

EMPLOYEE APPLICATION

(for 51-299 employees)

New Enrollment Re-Hire

DO NOT WRITE IN SHADED AREA

Employee Information (Please type or print clearly. Use black ink.)

SELF	1 Social Security Number		Employer (Group) Name Santa Barbara IBEW		Dept. Code		Group Number		B/U			
	Last Name			First Name			M.I.		OED		RSN	
	Mailing Address				City		State		Zip		S TOC NP PKG	
	Home Physical Address				City		State		Zip		Life/AD&D Amount	
	Bus. Phone () ()		Home Phone () ()		E-mail Address				Full-Time-Hire Date			
	How would you prefer we contact you? Select one of the following: <input type="checkbox"/> Electronic Mail <input type="checkbox"/> Standard Mail Telephone: <input type="checkbox"/> Home <input type="checkbox"/> Work Blue Shield of California/Blue Shield Life will use your preferred method when possible						Are you a full-time employee, actively working at least 30 hours per week for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain.					
	Date of Birth Mo Day Year			Sex M F		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		Language Preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Other		Check Yes If additional sheet(s) is attached to this Application <input type="checkbox"/> 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.

<p>2 Check Plan(s) (See Important Guidelines on Page 2)</p> <p>Medical Benefits</p> <p><input type="checkbox"/> Access+ HMO <input type="checkbox"/> Shield Spectrum PPO* <input type="checkbox"/> Added Advantage POS <input type="checkbox"/> Shield Spectrum PPO Savings Plus** <input type="checkbox"/> Access Baja HMO <input type="checkbox"/> Shield Spectrum™ PPO Plan 3000-80/50* <input type="checkbox"/> Active Choice Plans*</p>	<p>Optional Benefits</p> <p><input type="checkbox"/> Life* Only <input type="checkbox"/> Dental PPO <input type="checkbox"/> Dental HMO <input type="checkbox"/> Vision</p>
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3 DEPENDENT INFORMATION: Access+ HMO and Added Advantage POS applicants must select a primary care physician in the Blue Shield 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.

Dependent's address if different from employee

Do you have eligible dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No Are they enrolling? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please complete refusal of coverage	Enroll In	Access+ HMO and Added Advantage POS Only – Name of Primary Care Physician	Existing Patient?	Existing Patient?
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> M <input type="checkbox"/> F				
Last Name	<input type="checkbox"/> Medical	Dr's Name:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
First Name	<input type="checkbox"/> Dental	Prov. #	<input type="checkbox"/> No	<input type="checkbox"/> No
Social Security #		IPA/MG#		
Date of Birth				
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				
Last Name	<input type="checkbox"/> Medical	Dr's Name:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
First Name	<input type="checkbox"/> Dental	Prov. #	<input type="checkbox"/> No	<input type="checkbox"/> No
Social Security #		IPA/MG#		
Date of Birth				
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				
Last Name	<input type="checkbox"/> Medical	Dr's Name:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
First Name	<input type="checkbox"/> Dental	Prov. #	<input type="checkbox"/> No	<input type="checkbox"/> No
Social Security #		IPA/MG#		
Date of Birth				
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				
Last Name	<input type="checkbox"/> Medical	Dr's Name:	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
First Name	<input type="checkbox"/> Dental	Prov. #	<input type="checkbox"/> No	<input type="checkbox"/> No
Social Security #		IPA/MG#		
Date of Birth				

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

** Shield Spectrum™ PPO Savings Plan 1500 and Shield Spectrum™ PPO Savings Plan 2600 underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). PPO Savings Plus plans are HSA eligible.

EMPLOYEE APPLICATION
(for 51-299 employees, continued)

Employee Information, Continued

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 of California/Blue Shield Life coverage? Yes No
Will this coverage remain in effect after the Blue Shield of California/Blue Shield 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: _____	Name: _____
School: _____ STATE: _____ # of units: _____	School: _____ STATE: _____ # of units: _____

6 Life Insurance Beneficiary	Relationship to Applicant
Name	
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 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 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 of California/Blue Shield Life.

Authorization for Disclosure of Personal Information: By signing below, you authorize any "provider of care," insurer, health plan, or your Blue Shield of California agent or broker, to disclose to Blue Shield of California or Blue Shield of California Life & Health Insurance Company (individually or collectively referred to as "Blue Shield"), or its representatives, and vice versa, all "medical information" (as those terms are defined in the California Civil Code) regarding you and your applying family members, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for the purposes of evaluating this application, determining eligibility and claims for benefits, quality assurance, peer review, or administrative functions reasonably related to executing and managing this Agreement/Policy. In addition, you authorize Blue Shield of California to obtain personal and medical record information (as those terms are defined in the California Insurance Code) from an institutional source or an insurance support organization that gathers this type of information, for the purposes of determining eligibility for coverage. This authorization will remain valid as follows: (1) for 30 months from the date of authorization for the purposes of processing the application, a policy reinstatement, or a request for change in policy benefits; and (2) for all other activities under the policy, for the term of the coverage or for as long as may be necessary for processing of claims incurred during the term of coverage. You understand that you are entitled to a copy of this form and that a photocopy is as valid as the original.

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

Signature of Employee X _____ **Date X** _____