Blue View Vision Enrollment Form

California State Association of Letter Carriers

BC Life & Health Insurance Company

Effective Date | | | | | | | Group No. | | | | | | | | | | | Dept. No. | | | | | | |

I. PERSONAL INFORMATION

Last Name (Print)	First Name (Print)	M.I.	☐ Male ☐ Female
Street Address	City	State	ZIP
Home Telephone No. / Business Telephone No.	Employer	Date of Hire	
Job Title	Class / Dept. No.	E-mail Address	

II. SELECTED COVERAGE

Type of Coverage: ☐ New Enrollment ☐ Re-Hire ☐ Part Time to Full Time ☐ Open Enrollment ☐ COBRA

You must select one of the plan choices below:

☐ Plan Option A: Blue View Vision – Full Service Plan B25

☐ Plan Option B: Blue View Vision – Full Service Plan B10

III. LANGUAGE PREFERENCE

When information is sent to you, we may be able to send it in a language other than English.

What language would you prefer? (Optional)

☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Japanese

☐ Tagalog ☐ Vietnamese ☐ Khmer ☐ Hmong ☐ Farsi

☐ Arabic ☐ Armenian ☐ Russian ☐ Other _____

IV. ASSOCIATION MEMBER AND DEPENDENT INFORMATION

	Last Name	First Name	M.I.	Social Security No.	Birthdate	Age	If children are age 19 or over, you must check the appropriate boxes below: Full-Time Student	IRS No. Dependent	Totally Disabled	Sex
Self									☐Y ☐N	☐M ☐F
☐ Spouse ☐ Domestic Partner							☐Y ☐N	☐Y ☐N	☐Y ☐N	☐M ☐F
Child							☐Y ☐N	☐Y ☐N	☐Y ☐N	☐M ☐F
Child							☐Y ☐N	☐Y ☐N	☐Y ☐N	☐M ☐F
Child							☐Y ☐N	☐Y ☐N	☐Y ☐N	☐M ☐F
Child							☐Y ☐N	☐Y ☐N	☐Y ☐N	☐M ☐F

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

V. COBRA INFORMATION – To be completed by employer

Company Name _____

Check correct box indicating "Qualifying Event" causing loss of coverage

Association Member

☐ Termination of Association Member

☐ Reduction of Association Member's work hours

☐ Benefits terminated or reduced within one year before or after retired Association Member's employer filing for bankruptcy under Chapter 11, if plan provides benefits for retirees

Family Member:

☐ Death of the Association Member

☐ Divorce or legal separation from Association Member

☐ Loss of dependent child eligibility

☐ Association Member's entitlement to Medicare

☐ Other: If enrolling in COBRA coverage, please indicate the qualifying event date and coverage date below

☐ Benefits terminated or reduced within one year before or after retired Association Member's filing for bankruptcy, if the plan provides benefit for retirees

Date of Qualifying Event	Date of Loss of Coverage	Date When Continued Coverage Ends	Date Notice Given	Applicant's Initials
Group Policyholder Representative's Signature				Telephone No.

VI.-VIII. PLEASE READ CAREFULLY – Signature Required

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

VI. **DEDUCTION AUTHORIZATION:** If applicable, I authorize my employer to deduct from my wages the required dues.

VII. **NON-PARTICIPATING PROVIDER:** I understand that I am responsible for a greater portion of my vision cost when I use a non-participating provider.

VIII. **ARBITRATION AGREEMENT: If your coverage is under a private employer plan governed by ERISA (Employment Retirement Income Security Act of 1974), certain disputes may not be subject to the following arbitration provisions:** I understand that any and all disputes between myself (and/or any enrolled family member) and BC Life & Health, including claims for medical malpractice, must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of the Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both the member and BC Life & Health are giving up the right to have any dispute decided in a court of law before a jury. BC Life & Health and the member also agree to give up any right to pursue on a class basis any claim or controversy against the other. For more information regarding binding arbitration, please refer to your Evidence of Coverage/Certificate.

If I am enrolled in an employer-sponsored benefit plan that is subject to ERISA (Employee Retirement Income Security Act of 1974, 29 U.S.C. section 1001, et seq.) I understand that any dispute involving an adverse benefit determination for a health claim may not be subject to mandatory binding arbitration. However, I further understand that any dispute I may have with respect to an adverse benefit determination for a health claim may be submitted to voluntary binding arbitration after the ERISA claim appeal process is completed.

X _____

Association Member Signature Date

BC Life & Health Insurance Company is an Independent Licensee of the Blue Cross Association.
Vision coverage provided BC Life & Health Insurance Company.
www.bluecrossca.com

DISTRIBUTION: WHITE - Blue Cross Membership; CANARY - Blue Cross Marketing; PINK - Association Member

SC11968 10/07

UNITED STATES
POSTAL SERVICE™

DIRECT DEPOSIT

Privacy Act: The collection of this information is authorized by 39 USC 401, 1003 and 5 USC 8339. This information is used to transfer your salary or portion thereof, to financial organizations for credit to your designated account. As a routine use, the information may be disclosed to an appropriate government agency, domestic or foreign, for law enforcement purposes; where pertinent, in a legal proceeding to which the USPS is a party or has an interest; to a government agency in order to obtain informaiton relevant to a USPS decision concerning employment, security clearances, contacts, licenses, grants, permits, or other benefits; to a government agency at your request when relevant to its decisionconcerning employment, security clearances, security or suitable investigations, contracts, licenses, grants, permits or other benefits; to a congressional office at your request; to an expert, consultant, or other person under contract with the USPS to fullfill an agency function; to the Federal Records Center for storage; to the Office of Management and Budget for review or private relief legistlation; to an independent certified public accountant during an official audit of USPS finiances; to an investigator, adminstrative judge or complaints examiner appointed by the Equal Employment Opportunity Commission for investigation of a formal EEo complaint under 29 CFR 1613; to the Merit Systems Protection Board or Office of Special Counsel for proceedings or investigations involving personnel practices and other matters within their jurisdiction; to a labor organization as required by the National Labor Relations Act; to agencies having taxing authority for taxing purposes; to financial organizations receiving allotments; to State Employment Security Agencies to process unemployment compensation claims; to a Federal or state agency providing parent locator service or to other authorized persons as defined by Pub. L. 93-647; to the National Association of Postal Supervisors that relates to postal supervisors; to the Office of Personnel Management, Social Security Adminstration, Veterans Adminstration, Office of Workers' Compensation Programs, health insurance carriers, or plans, or other program management agencies or retirement systems for use in determining a claim for benefits; and to OPM for its active employees/annuitant data systems used to analyze Federal Ritrement and insurance costs. Completion of this form is voluntary; however, if this information is not provided, your desires may not be met.

Part I - (Initiated by Employee)

1. **Employee Name** *(As Shown on Check)*

2. Social Security Number

3. **Home Address** *(No. and Street, Apt, City, State, Zip+4)*

4a. Postal Installation Where Employed *(City, State, Zip+4)*

Employee ID

PostalEASE PIN Number

4b. Finance Number

Password

5a. REQUIRED Action (Check ONLY One)

☐ ESTABLISH a Net Check ☐ CANCEL a Net Check ☐ CHANGE a Net Check Financial Organization

5b. ESTABLISH an ALLOTMENT in the Amount of:
$

5c. CHANGE My PRESENT ALLOTMENT
FROM: $ TO: $

5d. CANCEL my ALLOTMENT in the Amount of:

5e. Check (✓)This Item if You Have More Than One Allotmentto a Financial Organization
☐

I certify that I am entitled to the payment identfied above, and that I have read and understand the information printed above. In signing this form, I authorize my payment to be sent to the financial organization named below to be deposited to the designated account.

6a. Employee (Signature)
X

6b. Date Signed

6b. Effective Date **ASAP**

Part II - (Completed by Financial Organization, Return Original and Copy to Employee)

Financial Organization Certification

I confirm the identity of the above signed named payee(s) and the account number in title. As representative of the below named financial organization, I certify that the financial organization agrees to receive and deposit the payment identified above in accordance with 31 CFR Parts 240, 209, and 210. Pursuant to Treasury Department regulations, multiple deposits will not be made to a single common account, except for those accounts (such as husband and wife) in which employees name(s) appear in the title.

7a. Financial Organization (Name, No. and Street, City, State, ZIP + 4)

CHASE MANHATTAN BANK, N.A.
1 CHASE MANHATTAN PLAZA
NEW YORK, N.Y. 10081

7b. Financial Organization Routing Number — Check Digit

0 2 1 4 0 9 1 6 — 9

7c. Employee's Account Number to Be Credited (Up to 17 positions)

0 1 5

7d. Type of Account

☒ Savings ☐ Checking

Authorized By

8a. Name (Print or Type)
ALLEN J. RUSKIN

8a. Title
VICE PRESIDENT

8c. Signature

8d. Date Signed
JAN 1, 2005

1 Request must be received at DDE site no later than Wednesday of the week in which the pay period ends in order to be effective for a particular pay period. Later receipts will be processed the following pay period.
2 Financial organizations must furnish their routing transit number (the number assigned by Rand McNally). This is an eight digit number plus a single digit. It is IMPORTANT that this number be accurate, as disbursements will be made according to this routing number

NOTE: The Employee must return in the original to the Personnel Office for processing.