Blue Shield of California
Blue Shield of California Life & Health Insurance Company
Dental plan, vision plan, and dental + vision package application

This form is to be used by applicants applying for a Blue Shield dental plan, vision plan or IFP Specialty Duo℠ dental + vision package. Please include first month's dues/premiums to avoid return of application.

You are eligible for any Individual and Family Plan (IFP) dental plan, vision plan or the Specialty Duo℠ dental + vision package if you are a California resident at the time of enrollment. If you had any Blue Shield IFP dental or vision plan cancelled for any reason (by yourself or by Blue Shield), you must wait six months from date of cancellation before reapplying.

Part 1 – Plan coverage information

Reason for application (choose one):
☐ Start new enrollment ☐ Transfer to a different plan ☐ Add dependent family member to existing coverage
Requested effective date: _____

Coverage options:

Dental plans:		**Vision plans:**	**Vision + dental package:**
☐ Dental HMO ☐ Dental Standard HMO ☐ Dental PPO	☐ Enhanced Dental PPO 50/1250 ☐ Enhanced Dental PPO 50/2000 ☐ Enhanced Dental PPO 50/2000 Lifetime Ortho 1500	☐ Ultimate Vision 15/25/120* ☐ Ultimate Vision 15/25/150*	☐ Specialty Duo℠ (dental + vision) package*

Dental HMO applicants only – please choose a dentist from the Provider Directory at **blueshieldca.com/fad**, or call **(888) 256-3650** for assistance.

Dental HMO provider name: _____ Dental HMO provider number: _____

Dental HMO and Dental Standard HMO plans are not available in certain ZIP codes, including all of Butte, Humboldt, Lake, Lassen, Nevada, Shasta, Sutter, Tehama, Marin, Napa, San Luis Obispo, and Santa Barbara counties.

Life insurance* option: Life insurance is available to applicants 1 year old to age 64. Coverage is offered in amounts starting at $10,000 and up to $100,000. Certain conditions apply for benefit amounts of $50,000 and above. 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**.

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

Note: Summary of Dental Benefits and Coverage (SDBC) forms are available for all dental plans. These forms summarize coverage and benefits for plans. Log in to **blueshieldca.com/policies** to download SDBC forms for any dental plan(s) you have applied for.

Part 2 – Primary applicant information

Applicant's Social Security number/Tax ID number	Sex: ☐ Male ☐ Female	Date of birth (month/day/year)	Married: ☐ Yes ☐ No Domestic partnership: ☐ Yes ☐ No

First name	Middle initial	Last name

Do you currently have dental coverage through Blue Shield? ☐ Yes ☐ No	If yes, please provide your plan	Dental subscriber ID number (if applicable)
Do you currently have medical coverage through Blue Shield? ☐ Yes ☐ No	If yes, please provide your plan	Medical subscriber ID number (if applicable)
Do you currently have vision coverage through Blue Shield? ☐ Yes ☐ No	If yes, please provide your plan	Vision subscriber ID number (if applicable)

Communication preference ☐ Electronic ☐ Paper	Applicant's cell phone number	Applicant's other phone number (non-cellular)	Applicant's business phone number

Primary applicant's initials _____

I agree that Blue Shield and its affiliated entities and agents may communicate with me about my account and various health and wellness programs available to me, and other promotional information that may benefit me and my dependents, including by phone or text to the numbers I have listed on this form, using an auto-dialer or artificial or prerecorded voice; standard data rates apply.

Participation is voluntary and you can opt out at any time. For more information, visit **blueshieldca.com/terms**.

☐ Yes ☐ No

Applicant's Email address **(Required for electronic communications)**

Go paperless! Please watch for an email with a link which will allow you to register your account, customize your communication preferences, and access your digital member ID card and benefit information.

Home address (**NO** P.O. Box)		Apt No.
City	State	ZIP code
Billing address (if different from home address)		Apt No.
City	State	ZIP code
Applicant's mailing address (if different from home address)		Apt No.
City	State	ZIP code

Preferred method of contact (check one):
☐ Home/Other phone ☐ Work phone ☐ Cell phone ☐ Email ☐ Standard mail

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

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

☐ Spouse ☐ Domestic partner Sex: ☐ Male ☐ Female

First name	Middle initial	Last name (if different from above)
Applicant's Social Security number/Tax ID number		Date of birth (month/day/year)

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)

Communication preference: ☐ Electronic ☐ Paper	Applicant's cell phone number	Applicant's other phone number (non-cellular)

Applicant's Email address **(Required for electronic communications)**

I am authorized by my partner/spouse to agree on his/her behalf that Blue Shield and its affiliated entities and agents may communicate with him/her about our account and various health and wellness programs available to us, and other promotional information that may benefit me and my dependents, including communications by phone or text to the numbers I have listed on this form, using an auto-dialer or artificial or prerecorded voice. ☐ Yes ☐ No

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. ☐

1. ☐ Male ☐ Female	Relationship (e.g., son/daughter)	
First name	Middle initial	Last name (if different from above)
Applicant's Social Security number/Tax ID number		Date of birth (month/day/year)

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)

2. ☐ Male ☐ Female	Relationship (e.g., son/daughter)	
First name	Middle initial	Last name (if different from above)
Applicant's Social Security number/Tax ID number		Date of birth (month/day/year)

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)

3. ☐ Male ☐ Female	Relationship (e.g., son/daughter)	
First name	Middle initial	Last name (if different from above)
Applicant's Social Security number/Tax ID number		Date of birth (month/day/year)

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)

4. ☐ Male ☐ Female	Relationship (e.g., son/daughter)	
First name	Middle initial	Last name (if different from above)
Applicant's Social Security number/Tax ID number		Date of birth (month/day/year)

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)

5. ☐ Male ☐ Female	Relationship (e.g., son/daughter)	
First name	Middle initial	Last name (if different from above)
Applicant's Social Security number/Tax ID number		Date of birth (month/day/year)

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)

6. ☐ Male ☐ Female	Relationship (e.g., son/daughter)	
First name	Middle initial	Last name (if different from above)
Applicant's Social Security number/Tax ID number		Date of birth (month/day/year)

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)

7. ☐ Male ☐ Female	Relationship (e.g., son/daughter)	
First name	Middle initial	Last name (if different from above)
Applicant's Social Security number/Tax ID number		Date of birth (month/day/year)

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)

8. ☐ Male ☐ Female	Relationship (e.g., son/daughter)	
First name	Middle initial	Last name (if different from above)

Primary applicant's initials _____

Applicant's Social Security number/Tax ID number	Date of birth (month/day/year)

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)

Part 4 – 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:** I understand that Blue Shield has the right to decline my application for coverage. I also understand that I must be residing in California in order to be eligible for enrollment in this plan/package. I will notify Blue Shield upon any change regarding my eligibility for the dental plan, vision plan, or Specialty Duo℠ dental + vision package. I also agree to provide information requested by Blue Shield to verify my eligibility or continued eligibility for coverage, and understand that failure to cooperate could result in cancellation of coverage. If you use a broker to help facilitate your enrollment, their compensation is based on a percentage of your total monthly premium. This is paid by Blue Shield. Your monthly premium will be the same whether you choose to use a broker or not. In addition, your broker may receive a bonus if certain sales thresholds are met.
2. **First month's dues/premiums:** Blue Shield requires first month's dues/premiums at the time of application submission. Find your estimated monthly dues/premiums by going to **buyblueshieldca.com** or contact your agent. Refer to Part 6 for payment options. Failure to submit full payment of dues/premiums will result in a return of your application. Please note that processing of your payment does not constitute approval of your application with Blue Shield or Blue Shield Life. If you include a check, it will be destroyed.
3. **Dues/premiums:** Dues/premiums are to be paid in full by the due date. Coverage will be canceled for failure to pay dues/premiums in a timely manner as set forth in the *Evidence of Coverage and Health Service Agreement*/Policy 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 the 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 cancellation or termination of coverage are not covered.
5. **Acceptance of application:** You understand that only Blue Shield can accept your application and issue coverage for a plan or policy requested on this form. Your agent or broker cannot issue or enroll you in 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 4. 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 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 only _____ (include name and relationship); or
   - ☐ Legal guardian only _____ (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:** By leaving this box blank you authorize your insurance agent, broker, or producer (referred to as "your agent") to access all information on this application. Check the box if you **do not want** to give your agent this authorization. ☐
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 the Use or Disclosure of Health Information. To obtain this form, go to **blueshieldca.com/privacy** or call **(888) 256-3650**.
10. **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

Primary applicant's initials _____

11. **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 deny this application or rescind or cancel your coverage.
12. **Receiving materials and communications electronically versus print:** You will receive required benefit plan and coverage-related materials and communications via email, at **blueshieldca.com/policies**, and/or by signing into the Blue Shield website **blueshieldca.com**, as applicable. Documents that are made available to you electronically include:
    - Blue Shield Identification (ID) cards
    - Statement of Benefits (SOB)
    - *Evidence of Coverage and Health Service Agreement* (EOC)/Policy
    - Summary of Dental Benefits and Coverage (SDBC)

    You have the right to obtain printed, mailed materials at any time and at no expense to you.
    To receive printed materials in the mail, to opt out of email communications, or if you have questions, please call **(888) 256-3650**.

I have reviewed all responses pertaining to me in this application. I have read the Summary of Dental Benefits and Coverage, as applicable, 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, if applicant is a minor)	Today's date	Print name (and your relationship if applicant is a minor)
Signature of applicant (parent or legal guardian, if applicant is a minor)	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 or over (if applying)	Today's date	Print name
Signature of family member age 18 or over (if applying)	Today's date	Print name
Signature of family member age 18 or over (if applying)	Today's date	Print name
Signature of family member age 18 or over (if applying)	Today's date	Print name
Signature of family member age 18 or over (if applying)	Today's date	Print name
Signature of family member age 18 or over (if applying)	Today's date	Print name
Signature of family member age 18 or over (if applying)	Today's date	Print name

Important: Return the application within 30 days of your date(s) and signature(s).

Primary applicant's initials _____

Part 5 – 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 *Evidence of Coverage and Health Service Agreement*/Policy sent directly to the subscriber? ☐ Yes ☐ No

Producer name (the entity/individual to whom commissions will be issued)

Email address ☐ Update email	Producer number 203415751
Telephone number ☐ Update phone	Fax number ☐ Update fax
Producer address ☐ Update address	
City	State / ZIP code
Super producer name	Super producer number

With my signature below, I, as an agent, broker, solicitor, solicitor firm, or representative who has assisted this applicant in submitting this application, verify that to the best of my knowledge, the information on the application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and that the applicant understood the explanation.
If a declarant willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000).

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.

Please fax or mail the completed and signed application to:
Installation and Billing
Blue Shield of California
P.O. Box 3008
Lodi, CA 95241-1912
Fax: **(888) 386-3420**

For internal use only
DSA name:_____
DSA number: _____
Producer number: _____

Part 6 – Billing and payment information

Calculate estimated monthly dues/premiums

- Go to **buyblueshieldca.com** to get your estimated dues/premiums or talk to your agent to get estimated dues/premiums.
- First month's dues/premiums are required at the time of application submission.
- Blue Shield will issue final dues/premium before any effective date of coverage. If the final amount differs from the estimated dues/premium and additional amounts are owed, payment must be received before coverage will take effect.

Payment options

Your first month's dues/premium can be paid by submitting a check* or money order.

* When you provide a check as payment, you authorize Blue Shield either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When we use the information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date we approve your application and you will not receive your check back from your financial institution.

NOTICES AVAILABLE ONLINE

Nondiscrimination and Language Assistance Services

Blue Shield complies with applicable state and federal civil rights laws. We also offer language assistance services at no additional cost.

View our nondiscrimination notice and language assistance notice: **blueshieldca.com/notices**. You can also call for language assistance services: **(866) 346-7198 (TTY: 711)**.

If you are unable to access the website above and would like to receive a copy of the nondiscrimination notice and language assistance notice, please call Customer Care at **(888) 256-3650 (TTY: 711)**.

Servicios de asistencia en idiomas y avisos de no discriminación

Blue Shield cumple con las leyes de derechos civiles federales y estatales aplicables. También, ofrecemos servicios de asistencia en idiomas sin costo adicional.

Vea nuestro aviso de no discriminación y nuestro aviso de asistencia en idiomas en **blueshieldca.com/notices**. Para obtener servicios de asistencia en idiomas, también puede llamar al **(866) 346-7198 (TTY: 711)**.

Si no puede acceder al sitio web que aparece arriba y desea recibir una copia del aviso de no discriminación y del aviso de asistencia en idiomas, llame a Atención al Cliente al **(888) 256-3650 (TTY: 711)**.

非歧視通知和語言協助服務

Blue Shield 遵守適用的州及聯邦政府的民權法。同時，我們免費提供語言協助服務。

如需檢視我司的非歧視通知和語言幫助通知，請造訪 **blueshieldca.com/notices**。您還可致電尋求語言協助服務：**(866) 346-7198 (TTY: 711)**。

如果您無法造訪上述網站，且希望收到一份非歧視通知和語言幫助通知的副本，請致電客戶服務部，電話：**(888) 256-3650 (TTY: 711)**。