Blue Shield of California
An Independent Member of the Blue Shield Association

Blue Shield of California
Life & Health Insurance Company
An Independent Licensee of the Blue Shield Association

DISABILITY ADDENDUM

PRIOR CARRIER INFORMATION	NAME AND ADDRESS OF GROUP'S PREVIOUS CARRIER	GROUP/SECTION NUMBER - PREVIOUS CARRIER

Please advise of Special Contract Provisions such as:

1. Self-Funded Plan: ☐ Yes ☐ No
2. Transferred from an underwritten Blue Shield contract to self funded Blue Shield Plan: ☐ Yes ☐ No
3. Please indicate below if the subscriber/dependent was actually covered on the prior carrier's contract.
4. OED with Prior Carrier:

MO.	DAY	YR.

NOTE: THIS MUST BE SUBMITTED WITH YOUR NEW GROUP APPLICATION

SUBSCRIBER NAME	SUBSCRIBER BLUE SHIELD IDENTIFICATION NUMBER	NAME OF PERSON DISABLED/HOSPITALIZED	AGE	SEX		CHECK ONE	
				F	M	DISABLED /	HOSPITALIZED

NAME AND ADDRESS OF ATTENDING PHYSICIAN

BRIEF DESCRIPTION OF ILLNESS / INJURY* AND DATE OF ONSET

SUBSCRIBER NAME	SUBSCRIBER BLUE SHIELD IDENTIFICATION NUMBER	NAME OF PERSON DISABLED/HOSPITALIZED	AGE	SEX		CHECK ONE	
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NAME AND ADDRESS OF ATTENDING PHYSICIAN

BRIEF DESCRIPTION OF ILLNESS / INJURY* AND DATE OF ONSET

* If work related, Please advise.