



# EmployeeElect for 2-50 Member Small Groups

Small Group Health Coverage offered by Blue Cross of California (BCC) and BC Life & Health Insurance Company (BCL&H)

[www.bluecrossca.com](http://www.bluecrossca.com)

# Employee Application

Group No.

Please complete using black ink/type, seal the inside pages for privacy and return to your Group Administrator. You, the employee, must complete this application. You are solely responsible for its accuracy and completeness. To avoid the possibility of delay, please answer all questions and be sure to sign and date your application.

## 1a. Medical Coverage ... please ask your employer which Medical plans are available before checking your selection:

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Basic PPO**            | <input type="checkbox"/> Lumenos HSA 3000**         | <input type="checkbox"/> Power HealthFund 750**      | <input type="checkbox"/> Power Select HMO* <i>If HMO, be sure to provide physician number in section 3</i> |
| <input type="checkbox"/> Saver PPO**            | <input type="checkbox"/> Lumenos HIA Plus 3000**    | <input type="checkbox"/> PPO 3500 (HSA-Compatible)** | <input type="checkbox"/> Saver HMO*  |
| <input type="checkbox"/> PPO \$35 Copay GenRx** | <input type="checkbox"/> Advantage PPO \$25 Copay** | <input type="checkbox"/> PPO 2400 (HSA-Compatible)** | <input type="checkbox"/> Classic HMO*  |
| <input type="checkbox"/> PPO \$45 Copay GenRx** | <input type="checkbox"/> Premier PPO \$20 Copay*    | <input type="checkbox"/> High Deductible EPO*        | <input type="checkbox"/> HMO 100%*   |
| <input type="checkbox"/> PPO \$30 Copay*        | <input type="checkbox"/> Premier PPO \$10 Copay*    | <input type="checkbox"/> Other: _____                |  |
| <input type="checkbox"/> PPO \$40 Copay*        | <input type="checkbox"/> Power HealthFund 500**     |  |  |
| <input type="checkbox"/> Lumenos HSA 1500**     |   |  |  |
- If directed by your employer, Blue Cross will facilitate the opening of a Health Savings Account in your name.

\* offered by BCC  
\*\* offered by BCL&H

## 1b. Dental Coverage ... please ask your employer which Dental options are available before checking your selection:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Dental Blue Platinum Plus** | <input type="checkbox"/> High Option PPO**   | <input type="checkbox"/> Dental Net*   | <b>Voluntary Dental Coverage</b><br><input type="checkbox"/> PPO Dental Plan**<br><input type="checkbox"/> Dental Saver SelectHMO* – You must select a Dental Office Number (to the left)<br><input type="checkbox"/> Other _____ * offered by BCC<br>** offered by BCL&H |
| <input type="checkbox"/> Dental Blue Platinum**      | <input type="checkbox"/> Standard Option PPO**   | <input type="checkbox"/> Dental SelectHMO*   |   |
| <input type="checkbox"/> Dental Blue Gold Plus**     | <input type="checkbox"/> Basic Option PPO**  | <i>For above 2 HMO plans, you must select a Dental Office Number:</i> <input type="text"/> |   |
| <input type="checkbox"/> Dental Blue Gold**          | <i>For above 3 PPO plans, fee-for-service coverage will be substituted if member is outside of PPO service area.</i> |  |   |
| <input type="checkbox"/> Dental Blue Silver Plus**   | <i>If you select a Dental Blue plan, you must also select a network. Please check one:</i>                           |  |   |
| <input type="checkbox"/> Dental Blue Silver**        | <input type="checkbox"/> 100 <input type="checkbox"/> 200 <input type="checkbox"/> 300                               |  |   |

## 1c. Vision Coverage ... please check with your employer to make sure these options are available before selecting:

- Blue View    OR     Blue View Plus *offered by BCL&H*

## 1d. Life Coverage ... please check with your employer to make sure these options are available before selecting:

- Optional Dependent Life Insurance (**only** if offered by your employer)
- \$10,000/\$1,000 (\$10,000 spouse/child 6 mo-24 yrs; \$1,000<6 mo)
- \$5,000/\$500 (\$5,000 spouse/child 6 mo-24 yrs; \$500<6 mo)
- Supplemental Life Insurance (in **addition** to Term Life, if it is offered)  Yes  No
- Amount:  \$15,000     \$25,000     \$50,000     \$100,000

## 2. Please provide the following enrollment information (must be completed by the employee):

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> New group enrollment | <input type="checkbox"/> New hire           | <input type="checkbox"/> COBRA                                  | <input type="checkbox"/> COBRA/Cal-COBRA |
| <input type="checkbox"/> Family addition      | <input type="checkbox"/> Change of coverage | <input type="checkbox"/> Cal-COBRA                              | Effective Date: <input type="text"/>     |
| <input type="checkbox"/> Late enrollment      | <input type="checkbox"/> Other: _____       | <i>(Cal-COBRA applicants must submit first month's premium)</i> |  |

Last Name		First Name		M.I.	Social Security or ID No.	
Home Address (P.O. Box not acceptable unless rural P.O. Box)				Apt No.	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner (DP)	
City		State	ZIP Code	# of Dependents including Spouse/DP		Spouse/DP Social Security or ID No.
Employer Name		Occupation/Job Title			Home Phone No. (    )	
Hire Date		<input type="checkbox"/> Part time <input type="checkbox"/> Full time	Salary (Required) \$	<input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		Business Phone No. (    )
Life Insurance Beneficiary – Last Name		First		M.I.	Relationship	

When information is sent to you, we may be able to send it in a language other than English. What language would you prefer? (Optional)  
 Spanish  Chinese  Korean  Japanese  Arabic  Khmer  Vietnamese  Armenian  Tagalog  Farsi  Russian  Hmong  Other \_\_\_\_\_

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Social Security or ID No.

**3. Please tell us about yourself and your eligible enrolling dependents ...**

**Eligible dependent** is an employee's lawful spouse or domestic partner; a child of an employee who is the permanent legal guardian of that child and for whom a valid court order establishing guardianship has been submitted; the unmarried child(ren) of the employee or, of the employee's spouse/domestic partner who are under age 19, or, the unmarried child(ren) of the employee or enrolled spouse/domestic partner from the nineteenth (19th) to the twenty-fourth (24th) birthday who qualify as dependents for federal income tax purposes and are full time students. Blue Cross requires written proof of student status annually. Written proof of relationship may be required for certain dependent enrollments. For example, an existing subscriber who is adding a dependent spouse or domestic partner must provide copy of a Marriage Certificate, Declaration of Domestic Partnership or equivalent document. For enrollment of an adopted child, legal evidence of adoption (or intent to adopt) is required.

FAMILY ADDITION: Date of marriage or Domestic Partnership Declaration: \_\_\_\_\_ Date of adoption: \_\_\_\_\_

Sex	Last Name	First Name	MI	Height	Weight	Birthdate Mo. Day Year	Disabled	HMO plans only:	
								Primary Care Physician No. or 3-digit Medical Group/IPA No.	Current Patient
<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse/DP						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Son <input type="checkbox"/> Daughter							<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

**Note:** If any enrolling dependent(s) do not live at the address you listed in Section 2 on the previous page, please provide their address(es) on a separate piece of paper.

**4. Please complete if you want to decline coverage for yourself and/or any eligible dependents:**

Type of Coverage:	Declined for:	Reason for declining: (proof of coverage may be required)
Medical plan	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Covered by another employer-sponsored group plan; carrier name is: _____
Dental plan (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Covered by Individual Policy <input type="checkbox"/> Covered by Tricare <input type="checkbox"/> Covered by Medicare
Vision plan (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Covered by MediCal <input type="checkbox"/> Enrolled in any other insurance carrier plan; name: _____
Life coverage (if offered)	<input type="checkbox"/> Self <input type="checkbox"/> Child(ren) <input type="checkbox"/> Spouse/DP	<input type="checkbox"/> Other: _____

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 decided 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 UP TO TWELVE (12) MONTHS TO BE ENROLLED IN THIS GROUP'S MEDICAL AND/OR GROUP LIFE INSURANCE PLAN, as well as a six-month pre-existing condition exclusion UNLESS ENTITLED TO A SPECIAL ENROLLMENT PERIOD DUE TO CERTAIN CHANGED CIRCUMSTANCES (E.G., ACQUISITION OF A DEPENDENT OR LOSS OF OTHER COVERAGE THROUGH A DEPENDENT.) The twelve (12) month wait will not apply if: (1) I certified at the time of initial enrollment that the coverage under another employer health benefit plan or no share-of-cost Medi-Cal coverage was the reason for declining enrollment and I lose coverage under that employer health benefit plan or no share-of-cost Medi-Cal; (2) my employer offers multiple health benefit plans and I elected a different plan during an open enrollment period; (3) a court orders that I provide coverage under this plan for a spouse or minor child or (4) if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, they may be able to be enrolled if enrollment is requested within 30 days after the marriage, birth, adoption or placement for adoption.

If I am declining enrollment for myself and/or my dependent(s) (including my spouse/domestic partner) because of other health insurance or group health plan coverage, I must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

**X** \_\_\_\_\_  
Signature if declining coverage for self/dependents

\_\_\_\_\_ Date (Month/Day/Year)

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**5. Health Questionnaire for Groups Enrolling 1-10 Employees**  
**Groups with 11-50 Enrolling Employees: Do not complete this section. Please skip to Section 5A.**  
*Blue Cross will not give this confidential information to your employer.*

All questions must be answered "Yes" or "No".

INCOMPLETE APPLICATIONS WILL BE RETURNED TO YOU FOR COMPLETION WHICH MAY DELAY THE EFFECTIVE DATE OF YOUR COVERAGE.

**Has any person listed on this application ever had, consulted for, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions?**

- 1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins, or any other disorder of the heart, blood, blood vessels, hyperlipemia or arteriosclerosis? .....  Yes  No
- 2. Ulcer, colitis, gall stone, hernia or any other disorder of the stomach, intestines, rectum, gall bladder, or liver?.....  Yes  No
- 3. Cancer, cyst, or tumor? .....  Yes  No
- 4. Disorder of the kidneys, blood or albumin, thyroid glands, diabetes, venereal disease or any related eye disorders, urinary systems, male or female organs, or menstrual dysfunction?.....  Yes  No
- 5. Tuberculosis, asthma, hay fever, adenoids, pleurisy or any other disorder of the lungs or respiratory system?.....  Yes  No
- 6. Epilepsy, fainting spells, mental or nervous condition, paralysis or any disorder of the brain or nervous system?.....  Yes  No  
If epileptic, date of last seizure: \_\_\_\_\_
- 7. Been treated for alcoholism or other drug or substance abuse or been advised to seek treatment for the same? .....  Yes  No
- 8. Arthritis, rheumatic fever, back trouble, or any other disorder of the joints, muscles, or bones? .....  Yes  No
- 9. Any physical deformity or defect? Any serious bodily injury, fracture, concussion, burn, and/or congenital problems? .....  Yes  No
- 10. Has any person to be covered had or been told that they had an immune deficiency disorder, AIDS, or AIDS-related complex, not including the results of HIV testing? .....  Yes  No
- 11. Within the last 12 months, taken medicine as prescribed by a physician or other health practitioner? .....  Yes  No
- 12a. Is any female to be covered currently pregnant? .....  Yes  No  
If yes, Due Date (Month): \_\_\_\_\_
- b. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application? .....  Yes  No
- 13. Does anyone listed on this application use tobacco products?.....  Yes  No

**If you answer "Yes" to all or part of above questions 1-12b, please complete the following** (Insert additional sheets if necessary):

Question # \_\_\_ Name of patient \_\_\_\_\_  
 Condition treated \_\_\_\_\_  
 Dates of treatment: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still under treatment   
 Treatment rendered \_\_\_\_\_  
 Medication and dosage taken \_\_\_\_\_  
 Dates taken: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still taking

Question # \_\_\_ Name of patient \_\_\_\_\_  
 Condition treated \_\_\_\_\_  
 Dates of treatment: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still under treatment   
 Treatment rendered \_\_\_\_\_  
 Medication and dosage taken \_\_\_\_\_  
 Dates taken: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still taking

Question # \_\_\_ Name of patient \_\_\_\_\_  
 Condition treated \_\_\_\_\_  
 Dates of treatment: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still under treatment   
 Treatment rendered \_\_\_\_\_  
 Medication and dosage taken \_\_\_\_\_  
 Dates taken: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still taking

Question # \_\_\_ Name of patient \_\_\_\_\_  
 Condition treated \_\_\_\_\_  
 Dates of treatment: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still under treatment   
 Treatment rendered \_\_\_\_\_  
 Medication and dosage taken \_\_\_\_\_  
 Dates taken: Start \_\_\_\_\_ End \_\_\_\_\_  
 check here if still taking



Social Security or ID No. \_\_\_\_\_

**6. Other Coverage – please be sure to complete this important information:**

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. 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 coverage:  Group  Individual  Other: \_\_\_\_\_

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

Date coverage began: \_\_\_\_\_ Dated ended: \_\_\_\_\_

3. Does any person applying for coverage currently have Dental Insurance Coverage?.....  Yes  No

If yes:

Applicant/family member name(s): \_\_\_\_\_

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

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

Date coverage began: \_\_\_\_\_ Dated ended: \_\_\_\_\_

4. 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 ID card **and** copy of payroll stub showing medical coverage deduction, **or**
3. Copy of most recent medical premium bill.

**Please note: If you or a family member have/had a medical condition before coming to our plan for which medical advice, diagnosis, care or treatment was recommended or received within the last six months and you do not advise and provide proof of prior coverage, you may be subject to a six-month preexisting condition exclusion (does not apply to HMOs).** That means that you might have to wait at least six months before the plan will provide coverage for that condition (does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption or placement for adoption). In some cases, the exclusion may last up to 12 months, or as long as 18 months for late enrollees. However, the length of the waiting period can be reduced by the number of days of prior "creditable coverage," which means not experiencing a break in qualified prior health coverage that lasted more than 63 days for an Individual plan or 180 days for an employer-sponsored or employer-related plan. Proof of creditable coverage is required to reduce a waiting period, including a copy of the certificate or other documentation, which we can help you obtain from a prior plan/issuer if needed.

After completion, remove tape on inside pages, fold closed to seal, and submit application to your employer.

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**7. 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 his application and any information Blue Cross of California and/or BC Life & 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 my employer's place of business in permanent employment.

I understand that 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.

**RESCISSION OF MEMBERSHIP:** I have provided a complete history of material information that is considered in the acceptance or denial of this enrollment application. I understand and agree that I alone am responsible for the accuracy and completeness of this application, and to the best of my knowledge and belief, I have done everything necessary to be able to assure you that all information about any children under the age of 18 listed on this application is true and complete. Also, all of my dependents listed on this application that are over the age of 18 years have read this application and have provided complete and accurate information for this application. I understand and agree that following approval of the enrollment application, if Blue Cross discovers that I intentionally provided incomplete or false material information or withheld material information from Blue Cross prior to the Effective Date of the Agreement, Blue Cross may revoke coverage. This means Blue Cross may cancel coverage as if it never existed.

If Blue Cross revokes your coverage under the Combined Evidence of Coverage and Disclosure Form, Blue Cross will send you a written notice explaining the basis for the decision and your appeal rights. You have the option to submit a new application in the future to be underwritten and considered for enrollment. You will be required to pay for any services that were covered while you were a Member, and Blue Cross will refund any amounts paid by you except amounts already paid by Blue Cross.

I have personally read and attest to the completeness and validity of the information provided on this application for coverage. If I am accepted, this application will become part of the contract between Blue Cross and I. I and any enrolled family members agree to abide by the terms of this contract. **Initials:**

**I AM APPLYING FOR TERM LIFE COVERAGE:** I understand that I am submitting this application to the life insurance department of BC Life & Health Insurance Company (BCL&H) and that if one or more of the following circumstances apply, then the medical information on this application will be used in the life department of BCL&H to determine whether or not life insurance will be offered to me: 1) my employer has 2-10 enrolled employees; 2) the date of this application is more than thirty (30) days after my eligibility date for coverage; 3) the amount of term life insurance coverage I am applying for is over \$50,000.

Signature of Employee (If applying for Term Life coverage)  
X

**I AM APPLYING FOR PPO COVERAGE:** I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

If a PPO Plan is selected and a non-participating provider is used, medical payments will be based upon the lesser percentage of the negotiated fee rate and I will be responsible for any amount over that payment.

**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.

**I AM APPLYING FOR A HEALTHCARE SAVINGS ACCOUNT (HSA) COMPATIBLE EPO PLAN:** I understand that the High Deductible EPO Plan is designed for Exclusive Provider Organization (EPO) usage, and that using non-participating providers could result in significantly higher out-of-pocket costs. I understand that having this coverage does not establish an HSA. To do so, I must contact a qualified financial institution. Also, I understand that I should consult my tax advisor.

**ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employment Retirement Income Security Act of 1974), certain disputes may not be subject to the following arbitration provisions:**

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employment 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 UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND BC LIFE & HEALTH MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF THE SMALL CLAIMS COURT, AND NOT BY LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THIS MEANS THAT I AND BC LIFE & HEALTH ARE WAIVING OUR RIGHTS TO A JURY TRIAL. UNDER THIS COVERAGE, BC LIFE & HEALTH INSURANCE COMPANY AND I THE GIVING UP THE RIGHT TO PURSUE ON A CLASS BASIS ANY CLAIM OR CONTROVERSY AGAINST THE OTHER. FOR MORE INFORMATION REGARDING BINDING ARBITRATION, PLEASE REFER TO YOUR CERTIFICATE.**

**I UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (AND/OR ANY ENROLLED FAMILY MEMBER) AND BLUE CROSS OF CALIFORNIA OR ITS AFFILIATES, 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 LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THIS MEANS THAT I AND BLUE CROSS ARE WAIVING OUR RIGHTS TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS AND ANY OTHER DISPUTES. UNDER THIS COVERAGE, BLUE CROSS OF CALIFORNIA OR ITS AFFILIATES AND I ARE TO GIVING UP THE 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.**

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.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY TRIAL.**

Signature of Employee

Date (MM/DD/YY)

X

**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.

Blue Cross of California and BC Life & Health Insurance Company are Independent Licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.

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