



SBCERS Use Only

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Blue Shield Subscriber Enrollment / Change Form

- New Enrollment Termination of Coverage Add Medicare A & B
 Open Enrollment Delete Dependent COBRA Election
 Address/Name Change Add Dependent Extended COBRA Election

Effective Date: _____

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

Notes: _____

SELECT MEDICAL AND PRESCRIPTION PLAN AND TYPE OF COVERAGE:

<p>Medical and Prescription Plan</p> <input type="checkbox"/> EPO Low Option Medical with Express Scripts Regular Prescription Drug Plan <input type="checkbox"/> EPO Low Option Medical with Express Scripts Medicare Prescription Drug Plan* <input type="checkbox"/> HDHP with Blue Shield Prescription Plan	<p>Type of Coverage</p> <input type="checkbox"/> RET only <input type="checkbox"/> RET + 1 Dependent <input type="checkbox"/> Retiree + Family
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**Selection of Medicare Prescription Drug Plan requires that you supply Medicare HICN and effective dates of Parts A & 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"/> Overage 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 93105

SBCERS
2236 S. 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: _____