Conversion to Individual Coverage Request Form

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

Now that your group plan coverage is ending, you may be eligible for an individual conversion plan for you and your enrolled dependents. This coverage is available to you regardless of your age, physical condition, or employment status. Coverage under this plan will begin the day following termination of your group coverage, if this form and dues/premium payments are received within 63 days of termination of your group coverage. Thereafter, you will be billed directly for dues/premiums. **When filling out this application, please print in blue or black ink.** If you have any questions, call Blue Shield at **(800) 431-2809**.

Eligibility: If you and your enrolled dependents have been continuously covered for the three months immediately preceding the date of termination of coverage, **you and your enrolled dependents** are eligible to enroll in an individual conversion plan upon termination of group coverage, except as follows:

- Your group coverage is replaced with a similar group health service contract/policy within 15 days of the end of your coverage under the first group plan;
- Your coverage was terminated for good cause, fraud or misrepresentation, or for knowingly furnishing incorrect information or improperly obtaining benefits under the plan;
- You failed to pay dues/premiums due to the plan;
- You are eligible for or are covered by hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured;
- You are eligible for or are covered by Medicare; or
- You are covered for similar benefits under an individual policy or contract.
- If you enroll in a short-term health insurance plan, you are no longer eligible for the conversion plan.

Your application must be received within 63 days of termination of group coverage, or within 30 days of your transfer from another Blue Cross/Blue Shield plan outside of California.

Part I – Current coverage information

1. I am a Blue Shield of California HMO, POS, or PPO plan member. ☐ Yes ☐ No

2. I am a Blue Shield of California Life & Health Insurance Company (Blue Shield Life) PPO plan member. ☐ Yes ☐ No

3. I am transferring from a Blue Cross/Blue Shield Plan from another state. ☐ Yes ☐ No If yes, name state:

Date of termination of individual coverage: ______ / ______ / ____________

Date of termination of group coverage (including COBRA): ______ / ______ / ____________

Employer group name:

Current group number:

Current subscriber number:

Notice: Please consider enrollment in an Individual Conversion Plan carefully. Enrollment in an individual conversion plan will affect your ability to obtain guaranteed issue individual plan coverage under the Health Insurance Portability and Accountability Act (HIPAA). HIPAA guaranteed issue plans vary in benefits and rates compared to an individual conversion plan. HIPAA established guaranteed availability of individual coverage for certain eligible persons whose group coverage is ending. For HIPAA purposes, individual conversion coverage is not considered a group plan, so you could be denied coverage in the individual market at a later date if you elect conversion plan coverage now. Please call Blue Shield for more information regarding your eligibility for a HIPAA guaranteed issue plan.

An Independent Member of the Blue Shield Association

Part 2 – Applicant information

Applicant Social Security number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

First name	MI	Last name	
Home street address (no P.O. Box)			Apt. No.
City	County	State	ZIP Code
Billing address (if different from home address)			Apt. No.
City	County	State	ZIP Code
Mailing address (if different from home address)			Apt. No.
City	County	State	ZIP Code
Home phone No. ( )	Work phone No. ( )	Date of birth ___/___/_______	Age

☐ Female ☐ Male

Married: ☐ Yes ☐ No Domestic partner: ☐ Yes ☐ No

How would you like us to contact you? Blue Shield will use your preferred method when possible.

☐ Home telephone ☐ Work telephone ☐ E-mail ☐ Standard mail

May Blue Shield contact you via e-mail? ☐ Yes ☐ No E-mail address:

If you have been a prior Blue Shield of California or Blue Shield Life member, indicate your subscriber number: ___ ___ ___ ___ ___ ___ ___ ___ Date cancelled: ___/___/_______

Are you covered by or eligible for Medicare? ☐ Yes ☐ No	Are you covered by or eligible for other group coverage? ☐ Yes ☐ No	Are you covered by another individual plan? ☐ Yes ☐ No

Part 3 – Dependent Information (please list all family members you wish to cover)

Relationship	First name	MI	Last name	Social Security No.	Date of birth	Covered by or eligible for Medicare?	Covered by another insurance carrier? If yes, please list.
☐ Husband ☐ Wife				___ ___ ___-___ ___-___ ___ ___ ___	___/___/______	☐ Yes ☐ No	☐ Yes ☐ No
Domestic partner: ☐ Male ☐ Female				___ ___ ___-___ ___-___ ___ ___ ___	___/___/______	☐ Yes ☐ No	☐ Yes ☐ No
☐ Son ☐ Daughter				___ ___ ___-___ ___-___ ___ ___ ___	___/___/______	☐ Yes ☐ No	☐ Yes ☐ No
☐ Son ☐ Daughter				___ ___ ___-___ ___-___ ___ ___ ___	___/___/______	☐ Yes ☐ No	☐ Yes ☐ No
☐ Son ☐ Daughter				___ ___ ___-___ ___-___ ___ ___ ___	___/___/______	☐ Yes ☐ No	☐ Yes ☐ No
☐ Son ☐ Daughter				___ ___ ___-___ ___-___ ___ ___ ___	___/___/______	☐ Yes ☐ No	☐ Yes ☐ No

Part 4 – Billing options

If approved, I would like to pay my dues/premiums: ☐ Monthly ☐ Quarterly (every 3 months)

Part 5 – 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 reviewing your application for Blue Shield coverage.

Further, by signing this form, 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.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your and/or your dependents' eligibility for coverage and enrollment determinations upon receipt of this signed 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 services 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.

____________________________________ ____/____/________

Signature of applicant (on behalf of myself and all covered dependents) Today's date

Part 6 – Authorizations, terms and conditions

On behalf of myself and my enrolled dependents, I:

1. Understand that this Conversion to Individual Coverage Request Form enrolls me in an individual conversion plan, and agree, on behalf of myself and my enrolled dependents, to pay in advance applicable dues/premiums. Dues/premiums will be billed to me and will be due for a three (3) month or one (1) month cycle, unless an alternative billing option is selected.
2. Understand that my signature on this Conversion to Individual Coverage Request Form constitutes my agreement to the terms and conditions of the Individual Conversion Plan as described in the *Evidence of Coverage and Health Service Agreement/ Policy*, a copy of which shall be provided to me at the time of my enrollment and which is available upon request. This form, the *Evidence of Coverage and Health Service Agreement/Policy*, and any endorsements, appendices, and attachments thereto, collectively constitute the entire agreement between the parties. Any prior agreements, promises, negotiations, or representations relating to the subject matter of this agreement/policy not expressly set forth herein are of no force or effect.
3. Accept this individual conversion plan agreement/policy, on behalf of myself and my covered dependents, by making dues/premium payments to Blue Shield. Such acceptance renders all terms and provisions of this agreement/policy binding on Blue Shield.
4. Agree to cooperate with Blue Shield by providing, or providing access to, documents and other information that Blue Shield may request to corroborate the information provided on this form. Coverage may be rescinded or cancelled for failure to provide this information.

I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. I understand and agree to each of them. I alone am responsible for the accuracy and completeness of the information provided on this enrollment form for individual conversion plan coverage. I understand that neither I, nor my enrolled dependents, will be eligible for coverage if any information provided is false or incomplete, and that coverage may be revoked based on such finding.

____/____/____	____________________	____________________
Today's date	Signature of applicant (on behalf of myself and all covered dependents)	Print name

Please mail this application to:

Blue Shield of California
Installation and Membership
P.O. Box 629013
El Dorado Hills, CA 95762-9013