HealthNow Administrative Services

RCCD RIVERSIDE COMMUNITY COLLEGE DISTRICT
MORENO VALLEY COLLEGE | NORCO COLLEGE | RIVERSIDE CITY COLLEGE

Blue Shield Network
ENROLLMENT FORM

Effective/
Change Date:

☐ New Enrollment
☐ Rehire or Reinstatement
☐ Add/Drop Dependents
☐ Drop Coverage
☐ Name Change
☐ Open Enrollment
☐ Beneficiary Change
☐ Address Change

EMPLOYEE INFORMATION

Employer Name:	Location:	Group Number:	Class

Name (Last, First, Middle):	Date of Birth: Mo / Day / Year	Social Security Number:	Gender: ☐ Male ☐ Female

Address: Street City State Zip

Occupation:	☐ Hourly ☐ Salaried	Earnings $ ☐ Hr ☐ Wk ☐ Mo ☐ Yr	Full-time employment date:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Name of Spouse:	Spouse Date of Birth:	Date of Marriage:	Number of eligible children:

COVERAGE INFORMATION

Coverage Elections (**Must be completed**)

	Medical Yes	Medical No
Employee	☐	☐
Spouse*	☐	☐
Child(ren)*	☐	☐
Family*	☐	☐

*If Yes, Please complete dependent section below

Preferred Provider Organization **HealthNow Administrators with Blue Shield**	Medical Plan Option **RCCD Medical PPO Plan**

List all dependents to be covered including spouse, if applicable:

Full Name	Relationship	Gender	Date of Birth:	Social Security Number:
		☐ Male ☐ Female	___/___/___	___-___-___
		☐ Male ☐ Female	___/___/___	___-___-___
		☐ Male ☐ Female	___/___/___	___-___-___
		☐ Male ☐ Female	___/___/___	___-___-___
		☐ Male ☐ Female	___/___/___	___-___-___

I hereby apply for coverage to which I am entitled or to which I may become entitled under the terms of the employee benefit plan issued to my employer and/or sponsored by my employer. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this coverage.

_____ Employee Signature

_____ Date

WAIVER OF GROUP COVERAGE

☐ I do not want Medical coverage: ☐ For myself ☐ For my dependents

I hereby certify that I have been offered the opportunity to become covered under the plan(s) sponsored by my employer and I have decided not to take advantage of this offer for the coverage listed above. I understand that enrollment into the plan(s) at a later date will be subject to the special enrollment/open enrollment provisions of the plan(s) for health coverages and evidence of insurability for all other coverage(s). I desire to enroll for benefits and hereby authorize my employer to use electronic means for purposes of my enrollment in the benefits plans that I have elected.

_____ Employee Signature

_____ Date