



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 <input type="checkbox"/> Student <input type="checkbox"/> Dependent <input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner								<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"/> M <input type="checkbox"/> F
Child								<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"/> M <input type="checkbox"/> F
Child								<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"/> 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:

Death of the Association Member
 Divorce or legal separation from Association Member

Loss of dependent child eligibility
 Other: If enrolling in COBRA coverage, please indicate the qualifying event
 Association Member's entitlement to Medicare 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

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

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



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 information relevant to a USPS decision concerning employment, security clearances, contracts, licenses, grants, permits, or other benefits; to a government agency at your request when relevant to its decision concerning 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 fulfill an agency function; to the Federal Records Center for storage; to the Office of Management and Budget for review or private relief legislation; to an independent certified public accountant during an official audit of USPS finances; to an investigator, administrative 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 Administration, Veterans Administration, 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 Retirement 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. Where Employed (City, State, Zip+4)							
Employee Express Login ID	Employee Express Password	4b. Finance Number							
		<table border="1"> <tr> <td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>							

Complete Applicable Item(s) Below

5a. Administration Section	
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 Allotment to a Financial Organization <input type="checkbox"/>

I certify that I am entitled to the payment identified 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 ¹ 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 ² <table border="1"> <tr> <td>0</td><td>2</td><td>1</td><td>0</td> <td>0</td><td>0</td><td>0</td><td>2</td> <td>1</td> </tr> </table>	0	2	1	0	0	0	0	2	1									
0	2	1	0	0	0	0	2	1											
	7c. Employee's Account Number to Be Credited (Up to 17 positions) <table border="1"> <tr> <td>B</td><td>U</td><td>I</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> </tr> </table>	B	U	I															
B	U	I																	
	7d. Type of Account <input checked="" type="checkbox"/> Savings <input type="checkbox"/> 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.