SADDLEBACK VALLEY UNIFIED SCHOOL DISTRICT
SUBSCRIBER ENROLLMENT FORM
(MUST BE RECEIVED IN BENEFITS DEPT WITHIN 31 DAYS OF EMPLOYMENT OR QUALIFYING EVENT)

EMPLOYEE INFORMATION

1

EMPLOYEE PIN	☐ ACTIVE ☐ RETIRED	☐ SVEA ☐ SVMTA ☐ SVPSA ☐ CSEA (More than 6 hours per day) ☐ CSEA (6 hours per day or less)	
LAST NAME	FIRST NAME	MIDDLE INITIAL	DATE OF BIRTH
FOR SPOUSE OF AN OVERAGE RETIRE, ENTER RETIREE'S SS#:		LEAVE THIS FIELD BLANK (HD/EF/SS) / /	

HEALTH PLAN INFORMATION

2

HEALTH BENEFIT CHOICE:
- ☐ Blue Shield PPO Medical, Behavioral Health, Dental, and Vision
- ☐ Blue Shield HMO Medical, Behavioral Health, Dental, and Vision
- ☐ Blue Shield HMO Medical & Behavioral Health Only (CSEA Part Time)
- ☐ Dental and Vision Only (Declining medical/behavioral health)

COMPLETE ONLY IF ADDING BLUE SHIELD HMO
View full provider directory at: www.blueshieldca.com
Select Access+HMO as Plan and Sub Plan
Search by full name and zip code *or* zip code only
Medical Group # are located underneath Physician's Info
Incomplete designations are invalid

EXISTING PATIENT?

SELF

- ❖ **To add Spouse/Domestic Partner** – Attach copy of Marriage Certificate/ Declaration of Domestic Partnership to this form.
- ❖ **To add Dependent(s)** – Attach proof of birth or court documentation establishing adoption or legal guardianship. New births may provide non-certified proof of birth; social security # may be submitted at a later time.

DR. FULL NAME ____
CITY OR ZIP CODE ____
PROVIDER # ____
MEDICAL GROUP NO. ____
☐ NO ☐ YES

DEPENDENTS

			Existing Patient?
☐ SPOUSE ☐ DOMESTIC PARTNER FIRST NAME M.I.	☐ MALE ☐ FEMALE LAST NAME	DR. FULL NAME ____ CITY OR ZIP CODE ____ PROVIDER # ____ MEDICAL GROUP NO. ____	☐ NO ☐ YES
SOCIAL SECURITY #	DATE OF BIRTH		
☐ MALE ☐ FEMALE FIRST NAME M.I.	LAST NAME	DR. FULL NAME ____ CITY OR ZIP CODE ____ PROVIDER # ____ MEDICAL GROUP NO. ____	☐ NO ☐ YES
SOCIAL SECURITY #	DATE OF BIRTH		
☐ MALE ☐ FEMALE FIRST NAME M.I.	LAST NAME	DR. FULL NAME ____ CITY OR ZIP CODE ____ PROVIDER # ____ MEDICAL GROUP NO. ____	☐ NO ☐ YES
SOCIAL SECURITY #	DATE OF BIRTH		
☐ MALE ☐ FEMALE FIRST NAME M.I.	LAST NAME	DR. FULL NAME ____ CITY OR ZIP CODE ____ PROVIDER # ____ MEDICAL GROUP NO. ____	☐ NO ☐ YES
SOCIAL SECURITY #	DATE OF BIRTH		
☐ MALE ☐ FEMALE FIRST NAME M.I.	LAST NAME	DR. FULL NAME ____ CITY OR ZIP CODE ____ PROVIDER # ____ MEDICAL GROUP NO. ____	☐ NO ☐ YES
SOCIAL SECURITY #	DATE OF BIRTH		

LIFE INSURANCE (Eligibility: SVEA/SVMTA/SVPSA-50% or more of a 40-hr work week; CSEA-More than 30 hours per week)

3

PRIMARY LIFE INSURANCE BENEFICIARY(IES): (For additional Beneficiaries, attach a list)

			Percentage*
NAME: FULL ADDRESS:	RELATIONSHIP:	SOCIAL SECURITY #: DATE OF BIRTH:	%
NAME: FULL ADDRESS:	RELATIONSHIP:	SOCIAL SECURITY #: DATE OF BIRTH:	%

CONTINGENT LIFE INSURANCE BENEFICIARY(IES): Applicable only if you are not survived by one or more primary beneficiaries.

NAME: FULL ADDRESS:	RELATIONSHIP:	SOCIAL SECURITY #: DATE OF BIRTH:	%
NAME: FULL ADDRESS:	RELATIONSHIP:	SOCIAL SECURITY #: DATE OF BIRTH:	%

This beneficiary designation revokes all prior beneficiary designation. Unless you indicate otherwise, if any beneficiary predeceases you, that beneficiary's share will be divided pro-rata among the surviving beneficiaries of the same class-primary or contingent. If no beneficiary survives you, primary or contingent, payment will be made pursuant to the terms of the application policy. * If no percentages are noted, benefits will be divided equally between the same beneficiary class.

EMPLOYEE SIGNATURE: ____________________ DATE: ____________

Rev: 01.16

(THE SIGNATURE ABOVE IS FOR LIFE INSURANCE DESIGNATION ONLY
<u>TURN OVER</u> FOR REQUIRED SIGNATURE)

PRIVACY DISCLOSURE STATEMENT:

Blue Shield understands 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.

ENROLLMENT AUTHORIZATION:

Blue Shield 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 that my coverage may be cancelled or, following notice, my employer's contact rescinded.

I understand that it is my responsibility to report any qualifying events (on the appropriate forms) within 31 days of the event including **additions, deletions and changes of address/phone number. Benefit enrollments will be made using last address on file with the Personnel Department.**

EMPLOYEE SIGNATURE: _____ DATE: _____

IF YOU, YOUR SPOUSE/DOMESTIC PARTNER OR DEPENDENTS ARE REFUSING COVERAGE, PLEASE COMPLETE "REFUSAL OF PERSONAL COVERAGE FORM".