Small Business Employee Enrollment Form
Blue Shield of California and
Blue Shield of California Life & Health Insurance Company

blue of california

Effective January 1, 2017

Subscriber information – Please note: Missing information may delay processing.

Additional subscriber information is located in Section 2.

Subscriber's last name	First name	MI
Social Security number		

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

☐ New group enrollment Group effective date: _____	☐ New hire/rehire Date of hire/rehire: _____
☐ Open enrollment Renewal date: _____	☐ COBRA/Cal-COBRA enrollment
☐ New spouse/dependant Date of marriage/birth/adoption: _____	☐ Other qualifying event (specify): _____ Qualifying event date: _____

Section 1a – Health plan selection – Select one health plan from the package offered by your employer.

Blue Shield of California Off Exchange Package for Small Business

PPO plans – Full PPO Network
- ☐ Platinum Full PPO 0/10 OffEx
- ☐ Platinum Full PPO 150/15 OffEx
- ☐ Gold Full PPO 0/20 OffEx
- ☐ Gold Full PPO 250/30 OffEx
- ☐ Gold Full PPO 750/20 OffEx
- ☐ Gold Full PPO 1000/35 OffEx
- ☐ Silver Full PPO 1300/45 OffEx
- ☐ Silver Full PPO 1700/40 OffEx
- ☐ Bronze Full PPO 3750/65 OffEx
- ☐ Bronze Full PPO 5100/60 OffEx

HSA-compatible HDHP plans – Full PPO Network
- ☐ Silver Full PPO Savings 2000/20% OffEx
- ☐ Bronze Full PPO Savings 4700/40% OffEx
- ☐ Bronze Full PPO Savings 5500/40% OffEx

Access+ HMO plans – Access+ HMO Network
- ☐ Platinum Access+ HMO® 0/20 OffEx
- ☐ Platinum Access+ HMO® 0/25 OffEx
- ☐ Platinum Access+ HMO® 0/30 OffEx
- ☐ Gold Access+ HMO® 500/35 OffEx
- ☐ Gold Access+ HMO® 1700/30 OffEx
- ☐ Silver Access+ HMO® 1700/55 OffEx

Local Access+ HMO plans – Local Access+ HMO Network
- ☐ Platinum Local Access+ HMO® 0/20 OffEx
- ☐ Platinum Local Access+ HMO® 0/25 OffEx
- ☐ Platinum Local Access+ HMO® 0/30 OffEx
- ☐ Gold Local Access+ HMO® 500/35 OffEx
- ☐ Gold Local Access+ HMO® 1700/30 OffEx
- ☐ Silver Local Access+ HMO® 1700/55 OffEx

Trio ACO HMO Plans – Trio ACO HMO Network
- ☐ Platinum Trio ACO HMO 0/20 OffEx
- ☐ Platinum Trio ACO HMO 0/25 OffEx
- ☐ Platinum Trio ACO HMO 0/30 OffEx
- ☐ Gold Trio ACO HMO 500/35 OffEx
- ☐ Gold Trio ACO HMO 1700/30 OffEx
- ☐ Silver Trio ACO HMO 1700/55 OffEx

Blue Shield of California Mirror Package for Small Business
- ☐ Blue Shield Platinum 90 HMO 0/15 + Child Dental INF
- ☐ Blue Shield Platinum 90 PPO 0/15 + Child Dental
- ☐ Blue Shield Platinum 90 PPO 0/15 + Child Dental INF
- ☐ Blue Shield Gold 80 HMO 0/30 + Child Dental INF
- ☐ Blue Shield Gold 80 PPO 0/30 + Child Dental
- ☐ Blue Shield Gold 80 PPO 0/30 + Child Dental INF
- ☐ Blue Shield Silver 70 HMO 2000/45 + Child Dental INF
- ☐ Blue Shield Silver 70 PPO 2000/45 + Child Dental
- ☐ Blue Shield Silver 70 PPO 2000/45 + Child Dental INF
- ☐ Blue Shield Bronze 60 PPO 6300/75 + Child Dental
- ☐ Blue Shield Bronze 60 PPO 6300/75 + Child Dental INF

Subscriber's last name	First name	MI	Social Security number

Section 1b – Specialty Benefits – Dental, Vision, and Life Insurance plan selection

If your employer offers specialty benefits, please complete the attached Specialty Benefits Employee Benefit Selection Form to select specialty benefits coverage.

Section SB1 – Dental benefits

Dental HMO Plans

☐ DHMO Basic	☐ DHMO Plus	☐ DHMO Deluxe	☐ DHMO Voluntary

Dental PPO Plans

☐ Ultimate Dental PPO for Small Business 50/2000	☐ Smile℠ 50/1500/No Ortho/MAC
☐ Ultimate Dental Plus PPO for Small Business 50/2000	☐ Smile℠ Plus 50/1500/Ortho/MAC
☐ Smile℠ Deluxe 2000 50/2000/No Ortho/MAC	☐ Smile℠ Value 50/1500/No Ortho/MAC
☐ Smile℠ Deluxe Plus 2000 50/2000/Ortho/MAC	☐ Smile℠ Plus Gold 50/1500/Ortho/U85
☐ Smile℠ Deluxe 50/1500/Ortho/MAC	☐ Smile℠ Basic 75/1000/No Ortho/MAC
☐ Smile℠ Deluxe Gold 50/1500/Ortho/U85	☐ Smile℠ Basic Voluntary 75/1000/No Ortho/MAC

Dental In-Network Only (INO) Plans*

☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/Ortho	☐ Smile℠ INO Dental Plan 50/2500/Endo-Perio 80%/Ortho
☐ Smile℠ INO Dental Plan 50/1500/Endo-Perio 80%/No Ortho	☐ Smile℠ INO Dental Plan 50/2500/Endo-Perio 80%/No Ortho
☐ Smile℠ INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/Ortho	☐ Smile℠ INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/Ortho
☐ Smile℠ INO Dental Voluntary Plan 50/1500/Endo-Perio 50%/No Ortho	☐ Smile℠ INO Dental Voluntary Plan 50/2500/Endo-Perio 50%/No Ortho

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Section SB2 – Vision coverage

Vision coverage*

Ultimate Vision for Small Business (12-12-12)	Preferred Vision for Small Business (12-12-24)	Enhanced Vision for Small Business (12-24-24)
☐ Ultimate Vision Plus 0/0/150/120	☐ Preferred Vision Plus 0/0/150/120	☐ Enhanced Vision Plus 0/0/150/120
☐ Ultimate Vision 0/0/150	☐ Preferred Vision 0/0/150	☐ Enhanced Vision 0/0/150
☐ Ultimate Vision Plus 15/25/150/120	☐ Preferred Vision Plus 15/25/150/120	☐ Enhanced Vision Plus 15/25/150/120
☐ Ultimate Vision 15/25/150	☐ Preferred Vision 15/25/150	☐ Enhanced Vision 15/25/150
☐ Ultimate Vision 0/0/120	☐ Preferred Vision 0/0/120	☐ Enhanced Vision 0/0/120
☐ Ultimate Vision 15/25/120	☐ Preferred Vision 15/25/120	☐ Enhanced Vision 15/25/120
☐ Ultimate Vision Voluntary 15/25/150[1]	☐ Preferred Vision Voluntary 15/25/120[1]	☐ Enhanced Vision Voluntary 15/25/120[1]

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1 Voluntary vision plans require a minimum of three enrolling, eligible employees.

Section SB3 – Life/AD&D insurance

Group Term Life Insurance*

Employee information

Full-time employment date	Average hours worked per week	Rehire date	Job class/occupation	Earnings $ _____ (excluding overtime, bonuses, etc.) ☐ Hour ☐ Week ☐ Month ☐ Year

Designation of beneficiary

Primary beneficiary – Blue Shield Life will pay the life insurance benefits to the primary beneficiary/beneficiaries identified. An employee may designate more than one primary beneficiary. Please show percentages for each primary beneficiary in the "% of benefits" column to total 100% of benefits. If the percentage is not defined, the benefits will be distributed equally to those primary beneficiaries who survive the employee. To designate more than two primary beneficiaries, please provide on a separate sheet of paper, which is signed and dated by the employee, and attach to this form.

First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits
Address		City		State	ZIP code	0.00%
First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits
Address		City		State	ZIP code	0.00%

Subscriber's last name	First name	MI	Social Security number

Contingent beneficiary – Proceeds will be paid to a contingent beneficiary only if no designated primary beneficiary survives the insured.

First name	MI	Last name	Social Security number	Relationship	Date of birth	% of benefits
						0.00%
Address		City		State	ZIP code	

Information on benefit amounts

Please contact your benefits administrator for more information regarding your group life insurance coverage. Coverage granted to individuals listed in this enrollment form shall be subject to all provisions and limitations stated in the Blue Shield of California Life & Health Insurance Company group life insurance policy.

Number of eligible dependents: _____	Basic Dependent Life Insurance: ☐ Yes ☐ No
Employee Basic Life and AD&D Insurance amount: $_____	Amount of coverage requested for dependent(s): $ _____ (Minimum amount of coverage is $1,000; maximum is $5,000)

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Section 2 – Subscriber information

Note: Social Security numbers are required per CMS.

Social Security number	Employer (group) name	Blue Shield Group ID

Last name	First name	MI

Home (physical) address (no P.O. Box addresses)	City	State	ZIP code
Mailing address (if different from home address)	City	State	ZIP code

Work phone number:	Home phone number:	Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____
Email address (required)		How would you prefer we contact you? Blue Shield will use your preferred method when possible. ☐ Email ☐ Standard mail ☐ Telephone: ☐ Work ☐ Home

Date of birth: _____	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Domestic partner

Date of hire: _____ (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.)	Job title: Job classification:

Do you have any eligible dependent children under the age of 26? ☐ Yes ☐ No How many?_____ How many are enrolling?_____

Employment status:

Do you actively work 30 hours or more per week for this employer? (full-time employee) ☐ Yes ☐ No **Or**

Do you actively work between 20 and 29 hours per week for this employer? (part-time employee) ☐ Yes ☐ No

If no to both of the above, are you an existing COBRA participant or enrolling due to a COBRA qualifying event? ☐ Yes ☐ No If yes, proceed to Section 3.

Section 3 – HMO Personal Physician/Dental HMO provider assignment

This section is only required if you selected an HMO plan. If you selected a PPO plan, please proceed to Section 4.

HMO plan Personal Physician selection

Would you like for Blue Shield to designate a Personal Physician for you and your dependents who is located near your home or work?

☐ Yes, I would like Blue Shield to designate a Personal Physician and/or Dental HMO provider for me and my dependents.

☐ No, I would like to request a specific Personal Physician and/or Dental HMO provider for myself and my dependents (please specify below).

* Please note: If Blue Shield is unable to assign the Personal Physician and/or Dental HMO provider you requested, Blue Shield will designate a provider. HMO Personal Physicians can be changed by visiting **blueshieldca.com** after enrollment.

HMO Personal Physician name	Provider number	IPA/MG name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	**Provider number**	Dental Group name	Existing patient? ☐ Yes ☐ No

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

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.

Dependent type: ☐ Spouse ☐ Domestic partner	**Gender:** ☐ Male ☐ Female	**Social Security number (required)**		**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No	
First name		MI	Last name		Suffix
Date of birth	Address (if different from employee)				
HMO Personal Physician name			Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name			Provider number	Dental Group name	Existing patient? ☐ Yes ☐ No

Dependent type: ☐ Dependent child ☐ Other dependent child: legal guardianship	**Gender:** ☐ Male ☐ Female	**Social Security number (required)**		**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No	
First name		MI	Last name		Suffix
Date of birth	Address (if different from employee)				
HMO Personal Physician name			Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name			Provider number	Dental Group name	Existing patient? ☐ Yes ☐ No

Dependent type: ☐ Dependent child ☐ Other dependent child: legal guardianship	**Gender:** ☐ Male ☐ Female	**Social Security number (required)**		**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No	
First name		MI	Last name		Suffix
Date of birth	Address (if different from employee)				
HMO Personal Physician name			Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name			Provider number	Dental Group name	Existing patient? ☐ Yes ☐ No

Dependent type: ☐ Dependent child ☐ Other dependent child: legal guardianship	**Gender:** ☐ Male ☐ Female	**Social Security number (required)**		**Enrolling in all products selected by subscriber?** ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No	
First name		MI	Last name		Suffix
Date of birth	Address (if different from employee)				
HMO Personal Physician name			Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name			Provider number	Dental Group name	Existing patient? ☐ Yes ☐ No

Subscriber's last name	First name	MI	Social Security number

Dependent type: ☐ Dependent child ☐ Other dependent child: legal guardianship	Gender: ☐ Male ☐ Female	Social Security number (required)	Enrolling in all products selected by subscriber? ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix
Date of birth	Address (if different from employee)		
HMO Personal Physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	Provider number	Dental Group name	Existing patient? ☐ Yes ☐ No

Dependent type: ☐ Dependent child ☐ Other dependent child: legal guardianship	Gender: ☐ Male ☐ Female	Social Security number (required)	Enrolling in all products selected by subscriber? ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix
Date of birth	Address (if different from employee)		
HMO Personal Physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name ☐ ☐	Provider number	Dental Group name ☐ ☐	Existing patient? ☐ Yes ☐ No

Dependent type: ☐ Dependent child ☐ Other dependent child: legal guardianship	Gender: ☐ Male ☐ Female	Social Security number (required)	Enrolling in all products selected by subscriber? ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix
Date of birth	Address (if different from employee)		
HMO Personal Physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	Provider number	Dental Group name	Existing patient? ☐ Yes ☐ No

Dependent type: ☐ Dependent child ☐ Other dependent child: legal guardianship	Gender: ☐ Male ☐ Female	Social Security number (required)	Enrolling in all products selected by subscriber? ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix
Date of birth	Address (if different from employee)		
HMO Personal Physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No
Dental HMO provider name	Provider number	Dental Group name	Existing patient? ☐ Yes ☐ No

Subscriber's last name	First name	MI	Social Security number

Dependent type: ☐ Dependent child ☐ Other dependent child: legal guardianship	Gender: ☐ Male ☐ Female	Social Security number (required)	Enrolling in all products selected by subscriber? ☐ Yes ☐ No If no, Refusal of Coverage attached? ☐ Yes ☐ No

First name	MI	Last name	Suffix

Date of birth	Address (if different from employee)

HMO Personal Physician name	Provider number	IPA name	Existing patient? ☐ Yes ☐ No

Dental HMO provider name	Provider number	Dental Group name	Existing patient? ☐ Yes ☐ No

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**.

Subscriber's last name	First name	MI	Social Security number

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.
If submitting for an existing Blue Shield plan, go to blueshieldca.com.

Refusal of Coverage form

Complete this form if you, your spouse, domestic partner, or child dependent(s) are refusing this group health, dental, vision, and/or life insurance coverage offered through the employer. (The employer must retain a copy of this form to provide to Blue Shield upon request.) Please type or print. Use black ink. ***Note: The employee's Social Security number is required for all eligible employees and dependents.**

Employee name	**Social Security number**	**Date of birth**
Employer (Group) name	**Hire date**	**State of residence**
Marital status Married ☐ Yes ☐ No Domestic partnership ☐ Yes ☐ No	Job title	

Is the employee a full-time employee, working at least 30 hours per week for this employer? ☐ Yes ☐ No **Or**
Is the employee a part-time employee working at least 20 hours per week for this employer? ☐ Yes ☐ No

Declining coverage for:

I decline health plan coverage for:

☐ Myself and all dependents.
- ☐ My spouse/domestic partner only
- ☐ My children only
- ☐ My spouse/domestic partner and children only
- ☐ The following dependents only:

_____

If dental plan offered, I decline dental plan coverage for:

☐ Myself and all dependents.
- ☐ My spouse/domestic partner
- ☐ My children
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:

_____

If vision plan offered, I decline vision plan coverage for:

☐ Myself and all dependents
- ☐ My spouse/domestic partner
- ☐ My children
- ☐ My spouse/domestic partner and children
- ☐ The following dependents only:

_____

If life insurance plan offered, I decline life plan coverage for:

☐ Myself

Reason for declining coverage

OTHER EMPLOYER HEALTH COVERAGE
- ☐ Enrolling as a dependent on this group health plan
- ☐ Covered by this employer's other health plan (through another carrier)
- ☐ Covered by another employer's health plan (e.g., through your spouse/domestic partner)
  - Carrier name _____
  - ID number _____
- ☐ Covered by TRICARE

OTHER NON-EMPLOYER HEALTH COVERAGE
- ☐ Covered by an individual health plan.
  - Carrier name _____
  - ID number _____
- ☐ Covered California or other State Health Exchange
- ☐ Medicare, Medi-Cal, Healthy Families Program
- ☐ Other _____

OTHER DENTAL COVERAGE
- ☐ Enrolling as a dependent on this group dental plan
- ☐ Covered by another employer's dental plan (e.g., through your spouse/domestic partner)
  - Carrier name _____
  - ID number _____
- ☐ Other _____

OTHER VISION COVERAGE
- ☐ Enrolling as a dependent on this group vision plan
- ☐ Covered by another employer's vision plan (e.g., through your spouse/domestic partner)
  - Carrier name _____
  - ID number _____
- ☐ Other _____

OTHER LIFE INSURANCE COVERAGE
- ☐ Covered by another employer's life insurance coverage (e.g., through your spouse/domestic partner)
  - Carrier name _____
  - ID number _____
- ☐ Other _____

I acknowledge that the coverage available to me has been explained to me by my employer and I know that I have every right to enroll in this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I now decline to enroll myself, my spouse/domestic partner, and/or my child dependent(s) in my employer's group health plan. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.

If I am declining enrollment for myself or my dependents because of other health coverage or because the employer stops contributing toward this coverage, I acknowledge that I may be able to enroll myself and my dependents in this plan if I request enrollment within 31 days (60 days if loss of Medi-Cal or Healthy Families coverage) after my or my dependents' other coverage ends or after the employer stops contributing toward the other coverage.

In addition, if I acquire a new dependent as the result of marriage/domestic partnership, birth, adoption or placement for adoption, I acknowledge that I, and my dependents, may request enrollment in my employer's health plan by applying for that coverage within 31 days of the marriage/domestic partnership, birth, adoption, or placement for adoption. I also acknowledge that if I, or my dependents, become eligible for the Healthy Families or the Medi-Cal Premium Assistance programs, I or my dependents may request enrollment in my employer's health plan by applying for coverage within 60 days of the notice of eligibility for these premium assistance programs.

If I have indicated above that the reason for declining coverage for myself or my dependent(s) is coverage under another employer health benefit plan, I acknowledge that if I or my dependent(s) involuntarily lose coverage under the other employer health benefit plan, I must request enrollment for myself and/or my dependent(s) in my employer health benefit plan within 31 days. Otherwise, I understand I may not enroll myself and/or my dependents in my employer's health plan until the earlier of the end of my employer's next open enrollment period or 12 months.

Signature of employee **Date**

Print name