLEASE COMPLETE REFUSAL OF COVERAGE**

LAST NAME FIRST	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HMO and POS ONLY NAME OF PRIMARY CARE PHYSICIAN	Existing Patient? Y / N	D/HMO ONLY PRIMARY CARE DENTIST
❑ SPOUSE ❑ PARTNER ❑ M ❑ F			Dr's Name: Prov. # IPA/MG#		Name: PCD #
❑ SON ❑ DAUGHTER			Dr's Name: Prov. # IPA/MG#		Name: PCD #
❑ SON ❑ DAUGHTER			Dr's Name: Prov. # IPA/MG#		Name: PCD #

4 **COORDINATION OF BENEFITS:** DO YOU OR ANY OF YOUR DEPENDENTS HAVE ANY OTHER HEALTH PLAN OR HEALTH INSURANCE IN ADDITION TO THIS INSURANCE? ❑ YES ❑ NO IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION, INCLUDE MEDICARE, IF APPLICABLE.

NAME OF INSURED LAST FIRST	NAME OF OTHER INSURANCE CARRIER	ID NUMBER	EMPLOYER

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 SCHOOLS LISTED BELOW.

NAME: ____________ # OF HOURS: ________ NAME: ____________ # OF HOURS: ________

SCHOOL: ____________ # OF UNITS: ________ SCHOOL: ____________ # OF UNITS: ________

6

LIFE INSURANCE BENEFICIARY	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 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 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.

X ______________________________ X ______________

Signature of Employee Date