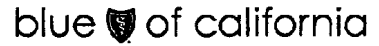


Employee Application (for 51+ employees)



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

- New enrollment (hire date)
Re-hire (re-hire date)

Are you enrolling your spouse/domestic partner or dependent children in any Blue Shield of California plan at this time? Yes No

Section 1 - Employee Information Please type or print clearly. Use black ink.

Internal use only. Do not write in shaded area.

Form with fields for Social Security number, Employer (group) name, Dept code, Group number, BU, Last name, First name, Middle initial, Effective date, Mailing address, Home address, Home phone number, E-mail address, Job title/classification, Contact preference, Full-time employee status, Birthdate, Gender, Marital status, Language preference, Access+ HMO or Added Advantage POS only, Provider number, IPA/MG number, Existing patient?

Section 2 - Plan(s) Check and fill in plan name(s) as appropriate (see Important Enrollment Guidelines on page 1).

Plans for 51+ employees

[X] Access+ HMO (circle one)

High Plan

Low Plan

Section 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 provider listed in the dental HMO provider directory. You may choose a different Access+ HMO primary care physician for each family member, your dependents must live (or work) in the physician's IPA service area. Be sure to include each primary care physician's name, provider number, and their IPA number, as well as each dental provider name and provider number (see coverage for your dependents on page 1 and 2).

Do you have eligible dependents? Yes No Are they enrolling? Yes No If No, please complete the Refusal of Personal Coverage Form

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

Dependent information	Enrollment	Access+ HMO and Added Advantage POS only – name of Personal Physician
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Male <input type="checkbox"/> Female First _____ MI _____ Last _____ Social Security number _____ Date of birth (mo/day/year) _____	<input checked="" type="checkbox"/> Medical	Doctor's name First _____ Last _____ Provider number _____ IPA/MG number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter First _____ MI _____ Last _____ Social Security number _____ Date of birth (mo/day/year) _____	<input checked="" type="checkbox"/> Medical	Doctor's name First _____ Last _____ Provider number _____ IPA/MG number _____ Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Full-time student? (if over 18) <input type="checkbox"/> Yes <input type="checkbox"/> No Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Son <input type="checkbox"/> Daughter First _____ MI _____ Last _____ Social Security number _____ Date of birth (mo/day/year) _____	<input checked="" type="checkbox"/> Medical	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Doctor's name First _____ Last _____ Provider number _____ IPA/MG number _____
Full-time student? (if over 18) <input type="checkbox"/> Yes <input type="checkbox"/> No Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Son <input type="checkbox"/> Daughter First _____ MI _____ Last _____ Social Security number _____ Date of birth (mo/day/year) _____	<input checked="" type="checkbox"/> Medical	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No Doctor's name First _____ Last _____ Provider number _____ IPA/MG number _____
Full-time student? (if over 18) <input type="checkbox"/> Yes <input type="checkbox"/> No Disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No		Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4 – 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.

Signature of employee _____ Date _____

Print employee name _____

Disclosure of Personal and Health Information

Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, "Blue Shield") understand the importance of keeping your and your dependents' personal and health information private. Blue Shield protects this information in electronic, written, and oral forms when used throughout our company. Blue Shield will not disclose this information without your authorization except as permitted by law.

For the purpose of administering your Blue Shield coverage, Blue Shield is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, Blue Shield is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.

A complete explanation of Blue Shield's policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing Blue Shield's Web site.