



## ENROLLMENT FORM FOR GROUP LIFE INSURANCE FOR BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY (BLUE SHIELD LIFE)

NOTE: Please complete the entire enrollment form and return it to your employer. This form cannot be processed if information is incomplete.

GROUP NAME	GROUP POLICY NO.	SECTION NUMBER
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### SECTION 1 – APPLICANT

FIRST NAME		M.I.	LAST NAME	
ADDRESS		CITY		STATE
				ZIP
GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		BIRTHDATE	SOCIAL SECURITY NO.	
				MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED
FULL TIME EMPLOYMENT DATE	AVERAGE HOURS WORKED PER WEEK	REHIRE DATE	CLASS/OCCUPATION	
				EARNINGS \$ _____ (EXCLUDING OVERTIME, BONUSSES, ETC.) <input type="checkbox"/> HOUR <input type="checkbox"/> WEEK <input type="checkbox"/> MONTH <input type="checkbox"/> YEAR

### SECTION 2 – BENEFICIARY

**Primary Beneficiary** – Blue Shield Life will pay the proceeds to the primary beneficiary. If more than one person is named as primary beneficiary, the proceeds will be distributed equally to those who survive the insured, unless otherwise specified in the % column.

FIRST NAME	MI	LAST	SOCIAL SECURITY NUMBER	RELATIONSHIP	% OF BENEFITS	D.O.B.
STREET ADDRESS		CITY		STATE	ZIP	
FIRST NAME	MI	LAST	SOCIAL SECURITY NUMBER	RELATIONSHIP	% OF BENEFITS	D.O.B.
STREET ADDRESS		CITY		STATE	ZIP	

**Contingent Beneficiary** – Proceeds will be paid to a contingent beneficiary only if no primary beneficiary survives the insured.

FIRST NAME	MI	LAST	SOCIAL SECURITY NUMBER	RELATIONSHIP	% OF BENEFITS	D.O.B.
STREET ADDRESS		CITY		STATE	ZIP	

### SECTION 3 – COVERAGE (COMPLETE ONLY TO APPLY FOR GROUP LIFE INSURANCE COVERAGE)

**Please contact your employer's or association's administrative office to clarify coverages available.** Coverage granted shall be subject to all provisions and limitations stated in the Blue Shield Life Group Insurance Policy. Evidence of Insurability must be submitted for amounts exceeding non-medical maximum limits or when enrolling outside of the initial eligibility period.

<b>APPLICANT:</b>	<input type="checkbox"/> BASIC LIFE	<input type="checkbox"/> AD&D	<input type="checkbox"/> SUPPLEMENTAL LIFE (& SUPPLEMENTAL AD&D IF WITHIN GROUP INSURANCE POLICY)
AMOUNT OF COVERAGE REQUESTED: \$ _____			
<b>DEPENDENT(S):</b>	<input type="checkbox"/> BASIC DEPENDENT LIFE	<input type="checkbox"/> SUPPLEMENTAL DEPENDENT LIFE	
NUMBER OF ELIGIBLE DEPENDENTS: _____		AMOUNT OF COVERAGE REQUESTED FOR SPOUSE: \$ _____ CHILD(REN): \$ _____	

I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. I reserve the right to revoke this deduction at any time on written notice.

**Sign Here to Apply** for Coverage \_\_\_\_\_ Date Applicant Signed \_\_\_\_\_

### SECTION 4 – WAIVER OF COVERAGE (COMPLETE ONLY TO WAIVE GROUP LIFE INSURANCE COVERAGE)

**The group program has been offered to me and after seriously considering its benefits, I have decided:**

(Please indicate your choice)  (A) not to enroll myself or dependents  (B) not to enroll my dependents

I understand that if I desire to participate in the program at some future date, my coverage or my dependent's coverage will not be effective until after Evidence of Insurability is submitted and approved. I understand that if a physical examination or other further medical information is required, it will be at my own expense.

**Sign Here to Waive** Coverage \_\_\_\_\_ Date Coverage Waived \_\_\_\_\_