Waiver of Premium Claim Form for Blue Shield of California Life & Health Insurance Company (Blue Shield Life)

Send completed form to: Blue Shield Life, 4203 Town Center Blvd., El Dorado Hills, CA 95762, or call (888) 800-2742 for information.

Note: Please complete the entire claim form. This form cannot be processed if information is incomplete. Please print using black ink.

Statement of applicant

First name	M.I.	Last name	Telephone number ( )
Address (number, street, apartment)		City	State / ZIP
Birth date (mo/day/year)	Social Security number	Gender ☐ Male ☐ Female	Date hired / Last day at work
Date you became unable to work at your occupation as a result of illness or injury		Did disability result from employment? ☐ Yes ☐ No	

Have you been continuously disabled since you became unable to work? ☐ Yes ☐ No

If Yes, when can you resume your duties? If No, when did you become able to work?

Is your disability due to an ☐ Accident ☐ Illness? If an accident, describe the incident (including date and place). If illness, identify when the symptoms first appeared. (Attach explanation if more space is needed)

_____

_____

Authorization to obtain and release medical information

I hereby authorize any hospital, healthcare facility, physician and surgeon, or other health care professional to provide Blue Shield Life, its agents or employees, or independent administrators acting on its behalf, all information pertaining to any examination or treatment furnished to the above named patient or to any illness, injury, or condition the patient has had at any time in the past, or in the future up until the expiration of this authorization. I understand this information is collected in connection with claim(s) for insurance benefits and to determine eligibility for benefits. This authorization is valid for the term of coverage of the policy. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this form.

Signed _____ Dated _____, 20 _____

Important notice: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

Statement of group policyholder (employer)

Group policy number	Effective date of policy		
Date of hire	Job title		
Was the employee actively at work the day before disability? ☐ Yes ☐ No	Last date premium paid	Last day of work before disability	Hours worked per week
Workers' compensation carrier name and address			
Amounts of all insurance with Blue Shield Life		Class	
Employer's name	Employers representative and title		Telephone number ( )
Address	City	State	ZIP

Attachments

Important information – please attach: 1. Original enrollment 2. Copy of job description 3. Copy of employment application or resumé

Attending physician's statement (please print)

Name of claimant | Date of birth

Primary sickness or injury causing inability to work (describe complications, if any)

When did symptoms first appear/accident happen? | When did patient cease work because of disability?

Has patient ever had the same or similar condition? ☐ Yes ☐ No | If Yes, please explain

Date of first visit | Date of last visit | Frequency of visits ☐ Weekly ☐ Monthly ☐ Semi-annually ☐ Annually ☐ Other (please specify)

What progress is the patient making in regard to this condition? (check one) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed

Planned course of treatment (include expected duration, surgeries, etc.)

If patient was hospitalized, name of hospital

Address of hospital | City | State | ZIP

Date patient entered hospital | Date released from hospital (please attach operative reports and discharge summary)

Medical prognosis (please include any changes in physical and mental limitations and work activity restrictions)

When do you think patient can return to work? Anticipated date _____/_____/_____, or ☐ Unable to determine, follow up in _____ months

Remarks

In your opinion, is the patient a candidate for rehabilitation? ☐ Yes ☐ No

Remarks

Attending physician (please print)

Name (please print) | Telephone number ( )

Address | City | State | ZIP

Specialty/degree | Date

Signature | Taxpayer ID number

X _____