



Blue View Vision Enrollment Form

California State Association of Letter Carriers

Effective Date Group No. Dept. No.

I. PERSONAL INFORMATION

Last Name (Print)		First Name (Print)		M.I.		<input type="checkbox"/> Male <input type="checkbox"/> 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	Totally Disabled	Sex
Self							Full-Time Student <input type="checkbox"/> Y <input type="checkbox"/> N IRS No. <input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Spouse							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Domestic Partner							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> M <input type="checkbox"/> F
Child							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> M <input type="checkbox"/> F
Child							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> M <input type="checkbox"/> F
Child							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> M <input type="checkbox"/> F
Child							<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> M <input type="checkbox"/> 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:		<input type="checkbox"/> Loss of dependent child eligibility		<input type="checkbox"/> Other: If enrolling in COBRA coverage, please indicate the qualifying event	
<input type="checkbox"/> Death of the Association Member		<input type="checkbox"/> Association Member's entitlement to Medicare		date and coverage date below	
<input type="checkbox"/> Divorce or legal separation from Association Member		<input type="checkbox"/> Benefits terminated or reduced within one year before or after retired Association Member's filing for bankruptcy, if the plan provides benefit for retirees		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	Telephone No.
Group Policyholder Representative's Signature					

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 by BC Life & Health Insurance Company.
 www.bluecrossca.com

DISTRIBUTION: WHITE - Blue Cross Membership; CAMMIR - Blue Cross Marketing; PPK - Association Member

