blue of california

Los Angeles Machinist Benefit Trust

Early Retiree Enrollment Application for Blue Shield of California Health Insurance

***Please note:** Failure to legibly fill out enrollment application completely may result in a delay in the enrollment process.

Reason for application:

☐ New hire ☐ Re-hire date ___/___/_____	☐ Loss of coverage date ___/___/_____ ☐ Open enrollment	☐ Late enrollment ☐ Other qualifying event type_____ Date above event occurred ____/____/____

Section 1 – Important enrollment guidelines for Specialty Benefits coverage

Dental, Vision, and Life Insurance coverage – An employee may enroll in a dental, vision, or Life plan without enrolling in a health plan. In order for a dependent to enroll in a dental or vision plan, the employee must be enrolled in the same dental or vision plan.

All of an employee's dependents enrolled in the health plan will automatically be enrolled in the Dependent Life Insurance plan if the employer offers dependent life insurance coverage.

An employee must enroll in basic life insurance to be eligible to enroll in supplemental life insurance coverage. The employee may also enroll their spouse/domestic partner and child(ren) in supplemental life insurance – only if supplemental dependent life insurance is offered by the employer. Coverage may be subject to evidence of insurability. For all life insurance coverage, if an employer contributes 100% of the premium, then 100% of eligible employees must enroll.

Section 2 – Employee information

Internal use only. Do not write in shaded area.

Social Security number	**Employer (group) name**	Department code	Group number	BU
Last name	**First name**	MI	Effective date _____/_____/_____	

Employment status: ☐ Full Time ☐ Part Time ☐ Retiree	**Date of Hire:** _____/_____/_____	Job title/classification

Home address – (street, city, state, ZIP)

Mailing address (if different than home address)

Home phone number	E-mail address	How would you prefer we contact you? ☐ E-mail ☐ Standard mail ☐ Telephone
Date of birth _____/_____/_____	**Gender** ☐ Male ☐ Female	**Marital status** ☐ Single ☐ Married ☐ Domestic partner

Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

Are you enrolling your spouse/domestic partner and/or child dependents ☐ **Yes** ☐ **No If yes, complete Section 3 of application.**

HMO Provider Information: Blue Shield of California directory website: www.blueshieldca.com/fap/app/search.html

Name of primary care physician (PCP):

Provider number:	IPA/Medical Group number:	Existing patient? ☐ Yes ☐ No

Section 3 – Dependent Spouse/Domestic Partner/Children information

If you, your spouse/domestic partner, or your dependents are refusing coverage, please complete and sign the Refusal of Personal Coverage Form.

Dependent's address, if different from employee – please indicate which dependent(s) this applies to:

Enrolling Spouse/Domestic Partner information	Access+ HMO – name of Personal Physician
☐ Spouse ☐ Domestic partner ☐ Male ☐ Female First MI Last **Social Security number** Date of birth (mm/dd/yyyy)	Doctor's name First Last Provider number IPA/MG number Existing patient? ☐ Yes ☐ No

Section 4 – Medicare Information

Employee:

Are you or any of your dependents currently covered by Medicare? ☐ No ☐ Yes. Please attach a copy of your Medicare card(s) and/or enter the type of coverage here: Part A: ☐ Effective date: ____/____/____(mm/dd/yyyy) Part B: ☐ Effective date: ____/____/____(mm/dd/yyyy)
Is Medicare eligibility due to End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
If yes, please answer the following questions:

a) What was the first date of dialysis treatment, and what type of dialysis are you receiving?
Date_____ Type: ☐ Hemo ☐ Self-dialysis (peritoneal)

b) If you have had a kidney transplant, what was the date of the transplant: ____/____/____(mm/dd/yyyy)

Enrolling Spouse/Domestic Partner:

Are you or any of your dependents currently covered by Medicare? ☐ No ☐ Yes. Please attach a copy of your Medicare card(s) and/or enter the type of coverage here: Part A: ☐ Effective date: ____/____/____(mm/dd/yyyy) Part B: ☐ Effective date: ____/____/____(mm/dd/yyyy)
Is Medicare eligibility due to End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
If yes, please answer the following questions:

a) What was the first date of dialysis treatment, and what type of dialysis are you receiving?
Date_____ Type: ☐ Hemo ☐ Self-dialysis (peritoneal)

b) If you have had a kidney transplant, what was the date of the transplant: ____/____/____(mm/dd/yyyy)

Section 5 – Authorization –

The following authorization section is to be signed by **all** employees applying for coverage with Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield Life"). **This enrollment cannot be processed without your signed authorization.**

I agree: All information on this 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 application within the first 24 months of coverage, my coverage may be cancelled, or 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/ Blue Shield Life.

Signature of employee_____ Date _____

Print employee name _____

Disclosure of Personal and Health Information

Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, "Blue Shield") understand the importance of keeping your and your dependents' personal and health information private. Blue Shield protects this information in electronic, written, and oral forms when used throughout our company.

Blue Shield will not disclose this information without your authorization except as permitted by law.

For the purpose of administering your Blue Shield coverage, Blue Shield is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, Blue Shield is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.

A complete explanation of Blue Shield's policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing Blue Shield's web site.