# Blue Shield of California
# Medicare Supplement Plan Transfer Application

Current Blue Shield of California Medicare Supplement plan members may use this application to:

1. Transfer to a Medicare Supplement plan of equal or lesser value during an open enrollment period – Guaranteed Acceptance.
2. Enroll into the Household Savings Program[1]. (Both participants must be current Blue Shield of California Medicare Supplement plan members).
3. Enroll in a dental or dental/vision plan.

If you are interested in transferring to a Medicare Supplement plan of equal or lesser value outside your enrollment period or to a richer benefit plan at any time, you must complete the Medicare Supplement Plan Enrollment Application (Form C12687).

## Transferring is easy!

**1** Provide ALL requested information and print clearly in all capital letters in black ink. Sign and date at the end.

**2** Submit your application within 30 days of your signature date by:
- Fax to **(844) 266-1850**
- Email: **msinstall@blueshieldca.com**
- Mail: Medicare Supplement Installation, P.O. Box 3008 Lodi, CA 95241-1912

**Please note: It is required that a signed copy of this contract is made for your records. Be sure to print and save the member copy pages of this application with all other important Blue Shield of California documents.**

If you have questions about how to enroll, please contact your broker or call us at **(888) 713-0000** or TTY: **711**.

**You may also contact the California Health Insurance Counseling & Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at (800) 434-0222 for a referral to your local HICAP office. HICAP services are provided free of charge by the state of California.**

## Personal information

| First name | Middle initial | Last name |
|---|---|---|
| Home address | | |
| Home city | Home state | Home ZIP |
| Home telephone | Gender: ☐ Male ☐ Female ☐ Non-binary | |
| Email | | |

I understand and agree that the email address I provide on this Application may be used by Blue Shield to contact me about my Blue Shield contract/policy. I understand that information sent to me by email could include important information about my coverage, renewal options, and any other information Blue Shield determines is relevant to my coverage. I consent to allow Blue Shield to contact me and/or any dependents covered on my contract/policy at the email I provide on this Application. _____ **Intial**

| Mailing address (if different from above) | | |
|---|---|---|
| Mailing city | Mailing state | Mailing ZIP |
| Billing address (if different from above) | | |
| Billing city | Billing state | Billing ZIP |
| Date of birth<br>___ ___ – ___ ___ – ___ ___ ___ ___<br>Month Day Year | Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____ | |

| Please check the plan type you are applying for:<br>☐ A ☐ Plan F Extra ☐ G ☐ G Extra ☐ N<br>Or are you choosing to stay in your current plan? ☐ Yes ☐ No | Requested effective date: The 1st day of<br>___ ___ – ___ ___ ___ ___<br>Month Year |
|---|---|

Medicare Beneficiary Identification (MBI) number

Blue Shield subscriber number

| Medicare hospital (Part A) effective date<br>___ ___ – ___ ___ – ___ ___ ___ ___<br>Month Day Year | Medicare (Part B) effective date<br>___ ___ – ___ ___ – ___ ___ ___ ___<br>Month Day Year |
|---|---|

## Household Savings Program[1]

If you and the other household member are age 65 and older and both members have, or are applying for, the same plan (including any dental/vision plans), you may be eligible for a 7% monthly savings on your combined medical plan dues when both members are enrolled in the same eligible plan. Both members must share the same home and mailing addresses. Tobacco users are not eligible for the Household Savings Program.

Is the other member of your household enrolled in, or applying for, the **same** Blue Shield Medicare Supplement plan that you are applying for and share both address types? ☐ Yes ☐ No

If "Yes," please provide the following information for the other household member:

Name

Beneficiary Identification (MBI) number

Blue Shield Medicare Supplement plan member ID (if available)

Please provide other household member's authorization to cancel their separate Blue Shield contract and enroll under the primary subscriber's agreement for the Household Savings Program by having the other household member sign at the end of the application.

**Each individual must complete their own new member application if not already a current member.** If both members are existing enrollees, the subscriber is determined based on which application is enrolled first. Otherwise the existing member already enrolled on the requested plan type will be designated as the subscriber.

The subscriber is responsible for payment of dues/premiums to Blue Shield and only the subscriber can make changes to the contract/policy. When enrolled under the Household Savings Program, Blue Shield will also accept payment of dues/premiums from the other household member enrolled on the plan. Billing information and amounts due can/will be shared with both parties enrolled on the plan when calling Customer Care.

## Dental PPO plans

**Dental plans and dental + vision package for Medicare Supplement plan members.**

Please see the page on **blueshieldca.com/medDental** for more information.

To sign up for Blue Shield dental coverage, select a plan below:

**Dental plan options (check one):**

☐ Specialty Duo℠ dental + vision package*

☐ Dental PPO 1000 ☐ Dental PPO 1500 ☐ No dental plan

**Please note that Plan G Extra includes a vision benefit. If you are interested in dental coverage and are also enrolling in Plan G Extra, please select the Dental PPO 1000 or Dental PPO 1500 plan to avoid duplicative coverage.**

**Conditions of coverage**

- Dental benefits aren't subject to health plan deductible requirements.
- If your dental or dental + vision coverage is cancelled for any reason (by you or by Blue Shield), you may apply for reenrollment, but you will have to wait six months to reapply.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). Specialty Duo package includes both Specialty Duo Dental Plan and Specialty Duo Vision Plan for Medicare Supplement plan members.

## Payment information

To determine the monthly dues amount, refer to Blue Shield's rate table included in the Medicare Supplement enrollment kit. Unless you currently participate in Easy$Pay[SM], you will receive a bill indicating the amount and the date your next payment is due.

**Please choose one of the following options below for ongoing billing and payments:**

☐ Quarterly billing ☐ Monthly billing

Save $3 a month by paying dues through automatic monthly debit from your checking or savings account using our Easy$Pay program[1]. To enroll, after receiving and paying for your first bill, register for and log into your Blue Shield account at **blueshieldca.com** and access the Payment Center tab. You may also call Customer Service at **(800) 248-2341** TTY: **711** 8 a.m - 5:30 Monday through Friday. Requests to enroll in the Easy$Pay program may take up to two billing cycles for completion. Members should pay all paper bills received until a letter confirming registration in the Easy$Pay program is received.

### Conditions of membership

**1** This transfer application will become part of the *Evidence of Coverage* for which I am applying, and together with any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.

**2** If I choose to enroll in a plan that goes up in value, I will not be covered by a Blue Shield Medicare Supplement plan unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.

**3** Only Blue Shield can approve this application. I understand that any insurance agent, broker, or sales representative cannot grant approval, change terms, or waive requirements.

**4** **I acknowledge receipt of the:**
**• Summary of Benefits • Rate table • The Guide to Health Insurance for People with Medicare**
**• A copy of this transfer application.**
**With my signature below, I represent that the information provided in this transfer application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage, the Household Savings Program, and the authorizations I have provided.**
**I have read the Summary of Benefits and the terms, conditions, and authorizations set forth above. I certify that I meet the eligibility requirements set forth in the Summary of Benefits. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.**

**5** I understand I may receive materials and communications electronically versus print: I may receive required benefit plan and coverage-related materials and communications via email and/or the Blue Shield website **blueshieldca.com**, as applicable. Obtaining a document electronically will confirm my consent to electronic delivery. I also have the right to obtain printed, mailed materials at any time and at no expense to me. To receive printed materials in the mail, to opt out of email communications, I can call **(800) 248-2341 TTY: 711** 8 a.m. – 5:30 P.m. Monday through Friday.

| **Applicant's signature** | **Date** |
|---|---|
| **Household member's signature (if applicable)** | **Date** |

## Producer information (For producer use only, if applicable)

FMO/Agency name _____
(please print appointed agency name)

FMO/Agency ID No. _____
(please print agency ID)

Producer (writing agent) name (required) _____
(please print writing agent name)

Producer (writing agent) SSN/TIN ID No. (required) _____
(please print agent ID number)

Producer email address _____

Producer fax number _____

Producer phone number _____

**Today's date (required)**

**Producer's signature (required)**

**Print name**

1 Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber.

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Producer fax number _____

Producer phone number _____

**Today's date (required)**

**Producer's signature (required)**

**Print name**

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