



Small Group Change of Coverage Application (For Existing Enrollments Only)

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Blue Cross Dental Net and Blue Cross Dental SelectHMO, and all medical products except Blue Cross Basic PPO, Blue Cross Saver PPO and Advantage PPO offered by Blue Cross of California. Blue Cross PPO and FFS Dental, Blue Cross Basic PPO, Blue Cross Saver PPO, Advantage PPO, Life and AD&D products offered by BC Life & Health Insurance Company.



INSTRUCTIONS

Before requesting a different plan, please read the Blue Cross brochure describing the plan you are thinking of choosing.

Be sure you are acquainted with the benefits, Copayments, annual deductibles and the limitations and exclusions of the plan you choose. The plan you choose must be part of your employer's Small Group benefit coverage.

- You, the employee, must complete this application.** You are solely responsible for its accuracy and completeness.
- All questions must be answered in full and all signatures and dates must be included where noted; otherwise, the application may be returned to you, resulting in a delay in processing and possibly a delay in the effective date of coverage.
- Type or print clearly using blue or black ink.**

1. CHOICE OF COVERAGE – Please change my coverage to:

Group No.				

A. MEDICAL COVERAGE SELECTION – Check only one Medical Plan:

- | | | | |
|------------------------------------|---|---|--------------------------------------|
| <input type="checkbox"/> Basic PPO | <input type="checkbox"/> PPO \$40 Copay | <input type="checkbox"/> Premier PPO \$20 Copay | <input type="checkbox"/> Saver HMO |
| <input type="checkbox"/> Saver PPO | <input type="checkbox"/> PPO \$30 Copay | <input type="checkbox"/> Premier PPO \$10 Copay | <input type="checkbox"/> HMO 100% |
| | <input type="checkbox"/> Advantage PPO \$25 Copay | <input type="checkbox"/> High Deductible EPO | <input type="checkbox"/> Other _____ |

If selecting an HMO, you must select a Primary Medical Group (PMG) or an Independent Practice Association (IPA).

If you are selecting an IPA, please select a Primary Care Physician for each enrolling family member and list them by number below in Section 3A.

HMO plan PMG or IPA Medical Office Number: Are you currently a patient of this facility? Yes No

B. DENTAL COVERAGE SELECTION – (If group has elected Dental Coverage) – Check only one Dental Plan:

- | | | |
|---|--|----------------------|
| <input type="checkbox"/> High Option PPO* | <input type="checkbox"/> Dental Net – You must select a Dental Office No. | <input type="text"/> |
| <input type="checkbox"/> Standard Option PPO* | <input type="checkbox"/> Blue Cross Dental SelectHMO – You must select a Dental Office No. | <input type="text"/> |
| <input type="checkbox"/> Basic Option PPO* | <input type="checkbox"/> Other _____ | Dental Office No. |

* Fee-for-service dental coverage is substituted if the member is outside of PPO dental service area.

C. OPTIONAL DEPENDENT LIFE INSURANCE (Available only if offered by employer.) Yes No

2. SUBSCRIBER INFORMATION: Complete address portion ONLY if a recent change.

Last Name		First Name		M.I.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Social Security or ID No.		
Street Address (P.O. Box not acceptable)					# of Dependents including Spouse		Spouse's Social Security or ID No.		
City		State	ZIP Code		Home Phone No. ()		Business Phone No. ()		
Occupation			Employer Name				No. of Hours Worked Per Week		

3. SUBSCRIBER / FAMILY INFORMATION –

List yourself and all eligible family members requesting a change in coverage.

If spouse's last name is different from yours, is he/she a domestic partner? Yes No

3A. HMO only – IPA
If you select an IPA you must choose a Primary Care Physician for each member of your family.

	Last Name	First Name	M. I.	Height	Weight	Age	Birthdate			Provider Number of Primary Care Physician
							Mo	Day	Yr	
10 <input type="checkbox"/> Male 20 <input type="checkbox"/> Female	Subscriber									
30 <input type="checkbox"/> Husband 40 <input type="checkbox"/> Wife	Spouse*									
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										
<input type="checkbox"/> Son <input type="checkbox"/> Daughter										

* Spouse includes domestic partner ONLY if your employer has elected that coverage. If coverage is available, domestic partner enrollment requires submission of a signed and notarized Domestic Partner Affidavit or, if applicable, a copy of a valid Declaration of Domestic Partnership filed with and stamped by the Secretary of State of California.

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4. HEALTH HISTORY OF MEMBERS CURRENTLY ENROLLED:

Your claims history with Blue Cross will also be used in addition to the history listed on this application.

Has any enrolled family member been hospitalized, seen a physician or other health care provider or taken prescription medication within the last 6 months? Yes No *If yes, provide the required medical information below:*

Member Name	Hospital / Provider Name and Address	Condition/Illness Treated	Medication (If applicable)

5. AUTHORIZATION: The following Authorization is to be signed by all employees applying for coverage.

I AGREE: To the best of my knowledge and belief, all information on this form is correct and true. I understand that this application and any information Blue Cross of California and/or BC Life & Health Insurance Company obtains prior to the effective date of coverage 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 to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by BLUE CROSS and BC LIFE & HEALTH INSURANCE COMPANY.

Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded.

I AM APPLYING FOR PPO COVERAGE: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider. If a PPO Plan is selected and a non-participating provider is used, medical payments will be based upon the lesser percentage of the negotiated fee rate and I will be responsible for any amount over that payment.

I AM APPLYING FOR HMO COVERAGE: I understand that I am responsible for paying for services rendered that are not authorized by my primary medical group.

I AM APPLYING FOR a Medical Savings Account (MSA) compatible EPO PLAN: I understand that the MSA compatible Plans are designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. I understand that having

this coverage does not establish an MSA. To do so, I must contact a qualified financial institution. Also, I understand that I should consult my tax advisor.

ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employment Retirement Income Security Act of 1974), certain disputes may not be subject to the following arbitration provisions:

I understand that any and all disputes between myself (and/or any enrolled family member) and Blue Cross of California/BC Life & Health, including claims for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and Blue Cross/BC Life & Health are giving up the right to have any dispute decided in a court of law before a jury. Blue Cross/BC Life & Health and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Evidence of Coverage/Certificate.

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

Signature of Employee X	Date (Mo/Day/Yr)	Signature of Employee's Spouse (If applying for coverage) X	Date (Mo/Day/Yr)
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AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION:

I authorize any physician or other health care professional, hospital or other health care facility, counselor, therapist, or any other medical or medically related facility or professional to give Blue Cross of California or Affiliate ("Blue Cross") its agents, employees, designees, or representatives, including my Blue Cross agent or broker any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related Complex) of me, or any of my dependents applying for or having Blue Cross coverage. I understand that this information may be collected in connection with the review, investigation or evaluation of any application for coverage or of any claim for benefits.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

I also authorize Blue Cross to disclose all such medical or personal information related to myself or any covered dependent, to a health care provider, a health care service plan, a self-insurer, or any insurance company for the purposes of investigating or evaluating any claim for benefits.

This authorization is effective immediately and shall remain in effect for a period of thirty (30) months, except that it shall remain effective for use in connection with any claim for benefits for as long as any Blue Cross coverage may be in effect. A photo copy of this authorization is as valid as the original, and I, and my Blue Cross agent or broker, am entitled to receive a copy of this form.

Signature of Employee X	Date (Mo/Day/Yr)	Signature of Employee's Spouse (If applying for coverage) X	Date (Mo/Day/Yr)
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Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.

