

**Blue Shield of California and  
Blue Shield of California Life & Health Insurance Company (Blue Shield Life)**

Section 1 – Company information				
1	Full legal business name of group		Requested effective date of coverage (month/day/year):	
	Doing business as (DBA), if applicable:		County location of physical address	
2	Billing street address (if providing P.O. Box, also complete #3 below)			
	City	State	ZIP code	
3	Physical address (if different from above)			
	City	State	ZIP code	
4	Legal entity type: <input type="checkbox"/> S-Corporation <input type="checkbox"/> C-Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> Nonprofit <input type="checkbox"/> Other (specify) _____			
	Federal Employer Tax Identification (TID) number _____			
	Is the group subject to ERISA? <input type="checkbox"/> Yes <input type="checkbox"/> No			
5	Is the group intending to offer Blue Shield alongside another carrier's plan? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Other carrier initial effective date of coverage (month/day/year):			
	Does the group have any subsidiary or affiliated companies? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	If yes, please provide the following:		Tax ID number	Include in coverage?
	Legal name 1			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Legal name 2			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Legal name 3			<input type="checkbox"/> Yes <input type="checkbox"/> No
	Are all employees covered by workers' compensation to the extent required by law?			
<input type="checkbox"/> Yes Carrier name: _____				
<input type="checkbox"/> No If no, please explain: _____				

<b>6</b>	<b>Group contact for:</b>		
	Overall group contact (primary - Daily general contact)	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Online administrator contact (This is applicable if you are providing your eligibility to Blue Shield via the Blue Shield proprietary online tool)	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Billing contact	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Evidence of Coverage/ Certificate of Insurance (EOC/COI) contact	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Legal contact (accountable for binding legal commitments on behalf of employer group)	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Account Based Health Plan (ABHP) contact	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	COBRA administrator contact	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Enrollment Discrepancy Report contact (if utilizing EDI for electronic enrollment)	A. Group contact name	B. Job title
		C. Phone number	D. Email address (required)
	Survey contact	A. Group contact name	B. Job title
C. Phone number		D. Email address (required)	
Additional contact (Please Specify)	A. Group contact name	B. Job title	
	C. Phone number	D. Email address (required)	

**Section 2 – Eligibility**

**7** Will you be utilizing an EDI electronic file for your ongoing enrollment?  Yes  No  
If yes, will your COBRA members be included on that file?  Yes  No

**Employment-based affiliation and waiting periods** – An employer may impose a bona fide employment-based orientation (affiliation) period for new employees which cannot exceed 30 days. A waiting period may also be imposed before coverage becomes effective, beginning the first day after any orientation period and not to exceed a combined total of 90 days.

Please note: An employee’s “date of hire” is the first day employment begins. However, if the employer imposes an orientation or waiting period, the “effective date of coverage” is the first day after completion of any orientation/waiting period.

**7a. Employer waiting period** – The group may select one or more of the following options.

Coverage for eligible employees will become effective following completion of the waiting period on the day specified.

If there are multiple waiting period options based on employment classification, please indicate at the option selected:

**No waiting period (effective date of hire)**

All employees

Other (please describe) \_\_\_\_\_

**Effective first of the month FOLLOWING DATE OF HIRE**

a.  If hired on the 1st of the month, coverage **effective 1st of following month.**

Example: employee hired 12/1/2022 = effective 1/1/2023

All employees

Other (please describe) \_\_\_\_\_

b.  If hired on the 1st of the month, coverage **effective on date of hire.**

Example: employee hired 12/1/2022 = effective 12/1/2022

All employees

Other (please describe) \_\_\_\_\_

**Effective first of the month FOLLOWING 30 DAYS FROM DATE OF HIRE**

All employees

Other (please describe) \_\_\_\_\_

**Effective first of the month FOLLOWING 60 DAYS FROM DATE OF HIRE**

Example: employee hired 12/15/2022 add 60 days = effective 3/1/2023

All employees

Other (please describe) \_\_\_\_\_

**Effective on the 91st DAY FOLLOWING DATE OF HIRE**

**7b.** Will the waiting period be waived:

Yes  No For current, actively at-work employees enrolling during the initial transition to Blue Shield.

Yes  No For part-time employees upon attaining full-time status.

Yes  No If “Yes”, the waiting period should be waived for employees rehired within:

1 month  90 days  3 months  6 months  12 months  13 weeks

Anytime, effective date of rehire  Anytime, effective first of month following date of rehire

Please note: If using EDI electronic file for ongoing enrollment and eligibility, the member effective dates are calculated by the dates on the EDI files and the applicable waiting period(s).

**8 Employee count**

Blue Shield asks the group to read these definitions of “employee” and provide the information requested using the definitions provided below. We rely upon the information provided by the group in determining group and employee eligibility for coverage.

**1. All employees** – Any individual employed by the group including full-time and part-time employees, (29 USC 1002 (6)).

**2. Full-time employee (FTE) and FTE Equivalent** – FTE and FTE Equivalent is defined in Section 4980H(c)(2) of the Internal Revenue Code.

An FTE is an employee who has on average at least 30 hours of service per week, or at least 130 hours of service total, during a calendar month.

The number of FTE Equivalents is determined by combining the number of hours of service of all non-FTEs for the month, but no more than 120 hours of service per employee, then dividing the total number by 120.

**3. Eligible employee** – This definition is used to determine which employees are eligible to enroll, and remain enrolled, in coverage. An eligible employee is an individual who:

- Is an individual engaged on a full-time basis in the conduct of the business of the employer, whose normal work week is at least 30 hours, and whose duties in such employment are performed at the employer’s regular places of business; or
- Is a sole proprietor or partner of a partnership engaged on a full-time basis, at least 30 hours per week, in the employer’s business and who is included as an employee under a healthcare plan contract of the employer.
- An eligible employee does not include individuals working on a part-time, temporary, or substitute basis.

**8a.** Total # of employees:

**8b.** Total # of eligible full-time employees:

**8c.** Total # of eligible employees enrolling in Blue Shield coverage (complete to the best of your knowledge):

**8d.** Total # of eligible employees declining Blue Shield coverage (complete to the best of your knowledge):

**8e.** Total # of FTE and FTE Equivalents:

**8f.** Do you plan to offer Blue Shield coverage to out-of-state employees?  Yes  No  
If yes, how many out-of-state employees do you have? \_\_\_\_\_

**Employer is responsible for collecting and retaining Refusal of Coverage forms, as well as providing the forms to Blue Shield upon request. If no Blue Shield medical plan is offered (e.g., dental, vision, or life insurance only), Refusal of Coverage forms are not required.**

9	9a. Are all full-time eligible employees being offered health coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	9b. If the response to 9a is no, please explain:		
	9c. Are all full-time eligible employees being offered health coverage actively working at least 30 hours per week?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	9d. If the response to 9c is no, please explain:		
	9e. Are retirees eligible for benefits? Note: Retiree coverage option requires prior underwriting approval.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	9f. If the response to 9e is yes, please check any that apply: <input type="checkbox"/> Early retirees under age 65 <input type="checkbox"/> Retirees age 65 and over Will the group contribute to retiree coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	9g. Do you require your retiree coverage to be billed separately from your active employee population?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, provide the contact information and address to which the monthly bill should be sent for retiree coverage.		
	Billing address		
City		State	ZIP code
Contact name		Email address	
9h. <b>Optional:</b> Benefit selections default to member level benefits (MLB1) allowing dependents to elect equal to or less than subscriber regardless of Medical elections. By checking the following box I am removing this option and all enrolled dependents will be equal to subscriber and must enroll in Medical.		<input type="checkbox"/>	
<b>Section 3 – COBRA/Cal-COBRA continuation coverage information</b>			
10	Your group is subject to federal COBRA if you employed 20 or more employees during at least 50% of the working days in the previous calendar year. The group is solely responsible for all aspects of the administration of Title X of the Consolidated Omnibus Budget Reconciliation Act (COBRA).		
	10a. How many existing COBRA participants do you have? _____		
	10b. Employees or COBRA/Cal-COBRA participants are required to complete a Disability Addendum (form C11248) if they are disabled or hospitalized. Name of COBRA administrator: _____ COBRA member billing should be sent to the: <input type="checkbox"/> Group <input type="checkbox"/> COBRA administrator		
Please provide COBRA administrator address:			
Billing address			
City		State	ZIP code

**Section 4a – Blue Shield of California health plan selection**

11	<b>Trio HMO plans</b>	
	<b>Access+ HMO® plans</b>	
	<b>Local Access+ HMO® plans<sup>1</sup></b>	
	<p><sup>1</sup> Local Access+ HMO products are only available in designated counties: Marin, Orange, San Francisco, San Luis Obispo, Santa Clara, Santa Cruz, Sonoma, Stanislaus, and Yolo, and portions of Contra Costa, Kern, Los Angeles, Riverside, Sacramento, San Bernardino, San Diego, San Mateo, and Ventura counties.</p>	
	<b>Added Advantage POS<sup>SM</sup> plans</b>	
	<b>Full PPO/EPO plans</b>	
	<b>PPO Savings plans</b>	
<b>Virtual Blue<sup>SM</sup> plans</b>		
<b>Tandem PPO/EPO plans</b>		
<b>Active Choice® Plus/Active Choice® Classic plans</b>		
<b>Blue Shield 65 Plus<sup>SM</sup> plans</b>		
<input type="checkbox"/> Custom plan (attach custom Summary of Benefits)		
12	<b>Required employer contribution for Blue Shield health plans</b>	
	Enter percentage of dues/premium paid by the group for employees and dependents. If the group contributes 100%, then all eligible employees must enroll.	
	<b>Indicate medical plan employer contribution amount here:</b>	
	<b>For employees</b> _____% For retirees (if applicable) _____%	<b>For dependents</b> _____% For retirees' dependents (if applicable) _____%

13	<b>Blue Shield account-based health plans (ABHP)</b>			
Indicate if you are offering any of the following account options (check all that apply) and provide the name of the administrator of each program. Also indicate any amount to be funded by employer contribution.				
Account type	Account administrator	Employer contribution amount <u>INDIVIDUAL</u> coverage	Employer contribution amount <u>FAMILY</u> coverage	
<input type="checkbox"/> Health savings account (HSA)	<input type="checkbox"/> HealthEquity (integrated model – Blue Shield shares eligibility and claims) • <b>Mandatory with medical enrollment:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other administrator (non-integrated option)	\$	\$	
<input type="checkbox"/> Health reimbursement arrangement (HRA)	<input type="checkbox"/> HealthEquity (integrated model – Blue Shield shares eligibility and claims) • <b>Mandatory with medical enrollment:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other administrator (non-integrated option)	\$	\$	
<input type="checkbox"/> Health incentive account (HIA)	<input type="checkbox"/> HealthEquity (integrated model – Blue Shield shares eligibility and claims) • <b>Mandatory with medical enrollment:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other administrator (non-integrated option)	\$	\$	
<input type="checkbox"/> Limited purpose flexible spending account (LPFSA – Dental and Vision) with HSA only	<input type="checkbox"/> HealthEquity (integrated model – Blue Shield shares eligibility and claims) • <b>Mandatory with medical enrollment:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other administrator (non-integrated option)	\$	\$	
<input type="checkbox"/> Flexible spending account (FSA) <input type="checkbox"/> Medical FSA <input type="checkbox"/> Dependent care FSA	<input type="checkbox"/> HealthEquity (integrated model – Blue Shield shares eligibility and claims) • <b>Mandatory with medical enrollment:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other administrator (non-integrated option)	\$	\$	

**Blue Shield of California optional benefits selection**

- 14**
- Cannot be purchased without a medical plan.
  - For Dual Choice packages, the same optional benefits must be purchased for all the plans selected.
  - The rider product type must match the medical plan product type – only HMO to HMO, etc.

**Infertility rider – select plan type:** **Select plan option:**


**Chiropractic and acupuncture riders – select plan type:** **Hearing aid rider – select plan option:**


**Blue Shield of California outpatient prescription drug plan options (available for HMO/POS)**

Choose the Rx drug plan (Basic Rx) that applies:<sup>1</sup>


Choose the Rx drug plan (Enhanced Rx) that applies:<sup>1</sup>


Choose the Rx drug plan (Rx Spectrum) that applies:<sup>1</sup>


1 Tier 4 Drugs, including Specialty Drugs, 20% up to a \$250 maximum.

**Blue Shield of California outpatient prescription drug plan options (available for PPO, EPO and Active Choice® Classic and Active Choice® Plus plans)**

Choose the Rx drug plan (Enhanced Rx or Premier Rx) that applies:<sup>1</sup>


Choose the Rx drug plan (Rx Spectrum) that applies:<sup>1</sup>


1 Tier 4 Drugs, including Specialty Drugs, 30% up to \$250 maximum.

**Section 4b – Blue Shield Life health plan\* and outpatient prescription drug plan\* options**

Check all boxes that apply:

**Active Choice\* plans**

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**Choose one calendar-year pharmacy deductible option below:**

\$0 per person    \$150 per person    \$250 per person

**Choose an Rx drug plan option below:**

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1 Tier 4 Drugs, including Specialty Drugs, 30% up to a \$250 maximum.

C17607-ML-MED

**Blue Shield Life Health plan\* optional riders**

**Hearing aid:**

Would the group like to add a hearing aid rider?  Yes    No

**Infertility**

Choose one of the infertility riders:	
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\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

**Section SB1 – Blue Shield of California dental plan options:**

**15 The group may select from one of the following plan options:**

**Single Dental Plan Option**

**Dual Choice Dental Plan Options**  
 • 1 DPPO + 1 DHMO • 1 DPPO + 1 DINO • 2 DHMOs • 2 DPPOs

**Triple Choice Dental Plan Options**  
 • 1 DPPO + 1 DHMO + 1 DINO

**Dental HMO**

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**Dental PPO**

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**Dental INO**

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**16 Required employer contribution for dental plans**  
 Enter percentage of dues/premium paid by the group for employees and dependents. For dental coverage, the employer must contribute at least 50% of the employee’s premium (except voluntary). If 100% is paid, all eligible employees must enroll.

**Indicate dental plan employer contribution amount here:**

<b>For employees</b> _____%	<b>For dependents</b> _____%
For retirees (if applicable) _____%	For retirees’ dependents (if applicable) _____%

**Section SB2 – Vision coverage\***

**17**

**Vision Voluntary†**

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\* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).  
 † A voluntary vision plan requires a minimum of 10 enrolling employees with Blue Shield Life medical coverage or 25% of eligible employees if without Blue Shield Life medical coverage. C17607-ML-SB

**18 Required employer contribution for vision plans**  
 Enter percentage of premium paid by the group for employees and dependents. For vision coverage, the employer must contribute a minimum of 25% of the total employee’s premium (except voluntary). If 100% is paid, all eligible employees must enroll.

**Indicate vision plan employer contribution amount here:**

<b>For employees</b> _____%	<b>For dependents</b> _____%
For retirees (if applicable) _____%	For retirees’ dependents (if applicable) _____%

**Section SB3 – Life/AD&D insurance\***

**19 Eligibility – All full-time employees who are actively at work**

**Basic Group Term Life/AD&D insurance for Employees:**

**Flat amount** \$ \_\_\_\_\_

**Multiple of salary** \_\_\_\_\_ times salary, maximum \$ \_\_\_\_\_

Benefit amounts established by salary are rounded to the next highest \$1,000.

**Graded:**

1. Class description _____	amount \$ _____
2. Class description _____	amount \$ _____
3. Class description _____	amount \$ _____
4. Class description _____	amount \$ _____

**Basic Dependent life insurance:**  
 The dependent coverage amount listed is per dependent (spouse/domestic partner and/or each child) for one flat rate. Employee enrollment in Basic Group Term Life is required; the dependent benefit may not exceed 50% of the employee’s benefit amount. Benefits for children ages 14 days to 6 months are 10% of the Basic Dependent Life amount elected.

<b>20</b>	<p><b>Required employer contribution for Basic Group Term Life/AD&amp;D insurance</b>  Enter percentage of premium paid by the group for employees and dependents. For employee coverage, the group must contribute a minimum of 25% of the total employee's premium. If the group pays 100% of the employee's premiums (non-contributory), then all full-time employees (who are actively at work) must be enrolled.</p> <p><b>Indicate Basic Group Term Life/AD&amp;D insurance contribution amount here:</b></p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <b>For employees _____%</b>  For retirees (if applicable) _____% </td> <td style="width: 50%; border: none;"> <b>For dependents _____%</b>  For retirees' dependents (if applicable) _____% </td> </tr> </table>	<b>For employees _____%</b> For retirees (if applicable) _____%	<b>For dependents _____%</b> For retirees' dependents (if applicable) _____%
<b>For employees _____%</b> For retirees (if applicable) _____%	<b>For dependents _____%</b> For retirees' dependents (if applicable) _____%		
<b>21</b>	<p><b>Group Supplemental Life and Supplemental AD&amp;D insurance*:</b>  Coverage is subject to participation levels and Evidence of Insurability.</p> <p><b>Employee Supplemental Life and Supplemental AD&amp;D insurance</b> (check all that apply):</p> <input type="checkbox"/> Supplemental Life insurance <input type="checkbox"/> Supplemental AD&D insurance Eligible class(es): <input type="checkbox"/> All Eligible Employees or <input type="checkbox"/> Classes _____ <input type="checkbox"/> Increments of \$ _____ or <input type="checkbox"/> Multiple(s) of salary: _____ times salary Maximum of \$ _____ or _____ x salary, whichever is less Guaranteed issue of \$ _____ <p><b>Spouse/domestic partner Supplemental Life and Supplemental AD&amp;D insurance.</b>  Only available if employee also elects Supplemental Life insurance and cannot exceed 50% of the employee benefit amount (check all that apply):</p> <input type="checkbox"/> Supplemental Life insurance <input type="checkbox"/> Supplemental AD&D insurance Increments of \$ _____ to a maximum of \$ _____    Guaranteed issue of \$ _____ <p><b>Child(ren) Supplemental Life and Supplemental AD&amp;D insurance.</b>  Only available if employee also purchases Supplemental Life and Supplemental AD&amp;D insurance and cannot exceed 50% of employee benefit amount (check all that apply):</p> <input type="checkbox"/> Supplemental Life insurance <input type="checkbox"/> Supplemental AD&D insurance Increments of \$ _____ to a maximum of \$ _____ <p><small>*Underwritten by Blue Shield of California Life &amp; Health Insurance Company (Blue Shield Life). C17607-ML-SB</small></p>		
<b>Section 5 – Employer distribution of member Evidence of Coverage/Certificate of Insurance (EOC/COI)</b>			
<b>22</b>	<p>You are responsible for the distribution of the EOC/COI booklets to your covered employees.</p> <p>Electronic versions will be distributed via the Blue Shield employer website. Blue Shield will notify the individual responsible for EOC/COI distribution, identified in Section 1, #6 above, by email when the EOC/COI is ready for distribution. Employer is responsible for distributing these documents using one of the following methods: (1) posting on the company intranet for employee access, (2) emailing these documents directly to their employees, or (3) providing employees with instructions from Blue Shield about how to electronically retrieve the documents from the Blue Shield website.</p> <p><b>Note:</b> You can log in to <a href="http://blueshieldca.com/policies">blueshieldca.com/policies</a> and download a <i>Summary of Benefits &amp; Coverage</i> (SBC) for each plan you are considering. Once you purchase a plan(s), you will be asked to complete an attestation confirming you have downloaded the SBC(s) for those plans and will issue them to enrollees and prospective enrollees as required by law.</p>		
<b>Payment (deposit check – this amount will be applied to the first month's premium)</b>			
<b>23</b>	<p>The group herewith agrees to tender an initial deposit based on expected Blue Shield enrollment and, in consideration of approval of the application it will make and in event of such approval, promises to pay this company as appropriate any balance necessary to constitute the full initial payment for the group benefits herein identified on this form. It is understood that coverage will not commence until the application has been approved and the conditions of coverage are accepted by the employer.</p> <p>Please note that depositing the group's check does not constitute approval of the group's application. Blue Shield of California will refund the full deposit to the group if the group application is declined.</p>		

**Agreement**

**24** The group hereby applies for the group products selected on this application, as those benefit plans are outlined in the benefit summary(ies), with the understanding and agreement that:

1. Group benefits will not become effective, unless:
  - a. Blue Shield receives and approves the application; and
  - b. The group meets Blue Shield’s underwriting requirements, including minimum participation and contribution requirements. (Participation and contribution requirements are required only upon renewal.)
2. The group agrees to pay the required monthly premium/dues to Blue Shield in a timely manner.
3. The group agrees to:
  - a. Enroll all employees as they become eligible, if the Health Service Contract/Group Policy is issued on a non-contributory basis; or
  - b. Give all eligible employees an opportunity to apply for such group benefits, if the Health Service Contract/Group Policy is issued on a contributory basis.
4. No waiver or requested change in coverage will become effective unless agreed to and signed by an officer of Blue Shield.
5. For life insurance/AD&D products only: enrolling employees must be actively at work or meet the active employment provisions for coverage before coverage may become effective. Coverage for any person not meeting these provisions on the effective date of the Group Policy, or any increase in coverage for any person not meeting these provisions on the effective date of such increase in coverage, will be deferred until the person returns to work or active employment.
6. The group consents to and authorizes Blue Shield to send all business correspondence through electronic communications. Blue Shield will notify the group contact, identified in Section 1, #6 above, by email. Other forms of contact will only be made upon direct request. Employers requesting mail correspondence may incur an additional cost.

It is understood that the group agrees to receiving electronic communications from Blue Shield.

**Authorization and signature**

**25** The following authorization section must be signed by the primary group representative/contact. **This is an application for coverage. The group understands that no contract for coverage will exist until Blue Shield has completed its review and communicated to the applicant or the applicant’s producer that the application has been accepted and a group health service contract has been issued. The group representative certifies, to the best of his or her knowledge and belief, all of the responses provided in this application are true, correct, and complete. The group understands that if it has committed fraud or made an intentional misrepresentation of any material fact in conjunction with this application, Blue Shield of California may pursue one of the following remedies within the first 24 months of coverage: group coverage may be cancelled, or the applicable premium/dues may be adjusted, or following notice, the Health Service Contract/Group Policy may be rescinded.**

**I certify to the best of my knowledge and belief that all responses given above are true and correct and complete.**

Authorized group representative signature	Name and title (please print)	Date
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For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Producer information (To be completed by producer or general agent. All information is required.)**

<b>26</b>	Primary producer company name		
	Primary producer contact name	Primary producer contact phone number	
	Primary producer office address		
	City	State	ZIP code
	Primary producer contact email		
	Primary producer Tax ID number		
	Primary producer contact Department of Insurance license number		
	Secondary producer company name		
	Secondary producer contact name	Secondary producer contact phone number	
	Secondary producer office address		
	City	State	ZIP code
	Secondary producer contact email		
	Secondary producer Tax ID number		
	Secondary producer contact Department of Insurance license number		
<b>Producer/General Agent Attestation</b>			
Attestation of Agent/Broker assisting in the submission of this application: (1) to the best of my knowledge, the information on the application is complete and accurate; and (2) I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.			
_____ Today's date (required)	_____ Primary producer signature (required)	_____ Print producer name	
_____ Today's date (required)	_____ Secondary producer signature (when applicable)	_____ Print producer name	
General agency Tax ID number			
General agency name			
_____ Today's date (required)	_____ General agent authorized signature (required)	_____ Print general agent contact name	

# Blue Shield of California

## Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

### Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California  
Civil Rights Coordinator  
P.O. Box 629007  
El Dorado Hills, CA 95762-9007

**Phone: (844) 831-4133 (TTY: 711)**

**Fax: (844) 696-6070**

**Email: [BlueShieldCivilRightsCoordinator@blueshieldca.com](mailto:BlueShieldCivilRightsCoordinator@blueshieldca.com)**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW.  
Room 509F, HHH Building  
Washington, DC 20201  
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at [www.hhs.gov/ocr/office/file/index.html](http://www.hhs.gov/ocr/office/file/index.html).

# Notice of the Availability of Language Assistance Services

## Blue Shield of California

**IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

**IMPORTANTE:** ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

**重要通知：** 您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以用您所講的語言書寫。如需免費幫助，請立即撥打登列在您的Blue Shield ID卡背面上的會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

**QUAN TRỌNG:** Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

**MAHALAGA:** Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

**Baa' ákohwiindzindoogí:** Díí naaltsoosish yíiniłta'go bíniǰhah? Doo bíniǰhahgóó éí, naaltsoos nich'í' yiidóoltaǰíí ła' nihee hółó. Díí naaltsoos áldó' t'áá Diné k'ehjí ádoolnííł nínízingo bíǰhah. Doo ɓaąh ílínígó shíká' adoowoł nínízingó nihich'í' béesh bee hodíłnih dóó námboo éí díí Blue Shield bee néího' díłzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jí' hodíłnih. (Navajo)

**중요:** 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

**ԿԱՐԵՎՈՐ Է:** Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

**ВАЖНО:** Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

**重要：** お客様は、この手紙を読むことができますか？もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。また、お客様の母国語で書かれた手紙をお送りすることも可能です。無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。(Japanese)

**مهم:** آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیاراتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسایی Blue Shield تان درج شده است و یا از طریق شماره تلفن (866) 346-7198 با خدمات اعضا/مشتری تماس بگیرید. (Persian)

**ਮਹੱਤਵਪੂਰਨ:** ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

**ប្រការសំខាន់៖** តើអ្នកអាចលិខិតនេះ បានដើរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

**المهم:** هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم (866) 346-7198. (Arabic)

**TSEEM CEEB:** Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

**สำคัญ:** คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยเหลือจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

**महत्वपूर्ण:** क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। निःशुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मँबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

**ສິ່ງສໍາຄັນ:** ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ່? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້. ສໍາລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

# Notice of the Availability of Language Assistance Services

## Blue Shield of California Life & Health Insurance Company

**No Cost Language Services.** You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

**Servicios de idiomas sin costo.** Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

**免費語言服務。** 您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

**Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí.** Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

**Walang Gastos na mga Serbisyo sa Wika.** Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

**Անվճար Լեզվական Ծառայություններ:** Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

**Бесплатные услуги перевода.** Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance), по телефону 1-800-927-4357. Russian

**無料の言語サービス** 日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、IDカード記載の番号または1-866-346-7198までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

**خدمات مجانی مربوط به زبان.** میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند. برای دریافت کمک، با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید. برای دریافت کمک بیشتر، به CA Dept. of Insurance (اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید. Persian

**ਮੁਫਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ:** ਤੁਸੀਂ ਦੁਬਾਰੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ਸਾਨੂੰ ਫੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ ਇਨਸੂਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫੋਨ ਕਰੋ। Punjabi

**សេវាកម្មភាសាភាគីតិចថ្លៃ។** អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយសូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

**خدمات ترجمة بدون تكلفة.** يمكنك الحصول علي مترجم و قراءة الوثائق لك باللغة العربية. للحصول علي المساعدة، اتصل بنا علي الرقم المبين علي بطاقة عضويتك أو علي الرقم 1-866-346-7198. للحصول علي المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا علي الرقم 1-800-927-4357. Arabic

**Cov Kev Pab Txhais Lus Tsis Them Nqi.** Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

บริการทางภาษาอย่างไม่เสียค่าใช้จ่าย คุณสามารถรับบริการจากสาม รวมถึงให้เจ้าหน้าที่อ่านเอกสารให้คุณฟัง หรือส่งเอกสารบางส่วนในภาษาของคุณไปหาคุณได้ หากต้องการความช่วยเหลือ กรุณาโทรศัพท์ตามหมายเลขที่ระบุอยู่ด้านหลังบัตรประจำตัวของคุณ หรือ ที่หมายเลข 1-866-346-7198 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรมาที่ กรมการประกันภัยแห่งมลรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया की सेवा प्राप्त कर सकते हैं। आप दस्तावेजों को पढ़वा के सुन सकते हैं और कुछ को अपनी भाषा में स्वयं को भिजवा सकते हैं। सहायता के लिए, अपने ID कार्ड पर दिए गए नंबर पर, या 1-866-346-7198 पर हमें फ़ोन करें। अधिक सहायता के लिए कैलीफोर्निया बीमा विभाग (CA Dept. of Insurance) को 1-800-927-4357 पर फ़ोन करें। Hindi

**Doo bááh ílínígó saad bee yát'i' bee aná'áwo'.** Díí shá ata'halne'dooígí hólíqodoo nínízingo éí bííghah. Naaltsoos naanínáhájeehígí shich'í' yíidooltah éí doodagó ła' shich'í' ádoolníí nínízingo bííghah. Shíká a'doowoł nínízingo nihich'í' béesh bee hodílnih dóó námboo éí díí ninaaltsoos dootł'ízhígí bee néiho'dílninígí bine'déé' bikáá' éí doodagó éí (866)346-7198jí' hodílnih. Hózhó shíká anáá'doowoł nínízingo éí díí béeso ách'áqah naa'nil bíł haz'áají' 1-800-927-4357jí' hodílnih. Navajo

**ບໍລິການແປພາສາໂດຍບໍ່ເສຍຄ່າ.** ທ່ານສາມາດຂໍເອົາຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງ ແລະ ສົ່ງເອກະສານບາງຢ່າງທີ່ເປັນພາສາຂອງທ່ານ. ສໍາລັບຄວາມຊ່ວຍເຫຼືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມເບີໂທລະສັບທີ່ມີ ໃນບັດປະຈໍາຕົວຂອງທ່ານ ຫຼື ໂທຫາເບີ 1-866-346-7198. ສໍາລັບຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມໂທຫາ ພະແນກ ປະກັນໄພຂອງ ລັດຄາລິຟໍເນຍໄດ້ທີ່ເບີ 1-800-927-4357. Laotian