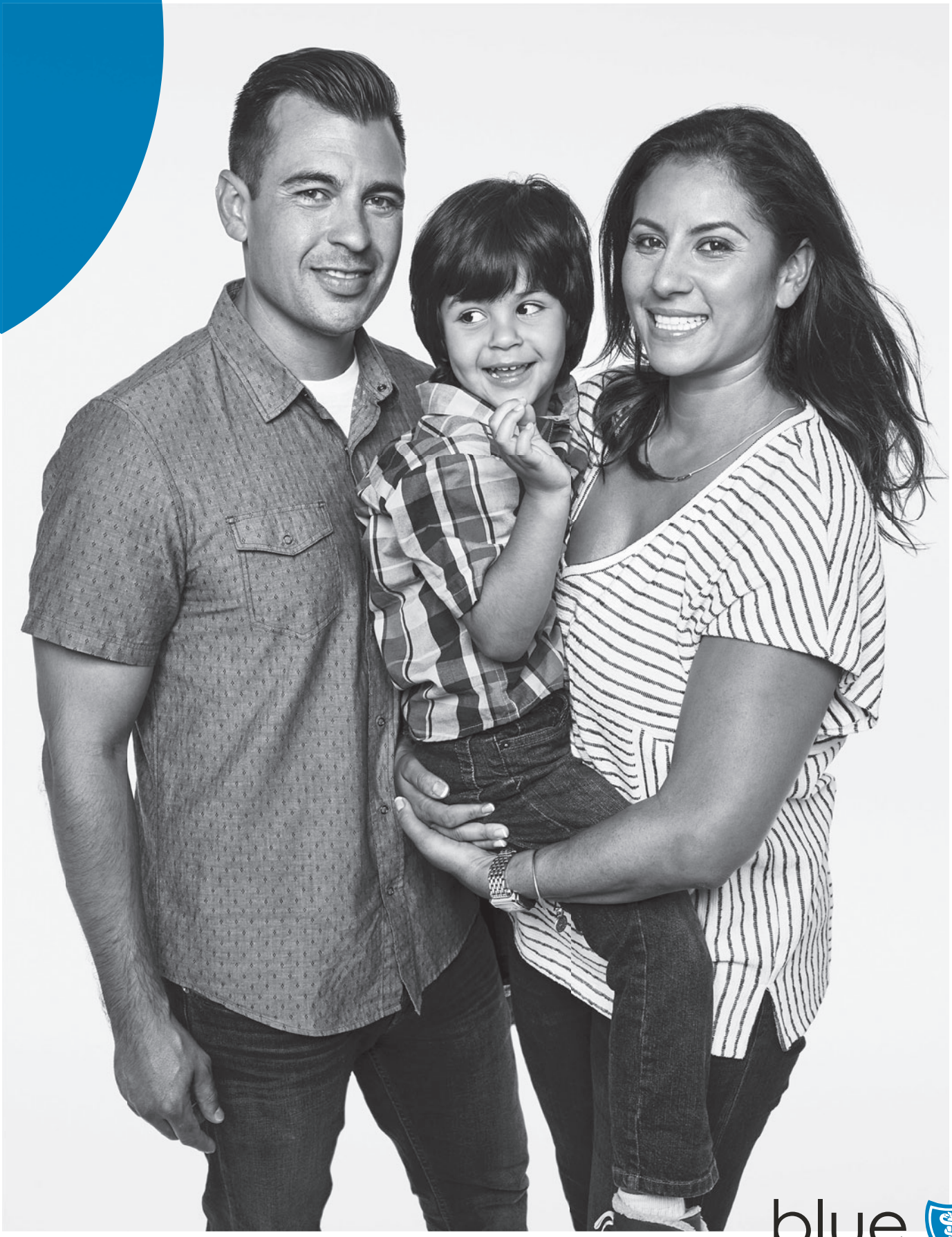
Plan information



blueshieldca.com

blue california

Plan information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AGC EMPLOYERS HEALTH TRUST

Effective Date: January 1, 2023

- **AGC Employers Health Trust – Class 1**
- **AGC Employers Health Trust – Class 2**
- **AGC Employers Health Trust – Class 3**
- **AGC Employers Health Trust – Class 4**

when you feel great, you're unstoppable.

When you go with Blue Shield of California, you're on your way to quality health coverage, large provider networks and a wide range of programs and services that offer more value with your plan. Blue Shield offers you:

High-quality provider networks of doctors and facilities

Innovative plan designs with comprehensive benefits

Proven programs and resources that add value

This booklet offers the information you need to choose the right health plan for you and your family. Go with Blue Shield and be unstoppable.

To access medical plan information disclosures, visit **blueshieldca.com/largegroupdisclosures**.

To access dental plan information disclosures, visit **blueshieldca.com/largegroupdisclosures/dental**.

To access vision plan information disclosures, visit **blueshieldca.com/largegroupdisclosures/vision**.

Table of Contents

What's inside

Browse through the sections below to read about the Blue Shield coverage available to you. You can learn more about our programs and services, as well as how different types of health plans work, at blueshieldca.com/employercoverage.

1.
choose a plan

Start here! In this section you can explore your Blue Shield benefit options.

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Blue Shield of California Life & Health Insurance Company

Basic Group Term Life Insurance
AGC Employers Health Trust – Class 1

Custom Benefit Summary Effective January 1, 2023

Basic Group Term Life Insurance is an important part of a complete benefits package. It provides protection to you and your beneficiaries. Below is information about how our coverage can meet your needs.

Employee Basic Group Term Life Benefit	**$10,000**
Age Reduction Schedule	Your Benefit will reduce to 65% of the original amount when you turn 65 and to 50% of the original amount when you reach 70.
Waiver of Premium Provision	If you become totally disabled, as defined in the certificate, you can continue your Life Insurance coverage without any premium payments. The amount of coverage will be the coverage in effect at the time you become disabled. This waiver is subject to age limitations, reductions and terminations.
Accelerated Death Benefit	If you become terminally ill, you may elect an advanced payment of up to 50% of the death benefit to a maximum of $250,000.
Conversion	You may convert your Basic Group Term Life Insurance coverage to a Whole Life policy if your employment ends. You must apply for conversion within 31 days after your termination of employment. Rates are based on your age at the time of conversion.

This Benefit Summary is an overview of Blue Shield of California Life & Health Insurance Company (Blue Shield Life) Basic Group Term Life Insurance available for eligible employees. Please refer to your Certificate for a complete description of benefits, limitations, exclusions and other terms and conditions of coverage.

In the event of a discrepancy between the English and Spanish versions of this Benefit Summary, the English version prevails.

Basic Group Term Life and AD&D insurance is underwritten by Blue Shield of California Life & Health Insurance Company.

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Blue Shield of California Life & Health Insurance Company

Basic Group Term Life Insurance
AGC Employers Health Trust – Class 2

Custom Benefit Summary Effective January 1, 2023

Basic Group Term Life Insurance is an important part of a complete benefits package. It provides protection to you and your beneficiaries. Below is information about how our coverage can meet your needs.

Employee Basic Group Term Life Benefit	**$50,000**
Age Reduction Schedule	Your Benefit will reduce to 65% of the original amount when you turn 65 and to 50% of the original amount when you reach 70.
Waiver of Premium Provision	If you become totally disabled, as defined in the certificate, you can continue your Life Insurance coverage without any premium payments. The amount of coverage will be the coverage in effect at the time you become disabled. This waiver is subject to age limitations, reductions and terminations.
Accelerated Death Benefit	If you become terminally ill, you may elect an advanced payment of up to 50% of the death benefit to a maximum of $250,000.
Conversion	You may convert your Basic Group Term Life Insurance coverage to a Whole Life policy if your employment ends. You must apply for conversion within 31 days after your termination of employment. Rates are based on your age at the time of conversion.

This Benefit Summary is an overview of Blue Shield of California Life & Health Insurance Company (Blue Shield Life) Basic Group Term Life Insurance available for eligible employees. Please refer to your Certificate for a complete description of benefits, limitations, exclusions and other terms and conditions of coverage.

In the event of a discrepancy between the English and Spanish versions of this Benefit Summary, the English version prevails.

Basic Group Term Life and AD&D insurance is underwritten by Blue Shield of California Life & Health Insurance Company.

blue of california

Blue Shield of California Life & Health Insurance Company

Basic Group Term Life Insurance
AGC Employers Health Trust – Class 3

Custom Benefit Summary Effective January 1, 2023

Basic Group Term Life Insurance is an important part of a complete benefits package. It provides protection to you and your beneficiaries. Below is information about how our coverage can meet your needs.

Employee Basic Group Term Life Benefit	**$75,000**
Age Reduction Schedule	Your Benefit will reduce to 65% of the original amount when you turn 65 and to 50% of the original amount when you reach 70.
Waiver of Premium Provision	If you become totally disabled, as defined in the certificate, you can continue your Life Insurance coverage without any premium payments. The amount of coverage will be the coverage in effect at the time you become disabled. This waiver is subject to age limitations, reductions and terminations.
Accelerated Death Benefit	If you become terminally ill, you may elect an advanced payment of up to 50% of the death benefit to a maximum of $250,000.
Conversion	You may convert your Basic Group Term Life Insurance coverage to a Whole Life policy if your employment ends. You must apply for conversion within 31 days after your termination of employment. Rates are based on your age at the time of conversion.

This Benefit Summary is an overview of Blue Shield of California Life & Health Insurance Company (Blue Shield Life) Basic Group Term Life Insurance available for eligible employees. Please refer to your Certificate for a complete description of benefits, limitations, exclusions and other terms and conditions of coverage.

In the event of a discrepancy between the English and Spanish versions of this Benefit Summary, the English version prevails.

Basic Group Term Life and AD&D insurance is underwritten by Blue Shield of California Life & Health Insurance Company.

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Blue Shield of California Life & Health Insurance Company

Basic Group Term Life Insurance
AGC Employers Health Trust – Class 4

Custom Benefit Summary Effective January 1, 2023

Basic Group Term Life Insurance is an important part of a complete benefits package. It provides protection to you and your beneficiaries. Below is information about how our coverage can meet your needs.

Employee Basic Group Term Life Benefit	**$100,000**
Age Reduction Schedule	Your Benefit will reduce to 65% of the original amount when you turn 65 and to 50% of the original amount when you reach 70.
Waiver of Premium Provision	If you become totally disabled, as defined in the certificate, you can continue your Life Insurance coverage without any premium payments. The amount of coverage will be the coverage in effect at the time you become disabled. This waiver is subject to age limitations, reductions and terminations.
Accelerated Death Benefit	If you become terminally ill, you may elect an advanced payment of up to 50% of the death benefit to a maximum of $250,000.
Conversion	You may convert your Basic Group Term Life Insurance coverage to a Whole Life policy if your employment ends. You must apply for conversion within 31 days after your termination of employment. Rates are based on your age at the time of conversion.

This Benefit Summary is an overview of Blue Shield of California Life & Health Insurance Company (Blue Shield Life) Basic Group Term Life Insurance available for eligible employees. Please refer to your Certificate for a complete description of benefits, limitations, exclusions and other terms and conditions of coverage.

In the event of a discrepancy between the English and Spanish versions of this Benefit Summary, the English version prevails.

Basic Group Term Life and AD&D insurance is underwritten by Blue Shield of California Life & Health Insurance Company.

2.
find a provider/Rx

Use the information in this section to help you find a doctor and learn about your prescription drug options.

Find the doctor of your choice

Blue Shield believes that finding a doctor shouldn't give you a headache. That's why blueshieldca.com features our most up-to-date listings of doctors, specialists, pharmacies, and hospitals.

We're making it easier!

Finding the latest listing of doctors, specialists, mental health providers, hospitals, dentists, vision care providers, or pharmacies is easy. Go to **blueshieldca.com** and select *Find a Doctor* from the menu. Here are some helpful shortcuts:

1. How you start depends on the type of plan:
   - For Access+ HMO®: Go to **blueshieldca.com/networkhmo**.
   - For Local Access+ HMO®: Go to **blueshieldca.com/networklocalaccess**.
   - For Access+ HMO SaveNet℠: Go to **blueshieldca.com/networksavenet**.
   - For Trio HMO: Go to **blueshieldca.com/networktriohmo**.
   - For PPO: Go to **blueshieldca.com/pponetwork**.
   - For Tandem PPO: Go to **blueshieldca.com/networktandemppo**.
2. Select the type of provider you need (e.g., doctor, facility, mental health).
3. Enter your preferred location.
4. Select whether you want to search by provider specialty or provider name.
5. Relevant results will be displayed.

Special considerations for each plan type

If you are enrolling in an HMO plan

When you enroll in an HMO plan, you and your dependents must choose a primary care physician (PCP) within 15 miles or a 30-minute drive* from where you live or work. You can either search for your PCP using Blue Shield of California's *Find a Doctor* tool found at **blueshieldca.com**, or call Member Services for assistance. If you do not select a PCP when you enroll, we will assign you one. You can then change your PCP at any time. PCPs provide routine checkups, immunizations, and urgent care and refer you to specialists.

If you are enrolling in a PPO plan

As a PPO plan member, you can choose your own doctor and do not need a referral to see a specialist. Choosing a provider in the PPO networks can save you money and ensure that you receive the highest level of benefits available to you.

When you visit doctors outside the PPO network, you may be responsible for higher copayments plus any charges in excess of Blue Shield's allowed amount for the services.

If you access care outside California

PPO members who access care outside California may do so through the BlueCard® Program Network, which includes access to more than 95% of doctors and 96% of hospitals nationwide. Whenever possible, you should choose a doctor or hospital from the BlueCard network to save you money and ensure you receive the highest level of benefits available to you. When you visit doctors who are not in the BlueCard network, you may be responsible for higher copayments plus any charges in excess of Blue Shield's allowed amount for the services.

To find a BlueCard physician or hospital in the United States, go to **provider.bcbs.com** or call BlueCard Access toll-free at **(800) 810-BLUE (2583)**.

To find an international Blue Shield Global Core Network physician or hospital, go to **bcbsglobalcore.com**. You can also call the Blue Shield Global Core Service Center at **(800) 810-BLUE (2583)** from within the United States, or call collect at **(804) 673-1177** from outside the country.

* Primary care physician service areas vary by contract.

Prescription drug program

Our prescription drug program provides access to a network of chain and independent pharmacies, as well as a mail service pharmacy and specialty pharmacies. For more information, visit **blueshieldca.com/pharmacy.**

Chain and independent pharmacies

The Blue Shield pharmacy network includes all major pharmacy chains and most independent pharmacies in California. It's easy to find a local network pharmacy. Search our online listing of pharmacies, where you'll find the most up-to-date information:

- Visit **blueshieldca.com/pharmacy** and go to the *Pharmacy networks* section.
- If you want to locate a pharmacy where your prescription is covered, go to **blueshieldca.com** and select *Find a Doctor* from the menu, then choose *Pharmacies*.

Mail service pharmacy

We offer a mail service pharmacy benefit that gives you up to a 90-day supply of covered maintenance drugs through the mail. This service is available if you are taking stabilized dosages of covered maintenance drugs on an ongoing basis for treatment of chronic health conditions, such as high blood pressure. For more information, go to **blueshieldca.com/90dayRX**.

Specialty pharmacy

Network specialty pharmacies are available to Blue Shield members. These pharmacies provide convenient delivery of specialty medications, including self-administered injectables. All supplies required for administration of specialty medications that are injectable (such as needles/syringes, alcohol swabs, sharps containers) are included at no additional charge.

Prior authorization is required for specialty medications. Members prescribed self-administered injectables with a specialty drug benefit are required to get these drugs from a network specialty pharmacy.

Learn if your prescription is covered

The Blue Shield drug formulary is a list of preferred generic and brand-name drugs.

It's easy to learn if your medication is covered in our formulary. Go to **blueshieldca.com/pharmacy**, and choose *Drug formularies* to find a drug formulary that applies to you.

3.
sign up

It's time to apply for Blue Shield coverage! In this section you'll find your enrollment application. Sign up today and learn more about your benefits.

blue california

Life Insurance Plan
Employee Enrollment Application
Blue Shield plans for 101+ employees

Blue Shield of California and
Blue Shield of California Life & Health Insurance Company (Blue Shield Life)

Please note: Failure to complete this enrollment application legibly and completely may result in a delay in the enrollment process.

Reason for application:

☐ New hire	☐ Loss of coverage date _____	☐ Late enrollment
☐ Rehire date _____	☐ Open enrollment	☐ Other qualifying event type_____
		Date above event occurred _____

Section 1 – Important enrollment guidelines for Specialty Benefits coverage

Life insurance enrollment is subject to the following rules:
1. All Basic Term Life insurance amounts for employees who enroll when first eligible for benefits are fully Guarantee Issued (no Evidence of Insurability required). Evidence of Insurability is required for late enrollees.
2. For Supplemental Life, Evidence of Insurability is required for all amounts over the Guarantee Issue.
3. An employee must be enrolled in Supplemental Life/AD&D coverage for their spouse/domestic partner or dependent children to be eligible for Supplemental Life coverage. Spouse/Domestic Partner and/or dependent children do not have to be covered under the Basic Dependent Life coverage to be eligible for Supplemental Life coverage.

Section 2 – Plan(s) Select plan(s) as appropriate.

☐ Basic group term life/AD&D insurance ☐ Dependent basic life insurance ☐ Supplemental Life insurance ☐ Supplemental AD&D insurance

Internal use only. Do not write in this section and skip to Section 3.

Department code	Group ID	Subgroup ID	Class ID	Effective date

Section 3 – Employee information

Social Security number	**Employer (group) name**	
Last name	**First name**	**MI**
Employment status: ☐ Full time ☐ Part time ☐ Retiree	**Date of hire:** _____	Job title/classification

Home address (street, city, state, ZIP code)	Basic group term life/AD&D insurance amount:
	Dependent life amount: (all eligible dependents will be covered)
Mailing address (if different from home address)	Supplemental Life insurance amount:
	Supplemental AD&D insurance amount:

Cell phone number	Landline phone number	**Email address (Required for electronic communications)**

I consent to Blue Shield and their covered entities contacting me about health and wellness education or promotional information to serve me better. Communications can be by phone or text using auto-dialer or prerecorded message. ☐ Yes ☐ No

BSC follows TCPA guidelines and will always provide you with an option to Opt-Out at any time. https://www.blueshieldca.com/terms.

Communication preference: ☐ Electronic ☐ Paper **Go paperless!** Please watch for an email with a link which will allow you to register your account, customize your communication preferences, and access your digital ID card and benefit information.

Date of birth ____________________	**Gender** ☐ Male ☐ Female	**Marital status** ☐ Single ☐ Married ☐ Domestic partner

Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Persian ☐ Other ____________________

Are you enrolling your spouse/domestic partner and/or child dependents ☐ **Yes** ☐ **No If "yes," complete Section 4 of application.**

Section 4 – 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 Coverage form.

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

Enrolling spouse/domestic partner information

☐ Spouse ☐ Domestic partner Gender: ☐ Male ☐ Female	First name:		MI	Last name:
	Communication preference: ☐ Electronic ☐ Paper		**Email address (Required for electronic communications)**	
	Social Security number:	Date of birth (mm/dd/yyyy)	Supplemental Life insurance amount:	Supplemental AD&D insurance amount:

Enrolling dependent child(ren) information

Gender: ☐ Male ☐ Female	First name:		MI	Last name:
	Communication preference (if 12+ years of age): ☐ Electronic ☐ Paper		**Email address (Required for electronic communications)**	
	Social Security number:	Date of birth (mm/dd/yyyy)	Supplemental Life insurance amount:	Supplemental AD&D insurance amount:
Gender: ☐ Male ☐ Female	First name:		MI	Last name:
	Communication preference (if 12+ years of age): ☐ Electronic ☐ Paper		**Email address (Required for electronic communications)**	
	Social Security number:	Date of birth (mm/dd/yyyy)	Supplemental Life insurance amount:	Supplemental AD&D insurance amount:
Gender: ☐ Male ☐ Female	First name:		MI	Last name:
	Communication preference (if 12+ years of age): ☐ Electronic ☐ Paper		**Email address (Required for electronic communications)**	
	Social Security number:	Date of birth (mm/dd/yyyy)	Supplemental Life insurance amount:	Supplemental AD&D insurance amount:

Section 5 – Life insurance beneficiary

Primary beneficiary – Blue Shield Life will pay the proceeds to the primary beneficiary. If more than one person is named as primary beneficiary, the proceeds will be distributed equally to those who survive the insured, unless otherwise specified in the % of benefits field.

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

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

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

If beneficiary is a trust or corporation, please provide name and date of trust agreement and state of incorporation.

Name of trust/corporation	Date of trust	State of incorporation

COMMUNITY PROPERTY LAWS – If you are married or in a domestic partnership, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin), and name someone other than your spouse/domestic partner as beneficiary, it is possible that payment of benefits will be delayed or disputed unless your spouse/domestic partner also signs the beneficiary designation.
I agree to the above-stated beneficiary designation(s).

Print spouse/domestic partner name:_____

Spouse/domestic partner signature:_____ Date:_____

Section 6 – Authorization

The following authorization section is to be signed by **all** employees applying for coverage with 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 Blue Shield of California/Blue Shield Life may pursue one of the following remedies within the first 24 months of coverage: my coverage may be canceled, or rescinded. 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 _____

I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

Signature of employee _____ Date _____

Print employee name _____

Disclosure of personal and health information

At Blue Shield Life, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously. We are required to maintain the privacy and security of your personal information in whatever format it is held – paper, electronic, or oral. This statement applies to personal information about you and your covered dependents that Blue Shield obtains, creates, and/or maintains.

In the course of administering your Blue Shield Life insurance coverage, we collect, use, and disclose information about you and your covered dependents, and we create records about you and the services we provide to you. The information in these records includes individually identifiable personal information such as your name, address, telephone number, and Social Security number, as well as your health information, such as healthcare diagnosis or claim information.

We obtain personal information about you and/or your covered dependents from you, at your direction, and/or with your permission. We also obtain this information from other sources as permitted by law, 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 Life insurance 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 Life maintains a GLBA Notice of Privacy Practices ("GLBA Notice") describing your privacy rights, our obligations to protect your privacy, and how we use 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 GLBA Notice, which applies to all records that we create, obtain, and/or maintain that contain your personal information. Our GLBA Notice will be made available to you when you enroll for Blue Shield Life insurance coverage. You may also obtain a copy of our GLBA Notice by calling the customer service number on your Blue Shield member ID card or by visiting our website at: **blueshieldca.com/bsca/about-blue-shield/privacy/GLBA_Notice_of_privacy_practices.sp**.

blue california

Subscriber Change Request

Blue Shield of California and
Blue Shield of California Life & Health Insurance Company (Blue Shield Life)

All changes must be received within 31 days of the effective date of change. This form cannot be used for primary care physician changes – subscriber must call the Member Services phone number on the back of their ID card.

Employee identification – this section must be completed.

Subscriber ID number (from ID card)	Social Security number	Group number (from ID card)
Cell phone number	Landline phone number	
Last name	First name	MI
Home street address – City	State	ZIP code
Group/employer name (if applicable)	Email address	

Changes

☐ Yes ☐ No Is this a change/correction of address?

☐ Yes ☐ No Is the change/correction of address for a dependent? (**Note**: Dependent's address will default to subscriber's address if 'No' is indicated here.)

If yes, please indicate dependent name and address change: _____

☐ Correct my Social Security number to: _____ (Copy of Social Security card, a photo ID, a letter of verification from the Social Security office, and a written statement of why the employee is requesting the change must be attached.)

☐ This is a change made during open enrollment.

☐ Transfer/add my health coverage to: ☐ Access+ HMO® _____ ☐ Access+ HMO® SaveNet℠ _____ ☐ Local Access+ HMO _____
☐ Trio HMO _____ ☐ Full PPO _____ ☐ Active Choice®* _____ ☐ Active Choice® Plus _____
☐ Active Choice® Classic_____ ☐ Full PPO Savings _____ ☐ Tandem PPO _____ ☐ Tandem PPO Savings _____
☐ Added Advantage POS℠ _____

☐ Transfer my ABHP benefits coverage to:

For Access+ HMO®: ☐ HRA ☐ HIA ☐ FSA
For Access+HMO® SaveNet℠: ☐ HRA ☐ HIA ☐ FSA
For Local Access+ HMO: ☐ HRA ☐ HIA ☐ FSA
For Trio HMO: ☐ HRA ☐ HIA ☐ FSA
For Full PPO: ☐ HRA ☐ HIA ☐ FSA
For Active Choice®: ☐ HRA ☐ HIA ☐ FSA
For Active Choice® Plus: ☐ HRA ☐ HIA ☐ FSA
For Active Choice® Classic: ☐ HRA ☐ HIA ☐ FSA
For Full PPO Savings: ☐ HSA ☐ HRA ☐ HIA ☐ FSA ☐ LPFSA
For Tandem PPO: ☐ HRA ☐ HIA ☐ FSA
For Tandem PPO Savings: ☐ HSA ☐ HRA ☐ HIA ☐ FSA ☐ LPFSA
Added Advantage POS℠: ☐ HRA ☐ HIA ☐ FSA

☐ Transfer my specialty benefits coverage to: ☐ DHMO _____ ☐ DPPO _____ ☐ DINO _____
From Group # _____ to Group # _____ in my employer group. Note: If transferring coverage to HMO, POS, or DHMO, please complete Section A.

☐ Change the amount of Basic Group Term Life or Supplemental Life and Supplemental AD&D insurance coverage: (provide prior coverage amount and new coverage amount)
Prior amount of Basic Group Term Life coverage: $ _____ New amount of coverage: $ _____
Prior amount of Supplemental Life and/or Supplemental AD&D coverage: $ _____ New amount of coverage: $ _____
(If Supplemental AD&D coverage is purchased, it is always in the same amount as the Supplemental Life coverage)

☐ Correct/change name to:

☐ Correct/change email address to:

☐ Correct/change my date of birth from: _____ to: _____

☐ Additional changes/comments: _____
☐ Subscriber cancellation: I decline health plan coverage for myself (and dependents, if any) effective: _____
☐ COBRA participant
☐ Qualifying event: _____
☐ Effective date of above qualifying event: _____
☐ Is this a termination? If yes, list name(s): _____

Spouse/domestic partner/dependent child(ren) coverage changes

Add spouse/domestic partner/dependent child(ren) – Complete section A – Requested effective date for additions: _____

☐ Date of marriage if adding spouse: _____ ☐ Domestic partner – date of domestic partnership if adding: _____

☐ If court ordered custody/coverage, enter date and attach copy of legal documents: _____
☐ If adoption, enter date of adoption or date placed for adoption, and attach copy of legal documents: _____
☐ Disabled dependent over the age of 25 (Attach a 'Declaration of disability for over age dependent child' form (C3674) or confirmation that your current health carrier is providing coverage for this disabled dependent.)

☐ Change the Supplemental Group Term Life and AD&D insurance coverage amount of the spouse or domestic partner: (provide prior coverage amount and new coverage amount) Prior amount of coverage: $_____ New amount of coverage: $_____

Cancel dependent(s) – Complete section A – Requested effective date for deletions: _____

For cancellation of spouse or domestic partner: (select appropriate cancellation reason and provide date of event)
☐ Divorce or termination of domestic partnership: Date: _____
☐ Death: Date: _____
☐ Other reason (please specify): _____ Date: _____

For cancellation of dependent children: (select appropriate cancellation reason and provide date of event)
☐ Death: Date: _____ ☐ Other reason (please specify) _____ Date: _____

Note: Newborn/adopted children or children placed for adoption require a completed Subscriber Change Request to be submitted within 31 days from the date of birth/adoption/placement for adoption to be added to your coverage.

Please be sure to return this form as the third page contains your signature, which is necessary to process these changes.

Section A

Complete this section if adding/canceling coverage for yourself or your dependents. Provide primary care physician/dental provider information if the change pertains to HMO/POS/DHMO coverage. Please fill in which benefit the change applies to:

Add	Cancel	Self
☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Basic Life/ AD&D** ☐ **Dep. Life** ☐ **Supp. Life†** ☐ **Supp. Life/ AD&D†**	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Basic Life/ AD&D** ☐ **Dep. Life** ☐ **Supp. Life** ☐ **Supp. Life/ AD&D**	Last name / First name / MI / Sex
		Please tell us about yourself. How would you describe your race or ethnicity? These questions are optional and are only used to help ensure all members have the same access to the highest quality of care.
		1. Are you of Hispanic or Latino origin? ☐ Yes ☐ No ☐ Unknown ☐ Declined 2. If yes, please select one: ☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Salvadoran ☐ 2 or more Ethnicities ☐ Other Hispanic, Latino, Spanish: _____ 3. Which race(s) do you identify with? (select one) ☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White ☐ 2 or more Races ☐ Other ☐ Unknown ☐ Declined
		Social Security number: / Date of birth (mm/dd/yyyy) _____
		Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Persian ☐ Other _____
		Job title/classification / Annual earnings (not including bonuses, overtime, etc.) $ _____
		If adding Basic Life and AD&D insurance please indicate amount requested: $ _____ If adding Supp. Life and/or Supp. AD&D insurance please indicate amount requested: $ _____ If adding Dependent Life, please indicate amount requested: $ _____ (Note: Spouse and all children will be covered for the same benefit amount)
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____ Current patient? ☐ Yes ☐ No **Dental HMO only dental provider** Dental provider name: _____ Dental provider #: _____

Add	Cancel	Spouse/domestic partner
☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life†** ☐ **Supp. Life/ AD&D†**	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life** ☐ **Supp. Life/ AD&D**	Last name / First name / MI / Sex
		What race or ethnicity does this member identify with:
		Social Security number: / Date of birth (mm/dd/yyyy) _____
		If adding Supp. Life and/or Supp. AD&D insurance please indicate amount requested: $ _____
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____ Current patient? ☐ Yes ☐ No **Dental HMO only dental provider** Dental provider name: _____ Dental provider #: _____

Add	Cancel	Child			
☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life†** ☐ **Supp. Life/ AD&D†**	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life** ☐ **Supp. Life/ AD&D**	Last name	First name	MI	Sex
		What race or ethnicity does this member identify with:			
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		If adding Supp. Life and/or Supp AD&D insurance please indicate amount: $ _____ ($5,000 or $10,000) (Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)			
		If adding Dependent Life, please indicate amount requested: $ _____ (Note: Spouse and all children will be covered for the same benefit amount)			
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: _____ Dental provider #: _____	

Add	Cancel	Child			
☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life†** ☐ **Supp. Life/ AD&D†**	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life** ☐ **Supp. Life/ AD&D**	Last name	First name	MI	Sex
		What race or ethnicity does this member identify with:			
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		If adding Supp. Life and/or Supp AD&D insurance please indicate amount: $ _____ ($5,000 or $10,000) (Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)			
		If adding Dependent Life, please indicate amount requested: $ _____ (Note: Spouse and all children will be covered for the same benefit amount)			
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: _____ Dental provider No. _____	

Add	Cancel	Child			
☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life†** ☐ **Supp. Life/ AD&D†**	☐ **Dental** ☐ **Medical** ☐ **Vision** ☐ **Supp. Life** ☐ **Supp. Life/ AD&D**	Last name	First name	MI	Sex
		What race or ethnicity does this member identify with:			
		Social Security number:		Date of birth (mm/dd/yyyy) _____	
		If adding Supp. Life and/or Supp AD&D insurance please indicate amount: $ _____ ($5,000 or $10,000) (Note: All children will be covered for the same amount for Supplemental Life and Supplemental AD&D coverage.)			
		If adding Dependent Life, please indicate amount requested: $ _____ (Note: Spouse and all children will be covered for the same benefit amount)			
		HMO/POS primary care physician name Doctor's name: _____ Provider #: _____ IPA/MG #: _____	Current patient? ☐ Yes ☐ No	**Dental HMO only dental provider** Dental provider name: _____ Dental provider #: _____	

All information I have provided on this form is accurate and complete. I understand that this form, along with any prior enrollment form, the *Evidence of Coverage/Certificate of Insurance* and Health Service Agreement/policy, and any endorsements and attachments thereto, collectively constitutes the entire agreement for coverage.

Employee signature _____ Date _____

If faxing this form, keep this document for your files.

Blue Shield of California/Blue Shield Life protects the confidentiality and privacy of your personal information. Personal and health information which may individually identifiable information, such as your name, address, telephone number, Social Security number, and health information. We will not disclose this information, except as permitted by law.

Please be sure to return this form as the third page contains your signature, which is necessary to process these changes.

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

† Evidence of Insurability form is required for Supplemental Life. Approval must be received for any added Supplemental Life coverage. The effective date of coverage will be the first of the month following approval.

Si desea recibir este Aviso Sobre Practicas de Privacidad en español, por favor llame a Servicios a Clientes en el numero que se encuentra en su tarjeta de identificación de Blue Shield.

Notice of privacy practices

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

This Notice describes how medical information about you, as a Blue Shield member, may be used and disclosed, and how you can get access to your information.

Our privacy commitment

At Blue Shield, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously.

In the normal course of doing business, we create records about you, your medical treatment, and the services we provide to you. The information in those records is called protected health information (PHI) and includes your individually identifiable personal information such as your name, address, telephone number, and Social Security number, as well as your health information, such as healthcare diagnosis or claim information.

We are required by federal and state law to provide you with this Notice of our legal duties and privacy practices as they relate to your PHI. We are required to maintain the privacy of your PHI and to notify you in the event that you are affected by a breach of unsecured PHI. When we use or give out ("disclose") your PHI, we are bound by the terms of this Notice, which applies to all records that we create, obtain, and/or maintain that contain your PHI.

How we protect your privacy

We maintain physical, technical, and administrative safeguards to ensure the privacy of your PHI. To protect your privacy, only Blue Shield workforce members who are authorized and trained are given access to our paper and electronic records and to non-public areas where this information is stored.

Workforce members are trained on topics including:

- Privacy and data protection policies and procedures, including how paper and electronic records are labeled, stored, filed, and accessed.
- Physical, technical, and administrative safeguards in place to maintain the privacy and security of your PHI.

Our corporate Privacy Office monitors how we follow our privacy policies and procedures, and educates our organization on this important topic.

How we use and disclose your PHI

Uses of PHI without your authorization. We may disclose your PHI without your written authorization if necessary while providing health benefits and services

to you. We may disclose your PHI for the following purposes:

- **Treatment:**
  - To share with nurses, doctors, pharmacists, optometrists, health educators, and other healthcare professionals so they can determine your plan of care.
  - To help you obtain services and treatment you may need – for example, ordering lab tests and using the results.
  - To coordinate your health care and related services with a healthcare facility or professional.
- **Payment:**
  - To obtain payment of premiums for your coverage.
  - To make coverage determinations – for example, to speak to a healthcare professional about payment for services provided to you.
  - To coordinate benefits with other coverage you may have – for example, to speak to another health plan or insurer to determine your eligibility or coverage.
  - To obtain payment from a third party that may be responsible for payment, such as a family member.
  - To otherwise determine and fulfill our responsibility to provide your health benefits – for example, to administer claims.
- **Healthcare operations:**
  - To provide customer service.
  - To support and/or improve the programs or services we offer you.
  - To assist you in managing your health – for example, to provide you with information about treatment alternatives you may be entitled to, or to provide you with healthcare service or treatment reminders.
  - To support another health plan, insurer, or healthcare professional who has a relationship with you, to improve the programs it offers you – for example, for case management or in support of an accountable care organization (ACO) or patient-centered medical home arrangement.
  - For underwriting, dues, or premium rating, or other activities relating to the creation, renewal, or replacement of a contract for health coverage or insurance. Please note, however, that we will not use or disclose your PHI that is genetic information for underwriting purposes – doing so is prohibited by federal law.

We may also disclose your PHI without your written authorization for other purposes, as permitted or required by law. This includes:

- **Disclosures to others involved in your health care.**
  - If you are present or otherwise available to direct us to do so, we may disclose your PHI to others, for example, a family member, a close friend, or your caregiver.
  - If you are in an emergency situation, are not present, are incapacitated, or if you are deceased, we will use our professional judgment to decide whether disclosing your PHI to others is in your best interest. If we do disclose your PHI in a situation where you are unavailable, we will disclose only information that is directly relevant to the person's involvement

with your treatment or for payment related to your treatment. We may also disclose your PHI in order to notify (or assist in notifying) such persons of your location, your general medical condition, or your death.

  - We may disclose your minor child's PHI to the child's other parent.

- **Disclosures to your plan sponsor.** We may disclose PHI to the sponsor of your group health plan, which may be your employer, or to a company acting on behalf of the plan sponsor, so that they can monitor, audit, and otherwise administer the health plan you participate in. Your employer is not permitted to use the PHI we disclose for any purpose other than administration of your benefits. See your plan sponsor's plan documents for information about whether your employer/plan sponsor receives PHI, and for a full explanation of the limited uses and disclosures that the plan sponsor may make of your PHI.
- **Disclosures to vendors and accreditation organizations.** We may disclose your PHI to:
  - Companies that perform certain services on behalf of Blue Shield. For example, we may engage vendors to help us provide information and guidance to members with chronic conditions like diabetes and asthma.
  - Accreditation organizations such as the National Committee for Quality Assurance (NCQA) for quality measurement purposes.

    Please note that before we share your PHI, we obtain the vendor's or accreditation organization's written agreement to protect the privacy of your PHI.
- **Communications.** We may use your PHI to contact you with information about your Blue Shield health plan coverage, benefits, health-related programs and services, treatment reminders, or treatment alternatives available to you. We do not use your PHI for fundraising purposes.
- **Health or safety.** We may disclose your PHI to prevent or lessen a serious and imminent threat to your health or safety, or the health or safety of the general public.
- **Public health activities.** We may disclose your PHI to:
  - Report health information to public health authorities authorized by law to receive such information for the purpose of preventing or controlling disease, injury or disability, or monitoring immunizations.
  - Report child abuse or neglect, or adult abuse, including domestic violence, to a government authority authorized by law to receive such reports.
  - Report information about a product or activity that is regulated by the U.S. Food and Drug Administration (FDA) to a person responsible for the quality, safety, or effectiveness of the product or activity.
  - Alert a person who may have been exposed to a communicable disease, if we are authorized by law to give such a notice.
- **Health oversight activities.** We may disclose your PHI to:
  - A government agency that is legally responsible for oversight of the healthcare system or for ensuring compliance with the rules of government benefit programs such as Medicare or Medicaid.

  - Other regulatory programs that need health information to determine compliance.
- **Research.** We may disclose your PHI for research purposes, but only according to, and as allowed by, law.
- **Compliance with the law.** We may use and disclose your PHI to comply with the law.
- **Judicial and administrative proceedings.** We may disclose your PHI in a judicial or administrative proceeding or in response to a valid legal order.
- **Law enforcement officials.** We may disclose your PHI to the police or other law enforcement officials, as required by law or in compliance with a court order or other process authorized by law.
- **Government functions.** We may disclose your PHI to various departments of the government, such as the U.S. military or the U.S. Department of State, as required by law.
- **Workers' compensation.** We may disclose your PHI when necessary to comply with workers' compensation laws.

Uses of PHI that require your authorization. Other than for the purposes described above, we must obtain your written authorization to use or disclose your PHI. For example, we will not use your PHI for marketing purposes without your prior written authorization, nor will we give your PHI to a prospective employer without your written authorization.

Uses and disclosure of certain PHI deemed "highly confidential." For certain kinds of PHI, federal and state law may require enhanced privacy protection. This includes PHI that is:

- Maintained in psychotherapy notes.
- About alcohol and drug abuse prevention, treatment, and referral.
- About HIV/AIDS testing, diagnosis, or treatment.
- About venereal and/or communicable disease(s).
- About genetic testing.

We can only disclose this type of specially protected PHI with your prior written authorization except when specifically permitted or required by law.

Authorization cancellation. At any time, you may cancel a written authorization that you previously gave us. When submitted to us in writing, the cancellation will apply to future uses and disclosures of your PHI. It will not affect uses or disclosures made previously, while your authorization was in effect.

Your individual rights

You have the following rights regarding the PHI that Blue Shield creates, obtains, and/or maintains about you:

- **Right to request restrictions.** You may ask us to restrict the way we use and disclose your PHI for treatment, payment, and healthcare operations, as explained in this Notice. We are not required to agree to your restriction requests, but we will consider them carefully.

  If we agree to a restriction request, we will abide by it until you request or agree to terminate the restriction. We may also inform you that we are terminating our agreement to a restriction. In that case, the termination will apply only to PHI created or received after we have informed you of the termination.

- **Right to receive confidential communications.** You may ask to receive Blue Shield communications containing PHI by alternative means or at alternative locations. As required by law, and whenever feasible, we will accommodate reasonable requests. We may require that you make your request in writing. If your request involves a minor child, we may ask you to provide legal documentation to support your request.
- **Right to access your PHI.** You may ask to inspect or to receive a copy of certain PHI that we maintain about you in a "designated record set." This includes, for example, records of enrollment, payment, claims adjudication, and case or medical management record systems, and any information we used to make decisions about you. Your request must be in writing. Whenever possible, and as required by law, we will provide you with a copy of your PHI in the form (paper or electronic) and format you request. If you request a copy of your PHI, we may charge you a reasonable, cost-based fee for preparing, copying, and/or mailing it to you. In certain limited circumstances permitted by law, we may deny you access to a portion of your records.
- **Right to amend your records.** You have the right to ask us to correct or amend the PHI that we maintain about you in a designated record set. Your request must be made in writing and explain why you want your PHI amended. If we determine that the PHI is inaccurate or incomplete, we will correct it if permitted by law. If a doctor or healthcare facility created the PHI that you want to change, you should ask them to amend the information.
- **Right to receive an accounting of disclosures.** Upon your written request, we will provide you with a list of the disclosures we have made of your PHI for a specified time period, up to six years prior to the date of your request. However, the list will exclude:
  - Disclosures you have authorized.
  - Disclosures made earlier than six years before the date of your request.
  - Disclosures made for treatment, payment, and healthcare operations purposes, except when required by law.
  - Certain other disclosures that we are allowed by law to exclude from the accounting.

  If you request an accounting more than once during any 12-month period, we will charge you a reasonable, cost-based fee for each accounting report after the first one.
- **Right to name a personal representative.** You may name another person to act as your personal representative. Your representative will be allowed access to your PHI, to communicate with the healthcare professionals and facilities providing your care, and to exercise all other HIPAA rights on your behalf. Depending on the authority you grant your representative, he or she may also have authority to make healthcare decisions for you.
- **Right to receive a paper copy of this Notice.** Upon your request, we will provide a paper copy of this Notice, even if you have agreed to receive the Notice electronically. See the "Notice Availability and Duration" section of this Notice.

Actions you may take

Contact Blue Shield. If you have questions about your privacy rights, believe that we may have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact us:

Blue Shield of California Privacy Office
P.O. Box 272540
Chico, CA 95927-2540

Phone: (888) 266-8080 (toll-free)

Fax: (800) 201-9020 (toll-free)

Email: privacy@blueshieldca.com

For certain types of requests, you must complete and mail us a form that is available either by calling the customer service number on your Blue Shield member ID card or by visiting our website at **blueshieldca.com/privacyforms**.

Contact a government agency. You may also file a written complaint with the Secretary of the U.S. Department of Health & Human Services (HHS) if you believe we may have violated your privacy rights. Your complaint may be sent by email, fax, or mail to the HHS Office for Civil Rights (OCR).

For more information, or to file a complaint with the Secretary of HHS, visit the OCR website at **www.hhs.gov/ocr/privacy/hipaa/complaints**.

If you are a California resident, you may contact the OCR Regional Manager for California as follows:

Region IX Regional Manager
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th St., Suite 4-100
San Francisco, CA 94103

Phone: (800) 368-1019

Fax: (202) 619-3818

TTY: (800) 537-7697

We will not take any action against you if you exercise your right to file a complaint, either with us or with HHS.

Notice availability and duration

Notice availability. A copy of this Notice is available by calling the customer service number on your Blue Shield member ID card or by visiting our website at **blueshieldca.com/privacynotice**.

Right to change terms of this Notice. We are required to abide by the terms of this Notice as long as it remains in effect. We may change the terms of this Notice at any time, and, at our discretion, we may make the new terms effective for all of your PHI in our possession, including any PHI we created or received before we issued the new Notice.

If we change this Notice, we will update the Notice on our website, and if you are enrolled in a Blue Shield benefit plan at that time, we will send you the new Notice when and as required by law.

Effective date. This Notice is effective as of August 16, 2013.

NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: **blueshieldca.com/notices**. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en **blueshieldca.com/notices**. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 **blueshieldca.com/notices**。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。

How to contact us

If you have questions about the information included in this booklet, please contact a Blue Shield representative at one of the numbers below. Service is available in multiple languages.

Or, you can always visit us online at **blueshieldca.com,** anytime, day or night.

forms

Look here to view more information on your Blue Shield of California plans.

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 or an employee 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 or an employee 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 or an employee 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 60 days 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 60 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 60 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