



# Subscriber Insurance Enrollment / Change Form

Group Number: \_\_\_\_\_ Effective Date: \_\_\_\_\_

- New Enrollment
- Add Dependent; Qualifying Event \_\_\_\_\_; Qualifying Event Date \_\_\_\_\_
- Change Address/Name
- COBRA; Qualifying Event \_\_\_\_\_; Qualifying Event Date \_\_\_\_\_
- Delete Dependent
- Termination
- Open Enrollment
- Other \_\_\_\_\_

**SELECTED COVERAGE:**

<b>Blue Shield Low EPO</b> <input type="checkbox"/> RET only <input type="checkbox"/> RET + 1 <input type="checkbox"/> Family	<b>Blue Shield PPO</b> <input type="checkbox"/> RET only <input type="checkbox"/> RET + 1 <input type="checkbox"/> Family
<b>Blue Shield High EPO</b> <input type="checkbox"/> RET only <input type="checkbox"/> RET + 1 <input type="checkbox"/> Family	<b>Blue Shield HDHP</b> <input type="checkbox"/> RET only <input type="checkbox"/> RET + 1 <input type="checkbox"/> Family

NOTE:

**Mid Year Plan Changes Only (Note: This section does not apply to open enrollment):**

I wish to ADD coverage for (check all that apply):    Retiree only    Spouse/RDP only    Child(ren) only

I wish to DELETE coverage for (check all that apply):    Retiree only    Spouse/RDP only    Child(ren) only

**RETIREE INFORMATION**

Last Name	First Name	M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number	Birth Date (mm/dd/yyyy)	Home Phone:	Work Phone:
Residence Street Address	City	State	Zip Code
Mailing Street Address	City	State	Zip Code
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Registered Domestic Partner (RDP) <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced			
Medicare: <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim / HICN #	E-Mail Address:	

**DEPENDENT INFORMATION (Please list all eligible family members to be enrolled. Attach additional sheets if necessary.)**

<input type="checkbox"/> Spouse <input type="checkbox"/> RDP	Last Name	First Name	M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number	Birth Date (mm/dd/yyyy)	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim / HICN #	
Residence Street Address <input type="checkbox"/> Check here if same as Retiree	City	State	Zip Code	
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Last Name	First Name	M.I.	
Social Security Number	Birth Date (mm/dd/yyyy)	Overage Dependent Type <input type="checkbox"/> Disabled <input type="checkbox"/> Over 50% IRS Support	Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B	Medicare Claim / HICN #
Residence Street Address <input type="checkbox"/> Check here if same as Retiree	City	State	Zip Code	

*Signature required (see page 2, under "Acceptance of Coverage")*

**DECLINATION OF COVERAGE** (Complete this section if any coverage is to be declined by you or your eligible dependents.)

**I decline Medical coverage for:**

- Self                       Spouse/RDP Only                       Other Coverage
- Child(ren) Only     Spouse/RDP and Child(ren) Only    Insurance Carrier Name \_\_\_\_\_; or
- The Following Dependents Only                       Other reasons \_\_\_\_\_

**STOP AND READ CAREFULLY.**  
**SIGN ONLY IF DECLINING COVERAGE. IF SIGNED IN ERROR, PLEASE CROSS OUT AND INITIAL.**

The available coverages have been explained to me. I have been given the chance to apply for the available coverages. I have decided not to enroll myself and/or my dependent(s).

**By declining coverage I acknowledge that my dependents and I may have to wait to be enrolled until the next Open Enrollment period or qualifying event. Additionally, by signing below I certify that the reason I am declining coverage is accurate as indicated by the check marks above.**

**Retiree Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**ACCEPTANCE OF COVERAGE** (Signature required.)

**Authorization to obtain or release medical information explanation:** The Authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et. Seq. of the California Civil Code. Your cooperation is being requested.

**Authorization to obtain or release medical information:** I hereby authorize my physician, health care practitioners, hospital, clinic or other medically related facility to furnish to my medical insurance provider, its representatives or designees, any and all records pertaining to medical history, service rendered or treatment given to anyone under the policy for the purpose of review, investigation, or evaluation of an application, claim, appeal, (including the release to an independent review organization) or grievance, or for preventive health or health management purposes. I authorize my health insurance provider, its representatives or designees to disclose to a hospital or health care service plan, self insurer any such medical information obtained if disclosure is necessary to allow the processing of any claim.

**Arbitration Agreement:** I agree and understand that any and all disputes, including claims relating to the delivery of services under the selected medical plan and claims of medical malpractice, (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered,) except for claims subject to ERISA, or any dispute that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or) any enrolled family member including heirs and assigns) and the insurance company providing my medical insurance (its parents, subsidiaries, or affiliates) through the above elected plan, or any Participating Physician Group/Independent Physician Association, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial. Please sign and date this application below. Your signature indicates that you have completed all requested information as accurately as possible and understand all agreements implied including your agreement to submit disputes to binding arbitration.

Retiree Signature	Signature of witness (only required if Retiree signature is "X")	Date
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**FOR SBCERS USE ONLY**

Date entered into System:	Entered by:
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