



BLUE CROSS ENROLLMENT FORM

WORKSHEET INSTRUCTIONS

SECTION I: PERSONAL INFORMATION

Requested information is required.

SECTION II: SELECTED COVERAGE

Check the appropriate boxes. Requested information is required.

SECTION III: EMPLOYEE & FAMILY INFORMATION

Requested information is required.

Please check the Totally Disabled box only if the condition prohibits you/your dependent from working or performing daily activities.

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.

For Blue Cross HMO and POS members only: Each person listed must receive all medical care through the Medical Group or Independent Practice Association he or she has selected in order to receive the HMO benefit, and must live or work within the service area of the group selected. Select a Primary Care Physician from the listing in your Provider Directory. You must indicate the Primary Care Physician number which is listed below the physician's name or after the address. (If you select an IPA, you must select a Primary Care Physician from within the IPA.)

For Dental Net and Blue Cross Dental SelectHMO only: Each family member needs to select a dental office.

SECTION IV: DO YOU OR YOUR DEPENDENTS HAVE OTHER HEALTH CARE COVERAGE?

Please fill in requested information if applicable.

SECTION V: PRIOR COVERAGE FOR PPO (Prudent Buyer or BlueCard) PLANS ONLY

Please fill in requested information if applicable.

SECTIONS VI - X: PLEASE READ CAREFULLY – SIGNATURE IS REQUIRED

Non-Participating Provider Agreement, Arbitration Agreement, please read.