Technology Integration Group dba PC Specialists

Enrollment Application
Effective Date: _______________

Blue Shield Group Number: • H56093 -HMO • 970739 – PPO High CA • 970740 – PPO High OOS • 970741 – PPO Low CA
• 970742 – PPO Low OOS • 970743 – PSP CA • 970744 – PSP OOS
Kaiser Purchaser ID: 227918
Guardian Group Number: 373506

PERSONAL INFORMATION

Last Name | First Name | M.I. | Date of Birth | Social Security Number

Address | City | State | Zip Code

Date of Hire | Home Phone | Email Address

☐ Male ☐ Female ☐ Single ☐ Married ☐ Domestic Partnership

Enrollment Reason: ☐ Open Enrollment ☐ Loss of Coverage ☐ New Hire ☐ Change
☐ Rehire Date ___________ ☐ Part-time to Fulltime Employment Date __________ Hours Worked ___________
☐ Event Date ____________

If there is other Health Coverage, please list family member, carrier name/group number and effective date

Name	Relation to you	Carrier Name	Group Number	Effective Date
Name	Relation to you	Carrier Name	Group Number	Effective Date

MANDATORY FOR Blue Shield PPO ENROLLEES: Names of persons with prior coverage:

Name	Coverage begin date	Coverage end Date	Carrier Name	Reason for ending coverage
Name	Coverage begin date	Coverage end Date	Carrier Name	Reason for ending coverage
Name	Coverage begin date	Coverage end Date	Carrier Name	Reason for ending coverage
Name	Coverage begin date	Coverage end Date	Carrier Name	Reason for ending coverage

MEDICAL ELECTIONS

Select One: ☐ **Enroll** ☐ **Decline**

				California Only	
Medical	**Blue Shield Savings Plus 3000 H.S.A.**	**Blue Shield 35/750 High PPO**	**Blue Shield 40/1000 Low PPO**	**Blue Shield Access + HMO**	**Kaiser Permanente Traditional HMO $20 OV EU: 0**
Employee	☐	☐	☐	☐	☐
EE + Spouse/DP	☐	☐	☐	☐	☐
EE + Child(ren)	☐	☐	☐	☐	☐
EE + Family	☐	☐	☐	☐	☐

If declining Medical, provide reason: ☐ **Other group coverage** ☐ **Individual Coverage** ☐ **Military**
☐ **Medicare/Medi-Cal** ☐ **Other** ______________________

DENTAL ELECTION

Select Dental option below:

☐ **Enroll**

☐ **Decline**

	California Only		
Dental	**Guardian HMO**	**Guardian Low PPO**	**Guardian High PPO**
Employee	☐	☐	☐
EE + Spouse/DP	☐	☐	☐
EE + Child(ren)	☐	☐	☐
EE + Family	☐	☐	☐

VISION ELECTIONS

Select Vision option:

☐ **Enroll**

☐ **Decline**

Vision	**Guardian VSP**
Employee	☐
EE+ Spouse/DP	☐
EE + Child(ren)	☐
EE + Family	☐

Employee Name: ________________________________ **SSN:** ________________

DEPENDENT INFORMATION

Relation	Coverage	Last Name, First Name, MI	FT Student? Y or N	SSN	Gender	Birthdate	Med HMO Only: Med Group #	Med HMO Only: Current MD?	Dental Office # (DHMO Only)
Self	☐ Medical ☐ Dental ☐ Vision	Same as above		Same as Above	☐ Female ☐ Male			☐ Yes ☐ No	
☐ Spouse ☐ Dom Partner	☐ Medical ☐ Dental ☐ Vision				☐ Female ☐ Male			☐ Yes ☐ No	
Child	☐ Medical ☐ Dental ☐ Vision				☐ Female ☐ Male			☐ Yes ☐ No	
Child	☐ Medical ☐ Dental ☐ Vision				☐ Female ☐ Male			☐ Yes ☐ No	
Child	☐ Medical ☐ Dental ☐ Vision				☐ Female ☐ Male			☐ Yes ☐ No	

GUARDIAN BASIC LIFE/AD&D COVERAGE

All Eligible Full Time Employees - Basic Life/AD&D Coverage Amount: $15,000

BENEFICIARY DESIGNATION

Name	Date of Birth	Relationship	Address	Percent%

Name	Date of Birth	Relationship	Address	Percent%

GUARDIAN VOLUNTARY LIFE COVERAGE

SEE BENEFITSTRACKER FOR RATES

Employee can elect up to $500,000 in $10,000 increments (Guaranteed Issue is $150,000).
Spouse can elect up to $250,000 in $5,000 increments (Guaranteed Issue is $50,000).
Child can elect up to $10,000 in $1,000 increments (minimum of $2,000) (Guaranteed Issue is $10,000).

☐ **Enroll** ☐ **Decline** **Annual Salary: $_________**

	Dependents Name:	Amount of Life Insurance:	DOB
Employee		$	
Spouse/DP		$	
Child		$	
Child		$	

BENEFICIARY DESIGNATION

Name	Date of Birth	Relationship	Address	Percent%

Name	Date of Birth	Relationship	Address	Percent%

GUARDIAN LONG TERM DISABILITY

YOU ARE AUTOMATICALLY ENROLLED IN THIS COVERAGE

LTD Benefit: 60% of base pay to a max of $5,000 per week

Annual Salary: $_________ **Job Title ______________**

GUARDIAN VOLUNTARY SHORT TERM DISABILITY

THIS IS A VOLUNTARY BENEFIT

STD Benefit: 60% of base salary to a max of $1,250 per month

☐ **Enroll** ☐ **Decline** **Annual Salary: $_________**

GUARDIAN FLEXIBLE SPENDING

IF YOU WISH TO ENROLL IN GUARDIAN FLEXIBLE SPENDING, PLEASE COMPLETE THE GUARDIAN FLEXIBLE SPENDING ENORLLMENT FORM LOCATED ON BENEFTISTRACKER.

Employee Name: SSN:

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation, or any claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Evidence of Coverage.

Signature Required for Kaiser Permanente Plan		Date

Blue Shield Health Plan Agreement

Disclosure of Personal and Health Information

Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, "Blue Shield") understand 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.

Please read carefully, signature required

I agree: 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 further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California / Blue Shield Life.

Signature Required for Blue Shield Plan		Date

Guardian Agreement

Dental Disclaimer

If you waive dental coverage and later decide to enroll, you may be subject to a late entrant penalty and your dental benefits may be limited for a period of time. Guardian may waive late-entrant penalties if you lose dental coverage due to termination of the plan, loss of employment, death of spouse, divorce or where a court has ordered coverage be provided for an eligible spouse or eligible children, provided you apply within 30 days.

DHMO Disclaimer

Late entrant penalties or proof of insurability do not apply to Pre-Paid dental coverage. The Pre-Paid dental plan refers to, as applicable, Managed DentalGuard dental HMO plans underwritten by Managed Dental Care. Eligibility for this coverage is only available at the open enrollment period.

- Life/DI Disclaimer

If you waive life or disability coverage and later decide to enroll, you will have to provide, at your own expense, proof of each person's insurability. Guardian has the right to reject your request.

- Truth & Knowledge Disclaimer

I attest that the information provided above is true and correct to the best of my knowledge.

- CA Fraud Statement

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Signature Required for Guardian Plan(s)		Date

EMPLOYEE AUTHORIZATION

I authorize my employer to deduct from my salary the premium amounts listed above for the benefits I have elected for the 2013-2014 plan year. I understand that the premiums for accounts eligible under Section 125 will be deducted on a pre-tax basis as established under Section 125 of the IRS Code. I understand that these elections cannot be changed during the plan year unless I experience a qualified life event as outlined in employer benefit plan documents. I further understand that qualified life events that may change my benefit elections must be reported to the Benefits Administrator within 30 days of the event.

I agree to have my gross salary reduced by the amount of the cost of benefits selected. By reducing my gross salary, I understand that Social Security, Life and Disability benefits will also reflect this change.

Employee Signature		Date

VOLUNTARY LIFE - WHAT DO YOU NEED TO DO?

- If you wish to enroll for the first time, or if you want to make a change to your current election to your Voluntary Life, please complete the Universal Enrollment Form.
    - Voluntary Life – Guaranteed Issue Amounts:
        - Employee: $150,000 + an additional $100,000 with a qualified NO answer to the additional amount health question attached.
            - *If you answer YES to the additional amount health question on the enrollment application, or if you elect an amount greater than $250,000 please complete and return the Guardian EOI (Evidence of Insurability) along with your enrollment application. Guardian will review the EOI and make a determination to approve or decline the additional amount. Approvals are effective first of the month following the approval at which time payroll deductions will be adjusted for the additional amount approved.*
        - Spouse: $50,000
        - Child(ren): $10,000
- If you are currently enrolled in voluntary life and if you want to waive your current election, please complete and mark the appropriate "decline" section of the Universal Enrollment Form.
- If you would like to update your Voluntary Life Beneficiary Designation, please complete the Universal Enrollment Form.
- ALL FORMS can be located in the Optional Term Life tab on BenefitsTracker®.

SUPPLEMENT TO APPLICATION TO
The Guardian Life Insurance Company of America

Employee's Name: ______________________ Group Name: ________________ Group #:___________

Please answer ALL questions in ink. Sign, date and witness form. Return within 3 days of request or full Evidence of Insurability will be required.

On your application you did not answer the questions listed below, please answer.

In the last 6 months, received medical treatment, consultation, care or services, including diagnostics measures or tool prescribed drugs for: cardiovascular disease; cancer; any condition related to AIDS or AIDS Related Complex; or any other life threatening condition?

Employee Yes No Spouse Yes No Child(ren) Yes No

For each "Yes" answer, please provide details including name and address of attending physician, condition, duration of symptoms, treatment and dates. If additional space is needed, attach a separate sheet of paper.

I represent that the answers as amplified and extended above are true and complete to the best of my knowledge and belief and are a part of my above described application to The Guardian Life Insurance Company of America.

Signed at______________________________ X______________________________________

City & State Signature of proposed insured

Date__________________________________ X______________________________________

Signature of applicant, if other than proposed insured