



# Tribe Application for Health Coverage

All medical products offered by Blue Cross of California (Blue Cross).  
Blue Cross PPO Dental offered by BC Life & Health Insurance Company (BC Life).



## 1. TRIBE INFORMATION – Please print

Federally Recognized Tribal Name (as published in the Federal Register)

Street Address

City	State	ZIP Code
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Mailing Address (if different)

City	State	ZIP Code
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Tribe Contact Person	Title	Phone No. ( )	Fax No. ( )
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## 2. HEALTH COVERAGE INFORMATION

### A. MEDICAL COVERAGE SELECTION

Check the PPO Medical Plan selected for your eligible tribe members:

- \$30 Copay Plan
- \$40 Copay Plan

### B. DENTAL COVERAGE SELECTION (Optional - may be selected on its own or with medical coverage)

Check only one Plan:

- Standard Option PPO
- Basic Option PPO

### C. TRIBE PREMIUM CONTRIBUTION:

Governing body of tribe must contribute 100% of the eligible tribal members' and dependents' medical premiums and dental premiums (if dental option is selected).

### D. TRIBAL PARTICIPATION:

100% of eligible tribal members must subscribe to the medical plan. Dental coverage is optional. If optional dental is selected, 100% of eligible tribal members must subscribe. Tribal members declining coverage for other group coverage may be excluded from participation requirements. Eligible tribal members and eligible dependents declining coverage must complete Sections 1 and 3 of the Tribal Member Application and sign the application. Proof of other coverage may be required.

### E. DEPENDENT COVERAGE SELECTION:

Dependents who are members of this tribe are included in the participation requirements.

In addition, will the tribe offer enrollment in this plan to dependents who are not members of this tribe?

- Yes – Dependents who are not tribal members will be considered eligible for enrollment in this plan.
- No – 100% of dependents who are not tribal members are not eligible for enrollment in this plan.

### F. REQUESTED EFFECTIVE DATE:

Requested Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Actual effective date will be assigned to either the first or fifteenth of a month if application is accepted.

## 3. TRIBAL MEMBER ELIGIBILITY

**Please include a copy of the tribal registry or other documentation showing the complete census of all tribal members.**

A. Total number of enrolled tribal members residing in California: .....

B. Total number of enrolled tribal members residing outside of California: .....  
(Tribal members residing outside of California are ineligible for coverage.)

C. Total number of enrolled tribal members residing in California and DECLINING coverage due to having other group medical coverage: .....

D. Total number of enrolled tribal members APPLYING for Blue Cross/BC Life coverage: .....

E. If "Yes" has been checked in Section 2E above, "Dependent Coverage Selection," please indicate the total number of eligible dependents who are **not** tribal members APPLYING for coverage: .....

- F. How will future eligible tribal members provide proof of tribal enrollment?
- Copy of I.D. card indicating tribal enrollment.
  - Letter from the governing body of the tribe stating they are enrolled in the tribe.

**4. AUTHORIZATION**

I, the undersigned Authorized Tribal Representative, represent to Blue Cross/BC Life that I am authorized to make and execute this application on behalf of the Tribe and to bind the Tribe as hereinafter set forth. The above information is furnished to Blue Cross/BC Life to allow Blue Cross/BC Life to evaluate this application and with the intention that Blue Cross/BC Life rely thereupon. To the best of the Tribe's knowledge and belief, all information on this application is true and complete. The Tribe understands and agrees that this application is subject to review by Blue Cross/BC Life in accordance with its permissible underwriting standards. The Tribe understands and agrees that no coverage will be effective before the date determined by Blue Cross/BC Life and only if the Tribe has paid its first month's contribution and this application is accepted, that the Tribe should keep prior coverage in force until notified of acceptance in writing by Blue Cross/BC Life, and that no agent or broker has the right to accept this application or bind coverage. If the application is not complete, Blue Cross/BC Life reserves the right to reject it and notify the Tribe in writing. If this application is accepted, Blue Cross/BC Life will issue to the Tribe a Group Benefit Agreement or similar agreement identified by a different name. This application will be a part of such agreement and such agreement, including this application, shall be a legally enforceable obligation of the Tribe.

Coverage may be rescinded if there are misstatements in this application. The Tribe has provided the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, with an explicit written notice specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage until the group's next anniversary date, as well as a six-month preexisting condition exclusion, and the Tribe has received signed acknowledgement.

**ARBITRATION AGREEMENT:** The Tribe understands that any and all disputes between the Tribe and Blue Cross/BC Life, including claims for medical malpractice, must be resolved by binding arbitration if the amount in dispute exceeds the jurisdictional limit of 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, Blue Cross/BC Life, the Tribe and covered persons are giving up the right to pursue on a class basis any claim or controversy against each other.

Name of Authorized Tribal Representative ( <i>please print</i> )	Title
Signature of Authorized Tribal Representative	Date ( <i>Month/Day/Year</i> )

**5. AGENT'S CERTIFICATION**

**I hereby certify that I am not aware of any information not disclosed in this application by the client which may have bearing on this risk.**

I hereby certify that I have advised the client not to terminate any existing coverage until receiving written notification from Blue Cross/BC Life that the coverage being applied for by this application has been accepted.

Name of Writing Agent ( <i>Print or type</i> )	%	Agent I.D. No.
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Agent Address	City/State/ZIP Code
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Phone No. ( )	Fax No. ( )	Writing Agent's Signature <b>X</b>	Date
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Name of Second Writing Agent ( <i>Print or type</i> )	%	Agent I.D. No.
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Phone No. ( )	Second Agent's Signature <b>X</b>	Date
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<b>For General Agent Use Only</b>	Name of General Agent	Agent I.D. No.
	Street Address	City/State/ZIP Code

<b>Send Administration Kit to:</b> <input type="checkbox"/> Agent <input type="checkbox"/> Group
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**FOR BLUE CROSS/BC LIFE USE ONLY**

Date Approved	Effective Date	Date Rejected	Product Code	Group Numbers
Group Type <b>71</b>	Underwriter			