



# 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

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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