blue of california

CSEBA Member Application

Reason for application – Please indicate the reason for your enrollment below:

- ☐ New group enrollment
  Group effective date: _____
- ☐ New hire/rehire
  Date of hire/rehire: _____
- ☐ Open enrollment
  Renewal date: _____
- ☐ New spouse/dependent
  Date of marriage/birth/adoption: _____
- ☐ Other qualifying event (specify): _____
  Qualifying event date: _____

Section 1 – Health plan selection – Select one health plan from the package offered by your employer.

CSEBA traditional plans

Trio ACO HMO plans – Trio ACO HMO network

- ☐ California Only / Early Retiree / Certificated, Classified, Management

Access+ HMO® plans – Access+ HMO network

- ☐ California Only / Early Retiree / Certificated, Classified, Management

PPO plans – Full PPO Network

- ☐ California and Out of State / Early Retiree / Certificated, Classified, Management

HSA-compatible HDHP plans – Full PPO Network

- ☐ California and Out of State / Early Retiree / Certificated & Management ONLY

- ☐ **TANDEM PPO**
  California ONLY / Early Retiree / Certificated, Classified, Management

- ☐ **TANDEM (HDHP) HSA PPO**
  California ONLY / Early Retiree / Certificated & Management ONLY

Section 2 – Subscriber information

Note: Social Security numbers are required for all Retirees and their dependents

Social Security number	**Employer (group) name**	**Blue Shield Group ID**
	Chino Valley Unified School District	W0064590

Last name	**First name**	**MI**

Home (physical) address (no P.O. Box addresses)	**City**	**State**	**ZIP code**
Mailing address (if different from home address)	City	State	ZIP code

Home Phone Number:	Cell Phone Number:

Email address (required)

Date of birth: _____ **Gender:** ☐ Male ☐ Female **Marital status:** ☐ Single ☐ Married ☐ Domestic partner

Job title: CVUSD Retiree

Subscriber's last name	First name	MI	Social Security number

Section 3 – HMO primary care physician

This section is only required if you selected an HMO plan. If you selected a PPO plan, please proceed to Section 4.

HMO plan primary care physician selection

Would you like for Blue Shield to designate a primary care physician for you and your dependents who is located near your home or work?

☐ Yes, I would like Blue Shield to designate a primary care physician for me and my dependents.

☐ No, I would like to request a specific primary care physician for myself and my dependents (please specify below).

* Please note: If Blue Shield is unable to assign the primary care physician you requested, Blue Shield will designate a provider. HMO primary care physicians can be changed by visiting **blueshieldca.com/cseba** after enrollment.

HMO primary care physician name	Provider number	IPA/MG name	Existing patient? ☐ Yes ☐ No

Section 4 – Dependent information

Please note: If the employee, spouse/domestic partner, or child dependent(s) are refusing coverage for any product offered by the group, the employee must complete and sign a Refusal of Personal Coverage form at the end of this application instead of completing the section below. Blue Shield will enroll dependents under all plans that the employee is also enrolled/enrolling in unless indicated otherwise.

Dependent type: ○ Spouse ○ Domestic partner	**Gender:** ○ Male ○ Female	**Social Security number (required)**	
First name	MI	Last name	Suffix
Date of birth	Address (if different from employee)		
HMO primary care physician name	Provider number	IPA name	Existing patient? ○ Yes ○ No

Dependent type: ○ Dependent child ○ Other dependent child: legal guardianship	**Gender:** ○ Male ○ Female	**Social Security number (required)**	
First name	MI	Last name	Suffix
Date of birth	Address (if different from employee)		
HMO primary care physician name	Provider number	IPA name	Existing patient? ○ Yes ○ No

Dependent type: ○ Dependent child ○ Other dependent child: legal guardianship	**Gender:** ○ Male ○ Female	**Social Security number (required)**	
First name	MI	Last name	Suffix
Date of birth	Address (if different from employee)		
HMO primary care physician name	Provider number	IPA name	Existing patient? ○ Yes ○ No

Dependent type: ○ Dependent child ○ Other dependent child: legal guardianship	**Gender:** ○ Male ○ Female	**Social Security number (required)**	
First name	MI	Last name	Suffix
Date of birth	Address (if different from employee)		
HMO primary care physician name	Provider number	IPA name	Existing patient? ○ Yes ○ No

Subscriber's last name	First name	MI	Social Security number

Section 7 - Disclosure of personal and health information

At Blue Shield of California, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously. Blue Shield protects the privacy and security of the personal information that we maintain, use, and disclose for purposes of administering your Blue Shield coverage.

Blue Shield obtains personal information about you and/or your covered dependents, including health and/or financial information, from you, at your direction, and/or with your permission. We are also permitted by federal and state law to obtain your personal information from other sources, including, for example, from your healthcare provider, insurer, insurance support organization, health plan, or insurance agent. We use and disclose your personal information to administer your Blue Shield coverage and as otherwise permitted or required by law. In doing so, we may disclose your personal information to others including, for example, a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Blue Shield will not disclose your personal information without your authorization except as permitted or required by law.

Blue Shield is required to provide you with a Notice of Privacy Practices ("Notice") that describes your privacy rights, our obligations to protect your privacy, and how we use and disclose your personal information with and without your specific authorization. When we use or disclose your personal information, we are bound by the terms of the Notice, which applies to all records that we create, obtain, and/or maintain that contain your personal information. You will receive our Notice when you enroll for Blue Shield coverage. You may also obtain a copy of our Notice by calling the customer service number on your Blue Shield member ID card or by visiting our website at **blueshieldca.com/bsca/documents/about-blue-shield/privacy**.

Acknowledgement and signature

I acknowledge and agree: All information I have provided on this enrollment 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 committed fraud or made an intentional misrepresentation of any material fact in conjunction with this enrollment within 24 months of issuance, Blue Shield may pursue one of the following remedies: coverage may be cancelled, or the applicable premium may be adjusted, or, following notice, coverage may be 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.

Signature of employee **Date**

Print employee name

All pages of this form are necessary to process your enrollment.
Missing information may delay processing.