Saddleback Valley USD Spouse as Primary Enrollment Form

Must be received in Benefits Department within 31 days of qualifying event.

Employee Pin: ______Last Name: ____________________ First Name: ____________________ DOB: _______

☐ SVEA ☐ SVMTA ☐ SVPSA ☐ CSEA (full time) ☐ CSEA (6 hrs per day or less)

☐ Active ☐ Retired Qualifying Event Date: _____________ Effective Date: _____________

Spouse SSN: _____________ Last Name: ____________________ First Name: ____________________

HEALTH BENEFIT CHOICE:

☐ Blue Shield PPO Medical, Behavioral Health, Dental, and Vision

☐ Blue Shield EPO Medical, Behavioral Health, Dental, and Vision

☐ Blue Shield Access+ HMO Medical, Behavioral Health, Dental, and Vision

☐ Blue Shield Trio HMO Medical, Behavioral Health, Dental, and Vision

☐ Blue Shield Trio HMO Medical & Behavioral Health Only (CSEA Part Time)

☐ Blue Shield Access+ HMO Medical & Behavioral Health Only (CSEA Part Time)

☐ Dental and Vision Only (Declining Medical/Behavioral Health)

COMPLETE DOCTOR INFO ONLY IF ADDING BLUE SHIELD ACCESS+ HMO or TRIO HMO

View provider directory at: www.blueshieldca.com/networkhmo for Access+ HMO or www.blueshieldca.com/networktriohmo for Trio HMO. Search by name, zip code, etc. If you do not select a physician, one will be selected for you.

DOCTOR INFORMATION:

DR FULL NAME: ____________________
CITY OR ZIP CODE: ___________________
PROVIDER #: ______________________
MEDICAL GROUP: __________________
EXISTING PATIENT? ☐ NO ☐ YES

PRIVACY DISCLOSURE STATEMENT:

Blue Shield understands the importance of keeping your and your dependents' personal and health information private. Blue Shield protects this information in electronic, written, and oral forms when used throughout our company. Blue Shield will not disclose this information without your authorization except as permitted by law.

For the purpose of administering your Blue Shield coverage, Blue Shield is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, Blue Shield is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.

A complete explanation of Blue Shield's policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing Blue Shield's web site.

ENROLLMENT AUTHORIZATION:

Blue Shield Authorization: I agree that all information on this form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have committed fraud or made an intentional misrepresentation of any material fact that my coverage may be cancelled or, following notice, my employer's contract rescinded. I understand that it is my responsibility to report any qualifying events within 31 days of the event including **additions, deletions and changes of address/phone number. Benefit enrollments will be made using last address on file with the Human Resources Department.**

EMPLOYEE SIGNATURE: ____ DATE: _____________________

FOR BENEFITS STAFF USE ONLY:
QE: __________ EFFECTIVE DATE: ______________ E-FILE: _____________
COUPONS____________
HR 2.0: _________ IRS CODES: __________ WARD: ______________