Application for Blue Shield Individual and Family Health Plans

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

blue of california

This application is for applying for coverage directly with Blue Shield for a Blue Shield IFP plan. To enroll or modify coverage obtained through Covered California, contact Covered California directly.

APPLICATION MUST BE COMPLETED IN BLUE OR BLACK INK PRINTING IN BLOCK CAPITAL LETTERS. Please make sure you answer all questions as completely and accurately as possible **and include first month's premium** to avoid a return of the application. Submit ALL pages, 1 through 10, as your complete application including any other supporting documentation to Blue Shield Attn: I&M – Applications, PO Box 3008, Lodi, CA 95241-9969 or fax: (888) 386-3420. Call Blue Shield at **(800) 431-2809**, or contact your agent for help filling out the application. **Boxes should be marked as follows:** ☒

(PRODUCER USE ONLY)
MARKET CODE

Reason for application: ☐ New enrollment ☐ Plan transfer ☐ Special Enrollment/Qualifying Event – By checking this box, you are certifying that to the best of your knowledge, you are eligible for Special Enrollment.

Date qualifying event triggering Special Enrollment occurred: _____/_____/_____

Please explain qualifying event type for Special Enrollment: _____

_____

Note: You must apply within 60 days from the triggering event to elect coverage.

If adding a dependent to existing coverage, please provide existing subscriber's Blue Shield subscriber number: _____

Part 1 – Primary applicant information

You are eligible to apply for a Blue Shield individual and family health plan if you are: a California resident

Applicant's Social Security number (Required. Blue Shield is mandated to collect this information for compliance with the individual responsibility requirement.)			
First name			MI
Last name			
☐ Male ☐ Female	Married: ☐ Yes ☐ No	Domestic partner: ☐ Yes ☐ No	Date of birth (month/day/year)
Applicant's business phone		Applicant's home phone	
Applicant's fax No.		Applicant's cell phone	
Applicant's email address:			
If a current Blue Shield member, provide subscriber number:			
Home address (**NO** P.O. Box)			Apt. No.
City	State	ZIP code	
Billing address (if different from above)			Apt. No.
City	State	ZIP code	
Mailing address (if different from home address)			Apt. No.
City	State	ZIP code	
Applicant's employer's ZIP code		Spouse/domestic partner's employer's ZIP code	
List other name(s) used in past			

Health plan option (check one box only):

☐ Ultimate PPO ☐ Preferred PPO ☐ Enhanced PPO ☐ Basic PPO ☐ Get covered PPO	☐ Ultimate EPO ☐ Preferred EPO ☐ Enhanced EPO ☐ Basic EPO ☐ Get Covered EPO	☐ Basic PPO for HSA ☐ Basic EPO for HSA	☐ BSL Ultimate PPO* ☐ BSL Preferred PPO* ☐ BSL Enhanced PPO* ☐ BSL Basic PPO*	☐ BSL Ultimate EPO* ☐ BSL Preferred EPO* ☐ BSL Enhanced EPO* ☐ BSL Basic EPO*

Pursuant to state and federal law, you must have pediatric dental coverage for yourself and all dependents (even if you are enrolling in coverage as an adult). Therefore, you must choose one of the pediatric dental plans listed below:

☐ Enhanced Dental HMO Pediatric $20 ☐ Preferred Dental HMO Pediatric $0 ☐ Enhanced Dental PPO Pediatric 60/0 ☐ Preferred Dental PPO Pediatric 50/0

Note: Summary of Benefits and Coverage (SBC) forms are available for all medical plans. These forms summarize coverage and benefits for plans in a uniform manner. Log on to **blueshieldca.com/sbc** to download SBC forms for any plan(s) you have applied for.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Primary applicant's initials _____

Part 1 – Primary applicant information (continued):

Requested effective date (see Part 5(b), Item 4 for information)
You must apply for coverage by the 15th of the month in order for coverage to be effective the first of the following month. If you apply between the 16th and last day of the month, coverage will be effective the first day of the second following month.

(a) Does the primary applicant currently reside in California? ☐ Yes ☐ No If no, where does the primary applicant reside? _____

Indicate language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other: _____

Preferred method of contact (check one): ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email ☐ Standard mail | Best time to contact: _____ ☐ AM ☐ PM

Check here if you have previously had coverage with Blue Shield. ☐
If prior coverage, indicate prior Blue Shield subscriber No., if known: _____

Part 2 – Primary applicant supplemental plan choices

You may also purchase a dental plan, or dental + vision package, and/or life insurance to supplement your medical coverage. Dental, dental + vision plans, and/or life insurance are also available without medical.

Dental and vision plan options (select only one dental plan and/or one vision plan OR Specialty Duo):
☐ Preferred Dental HMO Voluntary $0 ☐ Enhanced Dental HMO $0 ☐ Enhanced Dental PPO Voluntary 50/1000 ☐ Enhanced Dental PPO Plus 50/1250
☐ Enhanced Dental PPO 50/1250 ☐ Enhanced Dental PPO Plus 50/500 ☐ Enhanced Dental PPO 50/500 ☐ Specialty Duo (dental + vision) package*
☐ Ultimate Vision 15/25/150

Dental HMO only – visit **blueshieldca.com** to find a dental provider or for questions call **(800) 431-2809** | Dental Provider No.

Dental provider name:

Life insurance* option: Life insurance is available to applicants over the age of 1 year. Coverage is offered in the following amounts: $10,000 (ages 1-64); $30,000 (ages 1-64); $60,000 (ages 19-64); $90,000 (ages 19-64); $100,000 (ages 19-64).
In order to purchase life coverage, a separate life insurance application must be completed. For life insurance rates and to apply for coverage, please visit our website at **blueshieldca.com/term-life**.

Part 3(a) – Spouse/domestic partner dependent applicant information

☐ Spouse ☐ Domestic partner | Sex: ☐ Male ☐ Female | Date of birth (month/day/year)

Applicant's Social Security number (Required. Blue Shield is mandated to collect this information for compliance with the individual responsibility requirement)

First name | MI

Last name

Is the spouse/domestic partner applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state) _____

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one):
☐ Ultimate PPO ☐ Preferred PPO ☐ Enhanced PPO ☐ Basic PPO ☐ Get Covered PPO ☐ Ultimate EPO ☐ Preferred EPO ☐ Enhanced EPO
☐ Basic EPO ☐ Get Covered EPO ☐ BSL Ultimate PPO* ☐ BSL Preferred PPO* ☐ BSL Enhanced PPO* ☐ BSL Basic PPO* ☐ BSL Ultimate EPO*
☐ BSL Preferred EPO* ☐ BSL Enhanced EPO* ☐ BSL Basic EPO* ☐ Basic PPO for HSA ☐ Basic EPO for HSA

Pursuant to state and federal law, you must have pediatric dental coverage (even if you are enrolling in coverage as an adult). Therefore, you must choose one of the pediatric dental plans listed below:
☐ Enhanced Dental HMO Pediatric $20 ☐ Preferred Dental HMO Pediatric $0 ☐ Enhanced Dental PPO Pediatric 60/0 ☐ Preferred Dental PPO Pediatric 50/0

Dental and vision plan options (select only one dental plan and/or one vision plan OR Specialty Duo):
☐ Preferred Dental HMO Voluntary $0 ☐ Enhanced Dental HMO $0 ☐ Enhanced Dental PPO Voluntary 50/1000 ☐ Enhanced Dental PPO Plus 50/1250
☐ Enhanced Dental PPO 50/1250 ☐ Enhanced Dental PPO Plus 50/500 ☐ Enhanced Dental PPO 50/500 ☐ Specialty Duo (dental + vision) package*
☐ Ultimate Vision 15/25/150

Dental HMO only – visit **blueshieldca.com** to find a dental provider, or for questions call **(800) 431-2809** | Dental Provider No.

Dental provider name:

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Part 3(b) – Child dependent applicant information – Dependent children must be under age 26. If more than eight child dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date. Check here if a supplemental page is attached. ☐

☐ Male
☐ Female

Relationship: _____(e.g. son/daughter)

Date of birth (month/day/year)

Applicant's Social Security number (Required. Blue Shield is mandated to collect this information for compliance with the individual responsibility requirement)

First name

MI

Last name

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state) _____

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one):
☐ Ultimate PPO ☐ Preferred PPO ☐ Enhanced PPO ☐ Basic PPO ☐ Get Covered PPO ☐ Ultimate EPO ☐ Preferred EPO ☐ Enhanced EPO
☐ Basic EPO ☐ Get Covered EPO ☐ BSL Ultimate PPO* ☐ BSL Preferred PPO* ☐ BSL Enhanced PPO* ☐ BSL Basic PPO* ☐ BSL Ultimate EPO*
☐ BSL Preferred EPO* ☐ BSL Enhanced EPO* ☐ BSL Basic EPO* ☐ Basic PPO for HSA ☐ Basic EPO for HSA

Pursuant to state and federal law, you must have pediatric dental coverage. Therefore, you must choose one of the pediatric dental plans listed below:
☐ Enhanced Dental HMO Pediatric $20 ☐ Preferred Dental HMO Pediatric $0 ☐ Enhanced Dental PPO Pediatric 60/0 ☐ Preferred Dental PPO Pediatric 50/0

Dental and vision plan options (select only one dental plan and/or one vision plan OR Specialty Duo):
☐ Preferred Dental HMO Voluntary $0 ☐ Enhanced Dental HMO $0 ☐ Enhanced Dental PPO Voluntary 50/1000 ☐ Enhanced Dental PPO Plus 50/1250
☐ Enhanced Dental PPO 50/1250 ☐ Enhanced Dental PPO Plus 50/500 ☐ Enhanced Dental PPO 50/500 ☐ Specialty Duo (dental + vision) package*
☐ Ultimate Vision 15/25/150

Dental HMO only – visit **blueshieldca.com** to find a dental provider, or for questions call **(800) 431-2809**

Dental Provider No.

Dental provider name:

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Part 3(c) – Child dependent applicant information – Dependent children must be under age 26. If more than eight child dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date. Check here if a supplemental page is attached. ☐

☐ Male
☐ Female

Relationship: _____(e.g. son/daughter)

Date of birth (month/day/year)

Applicant's Social Security number (Required. Blue Shield is mandated to collect this information for compliance with the individual responsibility requirement)

First name

MI

Last name

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state) _____

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one):
☐ Ultimate PPO ☐ Preferred PPO ☐ Enhanced PPO ☐ Basic PPO ☐ Get Covered PPO ☐ Ultimate EPO ☐ Preferred EPO ☐ Enhanced EPO
☐ Basic EPO ☐ Get Covered EPO ☐ BSL Ultimate PPO* ☐ BSL Preferred PPO* ☐ BSL Enhanced PPO* ☐ BSL Basic PPO* ☐ BSL Ultimate EPO*
☐ BSL Preferred EPO* ☐ BSL Enhanced EPO* ☐ BSL Basic EPO* ☐ Basic PPO for HSA ☐ Basic EPO for HSA

Pursuant to state and federal law, you must have pediatric dental coverage. Therefore, you must choose one of the pediatric dental plans listed below:
☐ Enhanced Dental HMO Pediatric $20 ☐ Preferred Dental HMO Pediatric $0 ☐ Enhanced Dental PPO Pediatric 60/0 ☐ Preferred Dental PPO Pediatric 50/0

Dental and vision plan options (select only one dental plan and/or one vision plan OR Specialty Duo):
☐ Preferred Dental HMO Voluntary $0 ☐ Enhanced Dental HMO $0 ☐ Enhanced Dental PPO Voluntary 50/1000 ☐ Enhanced Dental PPO Plus 50/1250
☐ Enhanced Dental PPO 50/1250 ☐ Enhanced Dental PPO Plus 50/500 ☐ Enhanced Dental PPO 50/500 ☐ Specialty Duo (dental + vision) package*
☐ Ultimate Vision 15/25/150

Dental HMO only – visit **blueshieldca.com** to find a dental provider, or for questions call **(800) 431-2809**

Dental Provider No.

Dental provider name:

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

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Primary applicant's initials _____

Part 3(d) – Child dependent applicant information – Dependent children must be under age 26. If more than eight child dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date. Check here if a supplemental page is attached. ☐

☐ Male
☐ Female

Relationship: _____(e.g. son/daughter)

Date of birth (month/day/year)

Applicant's Social Security number (Required. Blue Shield is mandated to collect this information for compliance with the individual responsibility requirement)

First name | MI

Last name

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state) _____

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one):
☐ Ultimate PPO ☐ Preferred PPO ☐ Enhanced PPO ☐ Basic PPO ☐ Get Covered PPO ☐ Ultimate EPO ☐ Preferred EPO ☐ Enhanced EPO
☐ Basic EPO ☐ Get Covered EPO ☐ BSL Ultimate PPO* ☐ BSL Preferred PPO* ☐ BSL Enhanced PPO* ☐ BSL Basic PPO* ☐ BSL Ultimate EPO*
☐ BSL Preferred EPO* ☐ BSL Enhanced EPO* ☐ BSL Basic EPO* ☐ Basic PPO for HSA ☐ Basic EPO for HSA

Pursuant to state and federal law, you must have pediatric dental coverage. Therefore, you must choose one of the pediatric dental plans listed below:
☐ Enhanced Dental HMO Pediatric $20 ☐ Preferred Dental HMO Pediatric $0 ☐ Enhanced Dental PPO Pediatric 60/0 ☐ Preferred Dental PPO Pediatric 50/0

Dental and vision plan options (select only one dental plan and/or one vision plan OR Specialty Duo):
☐ Preferred Dental HMO Voluntary $0 ☐ Enhanced Dental HMO $0 ☐ Enhanced Dental PPO Voluntary 50/1000 ☐ Enhanced Dental PPO Plus 50/1250
☐ Enhanced Dental PPO 50/1250 ☐ Enhanced Dental PPO Plus 50/500 ☐ Enhanced Dental PPO 50/500 ☐ Specialty Duo (dental + vision) package*
☐ Ultimate Vision 15/25/150

Dental HMO only – visit **blueshieldca.com** to find a dental provider, or for questions call **(800) 431-2809**

Dental Provider No.

Dental provider name:

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Part 3(e) – Child dependent applicant information – Dependent children must be under age 26. If more than eight child dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date. Check here if a supplemental page is attached. ☐

☐ Male
☐ Female

Relationship: _____(e.g. son/daughter)

Date of birth (month/day/year)

Applicant's Social Security number (Required. Blue Shield is mandated to collect this information for compliance with the individual responsibility requirement)

First name | MI

Last name

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state) _____

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one):
☐ Ultimate PPO ☐ Preferred PPO ☐ Enhanced PPO ☐ Basic PPO ☐ Get Covered PPO ☐ Ultimate EPO ☐ Preferred EPO ☐ Enhanced EPO
☐ Basic EPO ☐ Get Covered EPO ☐ BSL Ultimate PPO* ☐ BSL Preferred PPO* ☐ BSL Enhanced PPO* ☐ BSL Basic PPO* ☐ BSL Ultimate EPO*
☐ BSL Preferred EPO* ☐ BSL Enhanced EPO* ☐ BSL Basic EPO* ☐ Basic PPO for HSA ☐ Basic EPO for HSA

Pursuant to state and federal law, you must have pediatric dental coverage. Therefore, you must choose one of the pediatric dental plans listed below:
☐ Enhanced Dental HMO Pediatric $20 ☐ Preferred Dental HMO Pediatric $0 ☐ Enhanced Dental PPO Pediatric 60/0 ☐ Preferred Dental PPO Pediatric 50/0

Dental and vision plan options (select only one dental plan and/or one vision plan OR Specialty Duo):
☐ Preferred Dental HMO Voluntary $0 ☐ Enhanced Dental HMO $0 ☐ Enhanced Dental PPO Voluntary 50/1000 ☐ Enhanced Dental PPO Plus 50/1250
☐ Enhanced Dental PPO 50/1250 ☐ Enhanced Dental PPO Plus 50/500 ☐ Enhanced Dental PPO 50/500 ☐ Specialty Duo (dental + vision) package*
☐ Ultimate Vision 15/25/150

Dental HMO only – visit **blueshieldca.com** to find a dental provider, or for questions call **(800) 431-2809**

Dental Provider No.

Dental provider name:

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

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Primary applicant's initials _____

Part 3(f) – Child dependent applicant information – Dependent children must be under age 26. If more than eight child dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date. Check here if a supplemental page is attached. ☐

☐ Male
☐ Female

Relationship: _____(e.g. son/daughter)

Date of birth (month/day/year)

Applicant's Social Security number (Required. Blue Shield is mandated to collect this information for compliance with the individual responsibility requirement)

First name | MI

Last name

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state) _____

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one):
☐ Ultimate PPO ☐ Preferred PPO ☐ Enhanced PPO ☐ Basic PPO ☐ Get Covered PPO ☐ Ultimate EPO ☐ Preferred EPO ☐ Enhanced EPO
☐ Basic EPO ☐ Get Covered EPO ☐ BSL Ultimate PPO* ☐ BSL Preferred PPO* ☐ BSL Enhanced PPO* ☐ BSL Basic PPO* ☐ BSL Ultimate EPO*
☐ BSL Preferred EPO* ☐ BSL Enhanced EPO* ☐ BSL Basic EPO* ☐ Basic PPO for HSA ☐ Basic EPO for HSA

Pursuant to state and federal law, you must have pediatric dental coverage. Therefore, you must choose one of the pediatric dental plans listed below:
☐ Enhanced Dental HMO Pediatric $20 ☐ Preferred Dental HMO Pediatric $0 ☐ Enhanced Dental PPO Pediatric 60/0 ☐ Preferred Dental PPO Pediatric 50/0

Dental and vision plan options (select only one dental plan and/or one vision plan OR Specialty Duo):
☐ Preferred Dental HMO Voluntary $0 ☐ Enhanced Dental HMO $0 ☐ Enhanced Dental PPO Voluntary 50/1000 ☐ Enhanced Dental PPO Plus 50/1250
☐ Enhanced Dental PPO 50/1250 ☐ Enhanced Dental PPO Plus 50/500 ☐ Enhanced Dental PPO 50/500 ☐ Specialty Duo (dental + vision) package*
☐ Ultimate Vision 15/25/150

Dental HMO only – visit **blueshieldca.com** to find a dental provider, or for questions call **(800) 431-2809**

Dental Provider No.

Dental provider name:

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Part 3(g) – Child dependent applicant information – Dependent children must be under age 26. If more than eight child dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date. Check here if a supplemental page is attached. ☐

☐ Male
☐ Female

Relationship: _____(e.g. son/daughter)

Date of birth (month/day/year)

Applicant's Social Security number (Required. Blue Shield is mandated to collect this information for compliance with the individual responsibility requirement)

First name | MI

Last name

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state) _____

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one):
☐ Ultimate PPO ☐ Preferred PPO ☐ Enhanced PPO ☐ Basic PPO ☐ Get Covered PPO ☐ Ultimate EPO ☐ Preferred EPO ☐ Enhanced EPO
☐ Basic EPO ☐ Get Covered EPO ☐ BSL Ultimate PPO* ☐ BSL Preferred PPO* ☐ BSL Enhanced PPO* ☐ BSL Basic PPO* ☐ BSL Ultimate EPO*
☐ BSL Preferred EPO* ☐ BSL Enhanced EPO* ☐ BSL Basic EPO* ☐ Basic PPO for HSA ☐ Basic EPO for HSA

Pursuant to state and federal law, you must have pediatric dental coverage. Therefore, you must choose one of the pediatric dental plans listed below:
☐ Enhanced Dental HMO Pediatric $20 ☐ Preferred Dental HMO Pediatric $0 ☐ Enhanced Dental PPO Pediatric 60/0 ☐ Preferred Dental PPO Pediatric 50/0

Dental and vision plan options (select only one dental plan and/or one vision plan OR Specialty Duo):
☐ Preferred Dental HMO Voluntary $0 ☐ Enhanced Dental HMO $0 ☐ Enhanced Dental PPO Voluntary 50/1000 ☐ Enhanced Dental PPO Plus 50/1250
☐ Enhanced Dental PPO 50/1250 ☐ Enhanced Dental PPO Plus 50/500 ☐ Enhanced Dental PPO 50/500 ☐ Specialty Duo (dental + vision) package*
☐ Ultimate Vision 15/25/150

Dental HMO only – visit **blueshieldca.com** to find a dental provider, or for questions call **(800) 431-2809**

Dental Provider No.

Dental provider name:

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Part 3(h) – Child dependent applicant information – Dependent children must be under age 26. If more than eight child dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date. Check here if a supplemental page is attached. ☐

☐ Male ☐ Female	Relationship: _____(e.g. son/daughter)	Date of birth (month/day/year)
Applicant's Social Security number (Required. Blue Shield is mandated to collect this information for compliance with the individual responsibility requirement)		
First name		MI
Last name		

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state) _____

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one):
☐ Ultimate PPO ☐ Preferred PPO ☐ Enhanced PPO ☐ Basic PPO ☐ Get Covered PPO ☐ Ultimate EPO ☐ Preferred EPO ☐ Enhanced EPO
☐ Basic EPO ☐ Get Covered EPO ☐ BSL Ultimate PPO* ☐ BSL Preferred PPO* ☐ BSL Enhanced PPO* ☐ BSL Basic PPO* ☐ BSL Ultimate EPO*
☐ BSL Preferred EPO* ☐ BSL Enhanced EPO* ☐ BSL Basic EPO* ☐ Basic PPO for HSA ☐ Basic EPO for HSA

Pursuant to state and federal law, you must have pediatric dental coverage. Therefore, you must choose one of the pediatric dental plans listed below:
☐ Enhanced Dental HMO Pediatric $20 ☐ Preferred Dental HMO Pediatric $0 ☐ Enhanced Dental PPO Pediatric 60/0 ☐ Preferred Dental PPO Pediatric 50/0

Dental and vision plan options (select only one dental plan and/or one vision plan OR Specialty Duo):
☐ Preferred Dental HMO Voluntary $0 ☐ Enhanced Dental HMO $0 ☐ Enhanced Dental PPO Voluntary 50/1000 ☐ Enhanced Dental PPO Plus 50/1250
☐ Enhanced Dental PPO 50/1250 ☐ Enhanced Dental PPO Plus 50/500 ☐ Enhanced Dental PPO 50/500 ☐ Specialty Duo (dental + vision) package*
☐ Ultimate Vision 15/25/150

Dental HMO only – visit **blueshieldca.com** to find a dental provider, or for questions call **(800) 431-2809** Dental provider name:	Dental Provider No.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Part 3(i) – Child dependent applicant information – Dependent children must be under age 26. If more than eight child dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date. Check here if a supplemental page is attached. ☐

☐ Male ☐ Female	Relationship: _____(e.g. son/daughter)	Date of birth (month/day/year)
Applicant's Social Security number (Required. Blue Shield is mandated to collect this information for compliance with the individual responsibility requirement)		
First name		MI
Last name		

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state) _____

Is this dependent applying for the same plan as the primary applicant? ☐ Yes ☐ No If no, which plan? (check one):
☐ Ultimate PPO ☐ Preferred PPO ☐ Enhanced PPO ☐ Basic PPO ☐ Get Covered PPO ☐ Ultimate EPO ☐ Preferred EPO ☐ Enhanced EPO
☐ Basic EPO ☐ Get Covered EPO ☐ BSL Ultimate PPO* ☐ BSL Preferred PPO* ☐ BSL Enhanced PPO* ☐ BSL Basic PPO* ☐ BSL Ultimate EPO*
☐ BSL Preferred EPO* ☐ BSL Enhanced EPO* ☐ BSL Basic EPO* ☐ Basic PPO for HSA ☐ Basic EPO for HSA

Pursuant to state and federal law, you must have pediatric dental coverage. Therefore, you must choose one of the pediatric dental plans listed below:
☐ Enhanced Dental HMO Pediatric $20 ☐ Preferred Dental HMO Pediatric $0 ☐ Enhanced Dental PPO Pediatric 60/0 ☐ Preferred Dental PPO Pediatric 50/0

Dental and vision plan options (select only one dental plan and/or one vision plan OR Specialty Duo):
☐ Preferred Dental HMO Voluntary $0 ☐ Enhanced Dental HMO $0 ☐ Enhanced Dental PPO Voluntary 50/1000 ☐ Enhanced Dental PPO Plus 50/1250
☐ Enhanced Dental PPO 50/1250 ☐ Enhanced Dental PPO Plus 50/500 ☐ Enhanced Dental PPO 50/500 ☐ Specialty Duo (dental + vision) package*
☐ Ultimate Vision 15/25/150

Dental HMO only – visit **blueshieldca.com** to find a dental provider, or for questions call **(800) 431-2809** Dental provider name:	Dental Provider No.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

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Primary applicant's initials _____

Part 4 – Authorization for release of information

By signing this form, you are authorizing the release of your and/or your dependents' healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent to Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, Blue Shield) for the purpose of processing claims and for administering benefits under the health service agreement/policy.

Further, by signing below you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or evaluating any claim for benefits. The healthcare information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under the federal health information privacy laws.

You have the right to refuse to sign this authorization.

You are entitled to a copy of this authorization after you sign it.

Expiration: This authorization will remain valid: 1) for thirty (30) months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health service agreement/policy.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

Applicant/parent or legal guardian	Today's date
Applicant's spouse/domestic partner	Today's date
Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date

Continue to Part 5 – your signature and today's date are required in that section.

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Part 5(a) - Applicant verification of accuracy

Please read the following carefully. Each applying family member age 18 and older is required to review the completed application and provide their own signature. Keep a copy of this application for your records.

I alone am responsible for the accuracy and completeness of the information provided on this application. I have personally reviewed all information provided on this application, even if I did not fill out the application myself. To the best of my knowledge and belief, all information on this application is accurate, true, and complete. If Blue Shield determines that there is fraud (by act, practice, or omission) or an intentional misrepresentation of material fact in the information on this application, I understand that coverage may be rescinded as allowed by law.

For applicants with a language preference other than English: If I indicated in Part 1 that I have a language preference other than English and have completed the English version of this application (or version other than in my language preference), I confirm that I understand the questions on this application.

Signature of applicant/parent or legal guardian	Today's date	Print name (and relationship if applicant is a minor)

☐ Verification for individuals age 18 and over: I verify that this is my signature made with the intent to sign this electronic application and confirm that no other person has made this signature on my behalf.

Signature of applicant's spouse/domestic partner (if applying)	Today's date	Print name

☐ Verification for individuals age 18 and over: I verify that this is my signature made with the intent to sign this electronic application and confirm that no other person has made this signature on my behalf.

Signature of family member age 18 and over (if applying)	Today's date	Print name

☐ Verification for individuals age 18 and over: I verify that this is my signature made with the intent to sign this electronic application and confirm that no other person has made this signature on my behalf.

Signature of family member age 18 and over (if applying)	Today's date	Print name

☐ Verification for individuals age 18 and over: I verify that this is my signature made with the intent to sign this electronic application and confirm that no other person has made this signature on my behalf.

Signature of family member age 18 and over (if applying)	Today's date	Print name

☐ Verification for individuals age 18 and over: I verify that this is my signature made with the intent to sign this electronic application and confirm that no other person has made this signature on my behalf.

Signature of family member age 18 and over (if applying)	Today's date	Print name

☐ Verification for individuals age 18 and over: I verify that this is my signature made with the intent to sign this electronic application and confirm that no other person has made this signature on my behalf.

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Primary applicant's initials _____

Part 5(b) – Authorizations, terms, and conditions

Please read the following terms and conditions carefully. Each applicant age 18 and older is required to review the completed application and provide their own authorization and signature. Keep a copy of this application for your records.

1. **Application for coverage**: It is important to know that Blue Shield of California or Blue Shield of California Life & Health Insurance Company (as applicable) may decline your application for coverage if you are not currently eligible. Your application must be approved by Blue Shield, and an effective date for coverage assigned, before coverage may become effective.
2. **First month's dues/premiums**: Blue Shield requires first month's dues/premium at the time of application submission. Find your estimated monthly dues/premiums in the rate book. Refer to Part 7 for payment options. Failure to submit full payment of dues/premiums will result in a return of your application. Please note that processing any payment does not constitute approval of your application with Blue Shield or Blue Shield Life. If you do not currently qualify for coverage, the dues/premium you submit with your application will not be processed.
3. **Dues/premiums**: Dues/premiums are to be paid in full by the due date. Coverage will be terminated for failure to pay dues/premiums in a timely manner as set forth in the health service agreement/policy and as allowed by law.
4. **Effective date of coverage**: If you qualify for coverage, Blue Shield will notify you of your effective date of coverage. If Blue Shield cannot honor your requested effective date, or is unable to issue coverage before your requested date, coverage will begin as soon as possible. If additional dues/premiums are owed, payment must be received before coverage becomes effective. Any charges incurred for services received prior to your effective date or after termination of coverage are not covered.
5. **Acceptance of application**: You understand that only Blue Shield can accept your application and issue coverage for an IFP plan requested on this form. Your agent or broker cannot enroll you for coverage or change any terms or conditions of coverage.
6. **Parents/guardians**: If you are the parent or legal guardian of an applicant who is a minor, please sign on behalf of the applicant at the bottom of this Part 5. As the parent or legal guardian, you are identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, you are agreeing to assume all responsibility for dues/premiums payments and for following the terms and conditions for coverage. If you are not the parent of the applicant, please attach the court documents that appoint you as the guardian of this minor. Mark one of the following boxes and identify the individual authorized to act on behalf of the minor (applicant):
   - ☐ Parent or legal guardian only: _____(include name and relationship), or
   - ☐ My designee _____(include name and relationship), or
   - ☐ Qualified medical child support order designee _____(include name and relationship).
   - ☐ Mark this box if Blue Shield is to only make changes to the contract upon written request by the person identified above.
7. **Authorization for spouse/domestic partner to make changes**: If you are an applicant whose spouse/domestic partner is also applying for coverage, please specify if you authorize your spouse/domestic partner to make changes to the contract/policy on your behalf. You may discontinue this authorization at any time by sending a written request to Blue Shield. ☐ **Yes** ☐ **No**
8. **Authorization for your agent to provide/obtain information**: Check here if you do **not** authorize your insurance agent, broker, or producer (referred to as "your agent") to access all information on this application. ☐
9. **Process to authorize Blue Shield to release personal and health information to a third party**: If you would like to authorize your spouse, domestic partner, or a third party to access your personal health information, please complete the form titled Authorization for Blue Shield to Disclose Personal & Health Information to a Third Party. To obtain this form, go to **blueshieldca.com** and click on the *Privacy* link at the bottom of the page, or call **(800) 431-2809**.
10. **Response to requested information**: You agree to cooperate with Blue Shield (or Blue Shield Life, as applicable) by providing, or by providing access to, documents and other information requested (such as court orders to provide dependent coverage, etc.) to corroborate information provided in this application for coverage. You acknowledge and agree that failure or refusal to provide these documents or the information requested may be cause to rescind or cancel your coverage.
11. **HIV or genetic testing prohibited**: No genetic information, including family medical history, and no information related to HIV testing should be provided. California law prohibits an HIV test from being required or used by a health insurance company or healthcare service plan as a condition of obtaining health coverage.

I have reviewed all responses pertaining to me in this application. I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. With my own signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided. (Important: Each adult applicant must provide their own signature.) I understand that I must inform Blue Shield if anything changes or is different from what I listed on this application before my enrollment with Blue Shield begins.

Signature of applicant/parent or legal guardian	Today's date	Print name (and your relationship if applicant is a minor)
Signature of applicant's spouse/domestic partner (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name

Important: Return the application within 30 days of your date(s) and signature(s).
We must receive your application during the open enrollment period or within 60 days from a Special Enrollment triggering event.

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Part 6 – Producer information: to be completed by an authorized Blue Shield agent

1. Did you complete this application? ☐ Yes ☐ No

2. If yes, did you ask each question in this application exactly as set forth? ☐ Yes ☐ No

3. Are the answers recorded exactly as given to you? ☐ Yes ☐ No, attach explanation.

4. Do you want the health service agreement/policy sent directly to the subscriber? ☐ Yes ☐ No

Producer name Stephen Masula

Email address smasula@ekaiserinsurance.com ☐ Update email | Producer number 573046100S

Telephone number 760-720-0007 ☐ Update phone | Fax number 888-436-4342 ☐ Update fax

Producer address 2235 Sara Way

☐ Update address

City Carlsbad | State CA | ZIP code 92008

Super producer name | Super producer number

Producer signature (required) | Today's date (required) | Print name

Producers: Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information.

Part 7 – Billing and payment information

Calculate estimated monthly dues/premiums

- Using the rate book, calculate your estimated rates or talk to your agent to get estimated rates.
- Initial or first month's dues/premium are required at the time of application submission.
  - You can enroll in Easy$Pay where automatic payments are handled via electronic transfer through your checking or savings account for the initial or first month's dues/premium and/or for ongoing payments.
  - Or you can pay the initial or first month's dues/premium by credit card.
- Blue Shield will issue a final rate before any effective date of coverage. If the final rate differs from the estimated rate and additional amounts are owed, payment must be received before coverage will take effect.

Payment options:

(Dues/premium payment is required with your application. Please select Option 1 or 2.)

☐ **Option 1**: Automatic payment through checking or savings account – Easy$Pay for **initial and ongoing monthly payments**
Payment date: ☐ 1st of month ☐ 15th of month (Note: If you do not select a payment date, the default will be the 1st of the month. Dental HMO must use 1st of the month.)

☐ **Option 2**: Please choose one of the options below for both: 1) your initial payment, and 2) for ongoing payments

Initial payment with application:

☐ By automatic payment through checking or savings account – Easy$Pay Payment date: 1st of month

☐ By credit card

Ongoing payments:

☐ By automatic monthly payment through checking or savings account – Easy$Pay Payment date: ☐ 1st of month ☐ 15th of month
(Note: If you do not select a payment date, the default will be the 1st of the month. Dental HMO must use 1st of the month.)

☐ Monthly billing

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