Blue Shield of California
Blue Shield of California Life & Health Insurance Company
Dental plan, vision plan, and dental + vision package application

blue of california

This form is to be used by applicants applying for a Blue Shield dental plan, vision plan or IFP Specialty Duo dental + vision package. Please include first month's dues/premiums to avoid return of application.

You are eligible for any Individual and Family Plan (IFP) dental plan, vision plan or the Specialty Duo dental + vision package if you are a California resident at the time of enrollment. If you had any Blue Shield IFP dental or vision plan cancelled for any reason (by yourself or by Blue Shield), you must wait 6 months from date of cancellation before reapplying.

Part 1 – Coverage, plan, and applicant information

Reason for application: ☐ New enrollment ☐ Plan transfer ☐ Add dependent family member to existing coverage
Requested effective date: ____/____/_____

Dental plan, vision plan or dental + vision package options:

Dental Plans:

☐ Dental HMO Plan
☐ Enhanced Dental HMO $0
☐ Dental PPO Plan
☐ Enhanced Dental Plus PPO 25/500
☐ Enhanced Dental Plus PPO 50/1250
☐ Enhanced Dental PPO 25/500
☐ Enhanced Dental PPO 50/1250

Vision Plans:

☐ Ultimate Vision 15/25/150*,†

Vision + Dental Package:

☐ Specialty Duo (dental + vision) package*,†

Dental HMO applicants only – please choose a dentist from the Provider Directory at **blueshieldca.com**, or call **(800) 431-2809** for assistance.

Dental HMO provider name: _____ Dental HMO provider number: _____

* Pending regulatory approval.

† Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Part 2 – Primary applicant information

Applicant's Social Security number ___ ___ ___-___ ___-___ ___ ___ ___	Sex: ☐ Male ☐ Female	Date of birth (month/day/year) ____/____/_____	Married: ☐ Yes ☐ No Domestic partnership: ☐ Yes ☐ No
First name	MI	Last name	
Do you currently have dental coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Dental subscriber number (if applicable)	
Do you currently have medical coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Medical subscriber number (if applicable)	
Do you currently have vision coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Vision subscriber number (if applicable)	
Applicant's business phone number	Applicant's home phone number	Applicant's fax number	Applicant's cell number
Home address (**NO** P.O. box)			Apt No.
City	State		ZIP code
Billing address (if different from home address)			Apt No.
City	State		ZIP code
Applicant's mailing address (if different from home address)			Apt No.
City	State		ZIP code
List other name(s) used in past			
Applicant's Email address			Best time to contact ☐ AM ☐ PM

Preferred method of contact (check one): ☐ Home phone ☐ Work phone ☐ Cell phone ☐ Email ☐ Standard mail

Indicate language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

Part 3(a) – Spouse/domestic partner dependent applicant information

☐ Spouse ☐ Domestic partner Sex: ☐ Male ☐ Female

First name	MI	Last name	
Applicant's Social Security number ___ ___ ___-___ ___-___ ___ ___ ___		Date of birth (month/day/year) ____/____/_____	

Is the spouse/domestic partner applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

Part 3(b) – Child dependent applicant information

Dependent children must be under age 26. If more than (eight) child dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date. Check here if a supplemental page is attached. ☐

1. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number ___ ___ ___-___ ___-___ ___ ___ ___ | Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

2. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number ___ ___ ___-___ ___-___ ___ ___ ___ | Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

3. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number ___ ___ ___-___ ___-___ ___ ___ ___ | Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

4. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number ___ ___ ___-___ ___-___ ___ ___ ___ | Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

5. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number ___ ___ ___-___ ___-___ ___ ___ ___ | Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

6. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number ___ ___ ___-___ ___-___ ___ ___ ___ | Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

7. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number ___ ___ ___-___ ___-___ ___ ___ ___ | Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

8. ☐ Male ☐ Female | Relationship _____ (e.g. son/daughter)

First name | MI | Last name (if different from above)

Applicant's Social Security number ___ ___ ___-___ ___-___ ___ ___ ___ | Date of birth (month/day/year) ____/____/_____

Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state)

Part 4 – Authorizations, terms, and conditions

Please read the following terms and conditions carefully. Each applicant age 18 and older is required to review the completed application and provide their own authorization and signature. Keep a copy of this application for your records.

1. **Application for coverage:** I understand that Blue Shield has the right to decline my application for coverage. I also understand that I must be residing in California in order to be eligible for enrollment in this plan/package. I will notify Blue Shield upon any change regarding my eligibility for the dental plan, vision plan, or Specialty Duo dental + vision package. I also agree to provide information requested by Blue Shield to verify my eligibility or continued eligibility for coverage, and understand that failure to cooperate could result in cancellation of coverage.
2. **First month's dues/premiums:** Blue Shield requires first month's dues/premiums at the time of application submission. Find your estimated monthly dues/premiums in the rate book. Refer to part 6 for payment options. Failure to submit full payment of dues/premiums will result in a return of your application. Please note that processing of your payment does not constitute approval of your application with Blue Shield or Blue Shield Life. If you do not currently qualify for coverage, the dues/premiums you submit with your application will not be processed. [If you include a check, it will be destroyed. If you complete the payment authorization form, your credit card or checking account will not be debited.]
3. **Dues/premiums:** Dues/premiums are to be paid by the due date. Coverage will be terminated for failure to pay dues/premiums in a timely manner as set forth in the *Evidence of Coverage* and Health Service Agreement/Policy as allowed by law.
4. **Effective date of coverage:** If you qualify for coverage, Blue Shield will notify you of your effective date of coverage. If Blue Shield cannot honor your requested effective date or is unable to issue coverage before requested date, coverage will begin as soon as possible. If additional dues/premiums are owed, payment must be received before coverage becomes effective. Any charges incurred for services received prior to your effective date or after termination of coverage are not covered.
5. **Acceptance of application:** You understand that only Blue Shield can accept your application and issue coverage for an IFP plan requested on this form. Your agent or broker cannot enroll you for coverage or change any terms or conditions of coverage.
6. **Parents/guardians:** If you are the parent or legal guardian of an applicant who is a minor, please sign on behalf of the applicant at the bottom of this Part 4. As the parent or legal guardian, you are identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, you are agreeing to assume all responsibility for dues/premiums payments and for following the terms and conditions for coverage. If you are not the parent of the applicant, please attach court documents that appoint you as the guardian of this minor. Mark one of the following boxes and identify the individual authorized to act on behalf of the minor (applicant):
   - ☐ Parent or legal guardian _____ (include name and relationship); or
   - ☐ My designee _____ (include name and relationship); or
   - ☐ Qualified medical child support order designee _____ (include name and relationship); or
   - ☐ Mark this box if Blue Shield is to only make changes to the contract upon written request by the person identified above.
7. **Authorization for spouse/domestic partner to make changes:** If you are an applicant whose spouse/domestic partner is also applying for coverage, please specify if you authorize your spouse/domestic partner to make changes to the contract/policy on your behalf. You may discontinue this authorization at any time by sending a written request to Blue Shield. ☐ **Yes** ☐ **No**
8. **Authorization for your agent to provide/obtain information:** Check here if you do **not** authorize your insurance agent, broker, or producer (referred to as "your agent") to access all information on this application. ☐
9. **HIV or genetic testing prohibited:** No genetic information, including family medical history, and no information related to HIV testing should be provided. California law prohibits an HIV test from being required or used by a health insurance company or a healthcare service plan as a condition of obtaining health coverage.

I have reviewed all responses pertaining to me in this application. I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. With my own signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided. (Important: Each adult applicant must provide their own signature.) I understand that I must inform Blue Shield if anything changes or is different from what I listed on this application before my enrollment with Blue Shield begins.

Signature of applicant/parent or legal guardian	____/____/_____ Today's date	Print name (and your relationship if applicant is a minor)
Signature of applicant's spouse/domestic partner (if applying)	____/____/_____ Today's date	Print name
Signature of family member age 18 or over (if applying)	____/____/_____ Today's date	Print name
Signature of family member age 18 or over (if applying)	____/____/_____ Today's date	Print name
Signature of family member age 18 or over (if applying)	____/____/_____ Today's date	Print name (and your relationship if applicant is a minor)
Signature of family member age 18 or over (if applying)	____/____/_____ Today's date	Print name (and your relationship if applicant is a minor)
Signature of family member age 18 or over (if applying)	____/____/_____ Today's date	Print name (and your relationship if applicant is a minor)

Important: Return the application within 30 days of your date(s) and signature(s).

Part 5 - Producer information: to be completed by an authorized Blue Shield agent

1. Did you complete this application? ☐ Yes ☐ No

2. If yes, did you ask each question in this application exactly as set forth? ☐ Yes ☐ No

3. Are the answers recorded exactly as given to you? ☐ Yes ☐ No, attach explanation.

4. Do you want the Health Service Agreement/Policy sent directly to the subscriber? ☐ Yes ☐ No

Producer name			
Email address	☐ Update email	Producer number	
Telephone number ( )	☐ Update phone	Fax number ( )	☐ Update fax
Producer address			☐ Update address
City	State	ZIP code	
Super producer name	Super producer number		

Producer signature (required)	____/____/_____ Today's date (required)	Print name

Producers: Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information. Please fax or mail the completed and signed application to:

Please fax or mail the completed and signed application to:

Installation and Membership
Blue Shield of California
P.O. Box 3008
Lodi, CA 95241-1912
Fax: **(209) 367-6490**

For internal use only
DSA name: _____
DSA number: _____
Producer number: _____

Part 6 – Billing and payment information

Calculate estimate monthly dues/premiums

- Using the rate book, calculate your estimated rates or talk to your agent to get estimated rates.
- Initial or first month's dues/premiums are required at the time of application submission.
  - You can enroll in Easy$Pay℠ where automatic payments are handled via electronic transfer through your checking or savings account for the first month's dues/premiums and for ongoing payments.
  - [If you are mailing your application, you can also pay the first month's dues/premiums by stapling a personal check or money order to your application in an amount equal to the dues/premiums for one month, payable to Blue Shield.]
  - [[Or you] [You]] can pay the initial first month's dues/premiums by credit card.
- Blue Shield will issue final rate before any effective date of coverage. If the final rate differs from the estimated rate and additional amounts are owned, payment must be received before coverage will take effect.

Payment options:

Dues/premiums payment is required with your application. Please select Option 1 or 2.

☐ **Option 1:** Automatic payment through checking or savings account – Easy$Pay for initial and ongoing payments
Payment date: ☐ 1st of month ☐ 15th of month (Note: If you do not select a payment date, the default will be the 1st of the month. Dental DHMO must use 1st of the month

☐ **Option 2:** Please choose one of the options below for both: 1) your initial payment, and 2) for ongoing payments

Initial payment with application:

☐ By automatic payment through checking or savings account – Easy$Pay. [(complete section A)] Payment date: 1st of the month
[☐ By check* (only if application is mailed)]
☐ By credit card [(complete section B)]

Ongoing payments:

☐ By automatic monthly payment through checking or savings account – Easy$Pay. [(complete section A)] Payment date: ☐ 1st of month ☐ 15th of month (Note: If you do not select a payment date, the default will be the 1st of the month. Dental HMO must use 1st of the month.
☐ Monthly billing

[* When you provide a check as payment, you authorize Blue Shield either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date we approve your application and you will not receive your check back from your financial institution.]

Part 7 –Payment Authorization form

Applicant information

Applicant name		
Mailing address		Apt. No.
City	State	ZIP code
Applicant's daytime phone number ( )		

Method of payment

A. Easy$Pay debit: ☐ Checking account ☐ Savings account

Payment date: ☐ 1st of month ☐ 15th of month (Note: If you do not select a payment date, the default will be 1st of the month. Dental HMO must use 1st of the month.)

Payment frequency: ☐ Monthly

Bank routing/transit number		
Bank account number		
Name(s) on bank account		
Name of financial institution		
Branch address		
City	State	ZIP code
Branch telephone number ( )		

B. Credit card (Visa or MasterCard only) – For initial payment only

Cardholder name		
Cardholder billing address		Apt. No.
City	State	ZIP code
Credit card number		
Card type: ☐ Visa ☐ MasterCard	Expiration date (mm/yyyy) ____/_____	

Authorization and signature(s)

Automatic payment by debit from checking/savings account:
I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to initiate debits (and/or make corrections to previous debits, as necessary) to the bank account identified on this form on the payment date (or within 2 to 3 days before or after the payment date) and with the frequency set forth above for the purpose of payment of the monthly dues/premiums owed for myself and any family members covered by Blue Shield. I also authorize my financial institution to reduce the balance of my account by the amount of such debits (and/or corrections to previous debits). I will maintain sufficient collected funds in my account for the full amount of each payment. If the automatic debit transaction ever fails (e.g., no funds are available), Blue Shield will mail a bill to me at my address on record and I will be responsible for making my payment by check or money order, along with a return item service charge.

Additional information if paying initial dues/premiums only by credit card:
If only the first month's dues/premiums box is checked, this authorization is only valid to charge the initial or first month's dues/premiums owed to Blue Shield. I understand my credit card will be charged for the first month's dues/premiums if my application is approved.

Notice to change/cancel required:
I I will continue to be debited/charged the amount of dues/premiums owed until I cancel this Automatic Payment authorization. upon at least (10) calendar days notice before a debit/charge is to occur. To cancel this automatic payment authorization, or if there are changes to my account being debited/charged, I must contact Customer Service at **(800) 431-2809**. Blue Shield may cancel this authorization at any time upon notice to me.

By signing below, I agree to the terms and conditions of this authorization form and I acknowledge that I have received a copy of this form. I acknowledge that all payment transactions must comply with the provisions of U.S. law. I will make payments by check or money order until my automatic payment service has been activated.

Cardholder/Account holder signature	Print Name
____ ____ ____ – ____ ____ – ____ ____ ____ ____ Social Security number	____/____/_____ Date
Cardholder/Account holder signature	Print Name
____ ____ ____ – ____ ____ – ____ ____ ____ ____ Social Security number	____/____/_____ Date