



**SECTION 3 - EMPLOYEE/DEPENDENT INFORMATION** -List yourself and only those eligible dependents who are enrolling.

An eligible dependent is an employee's lawful spouse or domestic partner (if employer has elected to cover domestic partners); a child (except a newborn) of an employee who is the permanent legal guardian of that child and for which a valid court order establishing guardianship has been submitted; the unmarried child(ren) of the employee or the employee's spouse who are under age 19, or the unmarried child(ren) of the employee or enrolled spouse of the nineteenth (19 ) to the twenty-fourth (24 ) birthday who qualify as dependents for federal income tax purposes and are full-time students. Blue Cross requires written proof of student status annually.

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

FAMILY ADDITION: Date of Marriage: \_\_\_\_\_

Date of Adoption: \_\_\_\_\_

**3A. HMO Only** - IPA (if you select an IPA, you must chose a primary care physician for each member of your family.

Sex	Last Name	First Name	M.I.	Social Security or ID No.	Height	W eight	Disabled?	Date of Birth (MM/DD/YY)	Primary Care Physician No.
<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee						<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse/Domestic Partner						<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Male <input type="checkbox"/> Female							<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Male <input type="checkbox"/> Female							<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Male <input type="checkbox"/> Female							<input type="checkbox"/> Yes <input type="checkbox"/> No		

**SECTION 4 - COVERAGE DECLINATION** -To be completed if any coverage is declined or refused by an eligible employee and/or their eligible dependents.

Health Plan Coverage Declined For: <input type="checkbox"/> Myself <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Child(ren)	
Reason for declining coverage: (Check One)	
<input type="checkbox"/> Covered by spouse's group coverage: Carrier name and I.D. # _____ <input type="checkbox"/> Covered by Blue Cross Individual Policy <input type="checkbox"/> Spouse covered by employer's group medical coverage: Carrier Name: _____	<input type="checkbox"/> Covered by Tricare <input type="checkbox"/> Enrolled in any other insurance carrier plan: Carrier Name: _____ <input type="checkbox"/> Medicare <input type="checkbox"/> Other (Explain): _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have declined not to enroll myself and/or my dependent(s), if any, I have made this decision voluntarily and no one has tried to influence me or put any pressure on me to decline coverage. BY DECLINING THIS GROUP MEDICAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP MEDICAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT TWELVE (12) MONTHS FROM THE DATE OF ANY FUTURE APPLICATION TO BE ENROLLED IN THIS GROUP MEDICAL PLAN. PRE-EXISTING CONDITIONS WHEN ENROLLED IN THIS GROUP MEDICAL PLAN, MAY NOT BE COVERED FOR SIX (6) MONTHS.

X \_\_\_\_\_  
Signature if declining coverage for employee/dependent(s)

\_\_\_\_\_  
Date (MM/DDD/YY)

**SECTION 5 - OTHER COVERAGE FOR ALL ENROLLING EMPLOYEES AND DEPENDENTS** -All questions must be answered

1. Do any persons on this application intend to continue other Group coverage if this application is accepted?  Yes  No

If Yes, name of person: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

2. Does any person applying for coverage currently have health insurance coverage?  Yes  No

Has any person applying for coverage had health insurance coverage at any time in the past six months?  Yes  No

If Yes, applicant/family member name(s): \_\_\_\_\_

Type of continuous coverage:  Group  Individual  Other: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Date coverage began: \_\_\_\_\_ Date Ended: \_\_\_\_\_

3. Is any person applying for coverage eligible for Medicare or currently receiving Medicare benefits?  Yes  No

NOTE: If you are eligible for Medicare, Blue Cross may not duplicate Medicare benefits.

**SUBMIT PROOF OF COVERAGE** -To comply with federal and state laws, proof of this coverage must accompany this application.

**Acceptable forms of proof are:**

1. Certificate of coverage from prior carrier;  
or
2. Copy of I.D. card and copy of payroll stub showing medical coverage deduction; or
3. Copy of most recent medical premium bill or certificate of coverage from prior carrier.

**Failure to advise and provide proof of prior coverage may subject you or a family member to a six-month pre-existing conditions clause.**

**SECTION 6 - 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 and 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 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 HMO COVERAGE:** I understand that I am responsible for paying for services rendered that are not authorized by my primary medical group.

**ARBITRATION AGREEMENT: If your coverage under a private employer plan governed by EROSA (Employment Retirement Income Security Act of 1976), 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 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.

**All signatures and dates below are required if applying for coverage.**

Signature of Employee <b>X</b>	Date (MM/DD/YY)	Signature of Employee's Spouse/Domestic Partner (if applying for coverage) <b>X</b>	Date (MM/DD/YY)
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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, AIDS (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related Complex), except the results of HIV testing, to me, or any of my dependants 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 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 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.

**All signatures and dates below are required if applying for coverage.**

Signature of Employee <b>X</b>	Date (MM/DD/YY)	Signature of Employee's Spouse/Domestic Partner (if applying for coverage) <b>X</b>	Date (MM/DD/YY)
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**After completing, sign Authorization and submit application to your employer. Incomplete applications will be mailed back to you for completion. This may delay the effective date of your coverage.**

**Mail or Fax Application Back To:**  
**Banyan Administrators, LLC**  
**1215 Manor Drive, Suite 200**  
**Mechanicsburg, PA 17055**  
**Phone: 877-480-7923 FAX: 877-237-4519**

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