

*SBCERS Use Only*

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**Blue Shield Subscriber Enrollment / Change Form**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> New Enrollment      | <input type="checkbox"/> Termination of Coverage | <input type="checkbox"/> Add Medicare A & B      |
| <input type="checkbox"/> Open Enrollment     | <input type="checkbox"/> Delete Dependent        | <input type="checkbox"/> COBRA Election          |
| <input type="checkbox"/> Address/Name Change | <input type="checkbox"/> Add Dependent           | <input type="checkbox"/> Extended COBRA Election |

**Effective Date:** \_\_\_\_\_

FOR SBCERS USE ONLY	From Code	To Code	To Premium
	_____	_____	\$ _____

**Notes:** \_\_\_\_\_

**SELECT MEDICAL/PRESCRIPTION PLAN AND COVERAGE TYPE**

<b>Medical and Prescription Plan (EPO and PPO Plans use Express Scripts for Retail and Mail Order)</b>		<b>Coverage Type</b>
<input type="checkbox"/> EPO Low Option with <i>Regular</i> Prescription Plan	<input type="checkbox"/> EPO Low Option with <u>Medicare</u> * Prescription Plan	<input type="checkbox"/> RET Only
<input type="checkbox"/> EPO High Option with <i>Regular</i> Prescription Plan	<input type="checkbox"/> EPO High Option with <u>Medicare</u> * Prescription Plan	<input type="checkbox"/> RET + 1
<input type="checkbox"/> PPO with <i>Regular</i> Prescription Plan	<input type="checkbox"/> PPO with <u>Medicare</u> * Prescription Plan	<input type="checkbox"/> Family
<input type="checkbox"/> HDHP with <u>Blue Shield</u> Prescription Plan		

*\*Selection of Medicare Prescription Plan requires that you supply Medicare HICN and effective dates of Parts A and B for all Medicare enrolled participants where indicated below. NOTE: All Medicare-enrolled participants must be enrolled in the same prescription plan.*

**RETIREE INFORMATION**

Last Name	First Name	M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number	Birth Date (mm/dd/yyyy)	Home Phone:	Work Phone:
Residence Street Address	City	State	Zip Code
Mailing Street Address	City	State	Zip Code
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Registered Domestic Partner (RDP) <input type="checkbox"/> Legally Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
E-Mail Address:	*Medicare: <input type="checkbox"/> Part A, Effective _____ <input type="checkbox"/> Part B, Effective _____	*Medicare Claim / HICN #	

**DEPENDENT INFORMATION (List all eligible family members to be enrolled. Attach additional sheets if necessary.)**

<input type="checkbox"/> Spouse <input type="checkbox"/> RDP	Last Name	First Name	M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Residence Street Address <input type="checkbox"/> Check here if same as Retiree		City	State	Zip Code
Social Security Number	Birth Date (mm/dd/yyyy)	*Medicare: <input type="checkbox"/> Part A, Effective _____ <input type="checkbox"/> Part B, Effective _____	*Medicare Claim / HICN #	
<input type="checkbox"/> Son <input type="checkbox"/> Daughter	Last Name	First Name	M.I.	<input type="checkbox"/> Coverage Dependent <input type="checkbox"/> Disabled <input type="checkbox"/> Over 50% IRS Support
Residence Street Address <input type="checkbox"/> Check here if same as Retiree		City	State	Zip Code
Social Security Number	Birth Date (mm/dd/yyyy)	*Medicare: <input type="checkbox"/> Part A, Effective _____ <input type="checkbox"/> Part B, Effective _____	*Medicare Claim / HICN #	

Signature is required on page 2

Retiree Name: \_\_\_\_\_

Initial either acceptance or declination of coverage:

ACCEPTANCE OF COVERAGE

DECLINATION OF COVERAGE

Complete the following section if coverage is to be declined by you or your eligible dependents.

I decline Medical coverage for (check all that apply):

- Self       Spouse/RDP       Child(ren)  
 Spouse/RDP and Child(ren)  
 The Following Dependents Only (List Name & SSN)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reason for Declination

Other Coverage  
Insurance Carrier Name

\_\_\_\_\_

Other reasons

\_\_\_\_\_

The available coverages have been explained to me. I have been given the chance to apply for the available coverages.

**Declination:** If I have decided not to enroll myself and/or my dependent(s), by signing below, I acknowledge that by declining coverage my dependents and I may have to wait until the next Open Enrollment period or qualifying event to be enrolled.

*Authorization to obtain or release medical information explanation: The Authorization below to obtain and release medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act, effective January 1, 1980, Section 56 et. Seq. of the California Civil Code. Your cooperation is being requested.*

**Enrollment and Authorization:** If I have decided to enroll myself and/or my dependent(s), by signing below, I acknowledge that by enrolling I am I hereby authorizing my physician, health care practitioners, hospital, clinic or other medically related facility to furnish to my medical insurance provider, its representatives or designees, any and all records pertaining to medical history, service rendered or treatment given to anyone under the policy for the purpose of review, investigation, or evaluation of an application, claim, appeal, (including the release to an independent review organization) or grievance, or for preventive health or health management purposes. I authorize my health insurance provider, its representatives or designees to disclose to a hospital or health care service plan, self insurer any such medical information obtained if disclosure is necessary to allow the processing of any claim.

\_\_\_\_\_  
**Retiree Signature (for Enrollment or Declination)**

\_\_\_\_\_  
**Date**

Return completed forms to your Benefits Specialist:

SBCERS  
130 Robin Hill Rd Suite 100  
Goleta, CA 93117

SBCERS  
2236 South Broadway Suite D  
Santa Maria, CA 93454

FOR SBCERS USE ONLY

Web Enrolled

Emailed to Carrier

Entered to PG

Entered to PR Input Log

Completed by: \_\_\_\_\_

Date: \_\_\_\_\_