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

BANK AUTHORIZATION PLAN: **It's the mistake-proof method of paying your premiums -- as easy as payroll deduction. Just authorize us to debit your personal checking account each month. We'll do the rest. There will be no paper work for you and no more checks to write. It's easy, reliable, and automatic so that your valuable coverage will not lapse.**

Type of Account: **Savings** ☒ **Checking** ☐

Authorization Agreement for [name] _____ Routing # _____

⇨⇨(PLEASE ATTACH ONE BANK VOIDED CHECK) Account #: _____

I (we) hereby authorize Beneftis Unlimited Inc. to initiate debit entries to my (our) checking account indicated below, and the bank or credit union named below, herein called BANK, to debit the same to such account. This authorization is to remain in full force and effect until BANK has received written notification from me (or either of us) of its termination in such time and manner as to afford BANK a reasonable opportunity to act on it. This authorization includes authority for increases in the program for as long as I remain a member in the program. A customer has the right to have the amount of an *erroneous* debit immediately credited to his/her account by BANK up to 15 days following issuance of statement of account or 45 days after charge, whichever comes first.

Bank Name: _____ **Bank Address:** _____

Bank City: _____ **State:** _____ **Zip:** _____ **Phone #** _____

Print Your Name: _____ **Social Secuirty #** _____

Signature⇨ _____ **date:** _____