Premium Only Plan Enrollment Form

Please complete using ballpoint, non-liquid ink.

Definitions

1. Plan year (must be 12 month period): First day _____ Last day _____

2. An employee of the company regularly performing services at least _____ hours per week shall become a participant on the first day of the month coincidental with or next following the date the employee completes _____ days of consecutive employment.

3. Employees rehired after a period of termination will become eligible for the program on the first day of the month coincidental with or next following the date the employee completes _____ days of consecutive employment, provided such date is not earlier than the first day of the first program year beginning after the employee's termination.

Group Information

A. Plan Sponsor (legal business name) _____

B. Address (no P.O.Box) _____

City, State, ZIP _____ Phone (_____) _____

e-mail _____ Fax (_____) _____

C. Business Type (corporation, partnership, proprietorship) _____

D. State of Incorporation or Domicile _____

E. Type of Plan (check one)
☐ New program effective as of _____
☐ Amendment or reinstatement of existing 125 Program
Original Program effective date: _____
Amendment/restatement date: _____

F. Existing Group Numbers (provide all Blue Cross of California and BC Life & Health Insurance Company Group Numbers if you have more than one) : _____

Agent/Broker Info

Agent's Name _____ Agent's Signature _____

Company/Agency _____

Address (no P.O. Box): _____

City, State, ZIP _____ Phone (_____) _____

Important Notes

Due to timing requirements specified by tax law, we must receive your completed enrollment form at least 15 business days prior to your requested effective date or amendment/restatement date.
• Please be sure to provide all requested information on this form to avoid the possibility of any delays.
• Also, please enclose a separate check for $125 payable to Blue Cross of California … or your first year is FREE if 10+ employees are enrolled in both Medical and Life.

Authorization

Group Administrator Name _____ Title _____

Signature _____ Date _____