

# CSEBA Member Application

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

<input type="checkbox"/> New group enrollment Group effective date: _____	<input type="checkbox"/> New hire/rehire Date of hire/rehire: _____
<input type="checkbox"/> Open enrollment Renewal date: _____	<input type="checkbox"/> COBRA/Cal-COBRA enrollment
<input type="checkbox"/> New spouse/dependent Date of marriage/birth/adoption: _____	<input type="checkbox"/> 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

☐ \_\_\_\_\_

#### Access+ HMO® plans – Access+ HMO network

☐ \_\_\_\_\_

#### PPO plans – Full PPO Network

☐ \_\_\_\_\_

#### HSA-compatible HDHP plans – Full PPO Network

☐ \_\_\_\_\_

### CSEBA marketplace plans

#### Trio ACO HMO plans – Trio ACO HMO network

- ☐ Trio ACO HMO 15 Platinum \$100 Admit  
☐ Trio ACO HMO 20 Gold \$500 Admit  
☐ Trio ACO HMO 20 Silver \$500 Facility Deductible  
☐ Trio ACO HMO 20 Bronze \$1500 Facility Deductible

#### Access+ HMO plans – Access+ HMO network

- ☐ Access+ HMO 15 Platinum \$100 Admit  
☐ Access+ HMO 20 Gold \$500 Admit  
☐ Access+ HMO 20 Silver \$500 Facility Deductible  
☐ Access+ HMO 40 Bronze \$1500 Facility Deductible

#### PPO plans – Full PPO Network

- ☐ PPO Gold 20 500/1500 90/70  
☐ PPO Silver 30 1000/3000 80/60

#### HSA-compatible HDHP plans – Full PPO Network

- ☐ PPO Bronze Savings 2600/5200 80/20

## Section 2 – Subscriber information

**Note: Social Security numbers are required for all employees and their dependents aged 40 and above.**

<b>Social Security number</b>		<b>Employer (group) name</b>		<b>Blue Shield Group ID</b>	
<b>Last name</b>		<b>First name</b>			<b>MI</b>
<b>Home (physical) address (no P.O. Box addresses)</b>		<b>City</b>	<b>State</b>	<b>ZIP code</b>	
Mailing address (if different from home address)		City	State	ZIP code	
Work phone number:	Home phone number:	Language preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____			
Email address (required)		How would you prefer we contact you? Blue Shield will use your preferred method when possible. <input type="checkbox"/> Email <input type="checkbox"/> Standard mail <input type="checkbox"/> Telephone: <input type="checkbox"/> Work <input type="checkbox"/> Home			
<b>Date of birth:</b> _____		<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>Marital status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic partner	
<b>Date of hire:</b> _____ (Full time or part time as noted below. If orientation period is applied, the date of hire is the first day after completion of the orientation period.)		<b>Job title:</b> _____			
		<b>Job classification:</b> _____			
Do you have any eligible dependent children under the age of 26? <input type="checkbox"/> Yes <input type="checkbox"/> No How many? _____ How many are enrolling? _____					
<b>Employment status:</b> Do you actively work 30 hours or more per week for this employer? (full-time employee) <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Or</b> Do you actively work between 20 and 29 hours per week for this employer? (part-time employee) <input type="checkbox"/> Yes <input type="checkbox"/> No If no to both of the above, are you an existing COBRA participant or enrolling due to a COBRA qualifying event? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, proceed to Section 3.					

<b>Subscriber's last name</b>	<b>First name</b>	<b>MI</b>	<b>Social Security number</b>
-------------------------------	-------------------	-----------	-------------------------------

### 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](https://www.blueshieldca.com/cseba) after enrollment.

<b>HMO primary care physician name</b>	<b>Provider number</b>	IPA/MG name	Existing patient? <input type="checkbox"/> Yes <input type="checkbox"/> 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.

<b>Dependent type:</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Social Security number (required)</b>	<b>Enrolling in all products selected by subscriber?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	--	---

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
---------------------------------	-----------------	----------	---

<b>Dependent type:</b> <input type="checkbox"/> Dependent child <input type="checkbox"/> Other dependent child: legal guardianship	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Social Security number (required)</b>	<b>Enrolling in all products selected by subscriber?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	--	---

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
---------------------------------	-----------------	----------	---

<b>Dependent type:</b> <input type="checkbox"/> Dependent child <input type="checkbox"/> Other dependent child: legal guardianship	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Social Security number (required)</b>	<b>Enrolling in all products selected by subscriber?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	--	---

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
---------------------------------	-----------------	----------	---

<b>Dependent type:</b> <input type="checkbox"/> Dependent child <input type="checkbox"/> Other dependent child: legal guardianship	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Social Security number (required)</b>	<b>Enrolling in all products selected by subscriber?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If no, Refusal of Coverage attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--	--	---

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? <input type="checkbox"/> Yes <input type="checkbox"/> No
---------------------------------	-----------------	----------	---

Subscriber's last name	First name	MI	Social Security number
------------------------	------------	----	------------------------

**Section 5 – Other health plan information** – If enrolling due to a loss of coverage under a prior health plan and/or to receive credit toward any employer waiting period, documentation is required to verify the date of the qualifying event.

Does any person applying for coverage currently have health coverage or previously had health coverage at any time in the past six (6) months? ☐ Yes ☐ No

If yes, specify carrier: \_\_\_\_\_

Type of coverage: ☐ Group ☐ Individual ☐ Medicare ☐ Covered California/State Health Insurance Exchange ☐ Other (specify): \_\_\_\_\_

Policy/ID No. \_\_\_\_\_ Date coverage began: \_\_\_\_\_ Date ended (if coverage is active, please leave blank): \_\_\_\_\_

Please list all subscriber and dependent member names currently or previously enrolled in the health coverage identified above:

Documentation attached?  
☐ Yes ☐ No

## Section 6 – COBRA/Cal-COBRA group continuation coverage

Please complete this section only if enrolling for COBRA or Cal-COBRA group continuation coverage. Those individuals already enrolled in COBRA or Cal-COBRA coverage from a prior carrier are eligible to continue that coverage with Blue Shield for the remaining duration of time allowed through COBRA and/or Cal-COBRA (as applicable). Proof of enrollment as a COBRA/Cal-COBRA participant is required.

Please provide the name of the employee through whom group coverage was obtained prior to the qualifying event, in order to be eligible for COBRA/Cal-COBRA continuation coverage.

Employee last name	Employee first name	MI
Employee's/subscriber's Blue Shield ID (if applicable)	Original qualifying event date _____	

### Qualifying event reason:

- ☐ Termination or reduction in hours (last day worked)
- ☐ Termination or reduction in hours due to disability
- ☐ Divorce or legal separation
- ☐ Entitlement to Medicare by covered employee

- ☐ Attainment of maximum age for a dependent child
- ☐ Death of covered employee
- ☐ Termination of domestic partnership

## 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](https://www.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.**