Blue Shield of California Life & Health Insurance Company
Application for Individual Term Life Insurance Coverage

Facing financial burdens after the loss of a loved one can be overwhelming and having life insurance can help. Individual term life insurance plans from Blue Shield of California Life & Health Insurance Company (Blue Shield Life) can help safeguard the future of the significant people in your life – your spouse, partner, or children – by providing critical financial protection you can use to cover living expenses, college education costs, mortgage payments, and more. Take a step toward safeguarding the financial future of those you care about by applying for coverage from Blue Shield Life.

We offer the financial protection and security of $10,000, $30,000, $60,000, $90,000, and $100,000 in term life insurance with low monthly rates based on your age.

Available Coverage Amounts*

Age range	$10,000	$30,000	$60,000	$90,000	$100,000
1 to 18†	$1.95	$2.95	N/A	N/A	N/A
19 to 29	$2.75	$5.35	$9.25	$13.15	$14.45
30 to 39	$3.05	$6.25	$11.05	$15.85	$17.45
40 to 49	$5.85	$14.65	$27.85	$41.05	$45.45
50 to 59	$13.85	$38.65	$75.85	$113.05	$125.45
60 to 64	$20.45	$58.45	$115.45	$172.45	$191.45

* Individual term life insurance is available to applicants ages 1-64. All plans terminate at age 65.

† Those under age 19 are not eligible for $60,000, $90,000, or $100,000 amounts of coverage.

Application Notice

Thank you for applying for insurance with Blue Shield Life.

As a part of the normal procedure of processing the application, information concerning the applicant(s) may be obtained for the purpose of determining insurability.

During the approval process, Blue Shield Life may collect personal information from persons other than the applicant, and you have a right of access and correction with respect to all personal information collected. A complete notice of information practices will be furnished upon request.

Information regarding your insurability will be treated as confidential. Blue Shield Life or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, Inc. ("MIB"), a not-for-profit membership organization of life insurance companies which operates as an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the Bureau, upon request, will supply such company with the information contained in its file.

Upon receipt of your request, the Bureau will arrange disclosure of any information it contains in your file. If you question the accuracy of this information, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, MA 02112, and the telephone number is (617) 426-3660.

For questions regarding this application, please contact (**888) 256-3650**.

Mail the completed forms to:

Blue Shield of California Life & Health Insurance Company
c/o HOVIN Underwriting Partners, Inc.
P.O. Box 249
Simsbury, CT 06070

Be sure to retain a copy of this application packet for your records.

Blue Shield of California Life & Health Insurance Company
Application for Individual Term Life Insurance Coverage

blue of california

This form is to be used by new enrollees who are applying for Blue Shield of California Life & Health Insurance Company (Blue Shield Life) term life insurance coverage, or for existing members to add a spouse/domestic partner or a dependent child, or to increase an existing level of coverage.
The effective date of coverage will be the first of the month following approval of the application. This form must be completed in black or blue ink.

Part 1 – Coverage, premium, and applicant/dependent information

Reason for application: ☐ New enrollment ☐ Add a dependent ☐ Increase my existing Blue Shield Life coverage
(Please provide your current level of coverage: $ _____)

The available term life coverage amounts and the eligible age ranges are as follows:
$10,000 (Ages 1-64) $30,000 (Ages 1-64) $60,000 (Ages 19-64) $90,000 (Ages 19-64) $100,000 (Ages 19-64)

Applicant information

First name	MI	Last name	Coverage amount requested $ _____

Applicant's Social Security number ___ ___ ___-___ ___-___ ___ ___ ___	Blue Shield Subscriber ID (if applicable)	☐ Male ☐ Female	Date of birth (mo/day/yr) ____/____/_____	State of birth	Height	Weight

Occupation	Base annual earnings	Total in force life insurance coverage	Email address

Home or mailing address	Apt No.

City	State	ZIP code

Home phone number	Cell phone number

If the applicant is a dependent (spouse/domestic partner or child) being added to an existing member, please provide the following information about the existing member:

Applicant's relationship to existing member: ☐ Spouse ☐ Domestic partner (check one): ☐ Male ☐ Female or ☐ Son ☐ Daughter

Existing member's first name	MI	Last name (if different from above)	SSN or Blue Shield Subscriber ID

Part 2 – Health questionnaire

Check Yes or No for each of the questions below. For any questions which are answered "Yes," provide details in Part 3. If you are not sure about an answer, your physician will be able to provide you with this information.

Question	Check Yes or No
1. Have you been diagnosed with or treated for any of the following conditions? Include all prescribed medications that you are currently taking in Part 3.	☐ Yes ☐ No
A. Heart or artery disorder, heart attack, arthritis, tuberculosis, liver disorder, kidney trouble, lung or other respiratory disorder, liver, stomach or intestine disorder?	☐ Yes ☐ No
B. High blood pressure? If yes, last 2 readings and dates:	☐ Yes ☐ No
C. Diabetes? Age of onset?_____ How controlled?	☐ Yes ☐ No
D. Cancer (including melanoma), leukemia, malignant growth, or any form of tumor?	☐ Yes ☐ No
E. Epilepsy or any mental/nervous disorder?	☐ Yes ☐ No
F. Paralysis or stroke?	☐ Yes ☐ No
G. Alcoholism, drug, or substance abuse?	☐ Yes ☐ No
H. Acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), or HIV?	☐ Yes ☐ No
I. Hepatitis or any sexually transmitted disease?	☐ Yes ☐ No
2. Other than the conditions listed above, have you within the past three years had any physical disorder not listed above?	☐ Yes ☐ No
3. Are you under observation or receiving treatment, or has future surgery, treatment, hospitalization, testing, or evaluation been recommended?	☐ Yes ☐ No
4. Have you ever smoked or used tobacco? Packs a day? _____ How many years? _____ If stopped, when?_____	☐ Yes ☐ No
5. Have you ever been denied life or health insurance? If yes, give date and reason.	☐ Yes ☐ No
6. Have you been convicted of three or more moving violations within the past three years, or have you ever been convicted of driving under the influence of alcohol or drugs? If yes, provide details, as well as your driver's license number and state of issuance in Part 3.	☐ Yes ☐ No
7. Have you participated in, or intend to participate in, any potentially hazardous sports or hobbies, such as mountain climbing, scuba diving, sky diving, or vehicle racing (includes auto, motorcycle, boat, or other)?	☐ Yes ☐ No
8. Do you have existing life insurance coverage? If Yes, provide the coverage amount: $ _____ If this application will replace any existing life insurance coverage with this or any other carriers, complete the attached Acknowledgement of Life Insurance Replacement Coverage form.	☐ Yes ☐ No

Part 3 – Provide details of all "yes" answers given to questions in Part 2 – Health questionnaire

If additional space is required, attach a separate signed and dated sheet.

Question #	Details, e.g.: Illness/reason for checkup or doctor's treatment/ consultation; prescribed medications you are currently taking; driver's license number and state of issuance	Dates From To	Full name and complete address of attending physician or other practitioner

Part 4 – Designate your beneficiaries

Primary beneficiary – Blue Shield Life will pay the life insurance benefits to the primary beneficiary, and you may designate more than one primary beneficiary. Please show percentages for each primary beneficiary in the "% of benefits" column to total 100% of benefits. If the percentage information is not included, the benefits will be distributed equally to those primary beneficiaries who survive you. To designate more than two primary beneficiaries, attach a separate signed and dated sheet to this application.

First name	MI	Last name
Relationship to applicant		% of benefits
Home or mailing address, City, State, ZIP code		
Social Security number ___ ___ ___ -___ ___ -___ ___ ___ ___		Date of birth (month/day/year) ____/____/_____
First name	MI	Last name
Relationship to applicant		% of benefits
Home or mailing address, City, State, ZIP code		
Social Security number ___ ___ ___ -___ ___ -___ ___ ___ ___		Date of birth (month/day/year) ____/____/_____

Contingent beneficiary – Blue Shield Life will pay the life insurance benefits to a contingent beneficiary only if no primary beneficiary survives the applicant.

First name	MI	Last name
Relationship to applicant		% of benefits
Home or mailing address, City, State, ZIP code		
Social Security number ___ ___ ___ -___ ___ -___ ___ ___ ___		Date of birth (month/day/year) ____/____/_____

If beneficiary is a Trust or Corporation, please provide name and date of trust agreement and state of incorporation.

Name of Trust/Corporation	Date of Trust	State of incorporation

COMMUNITY PROPERTY LAWS – If you are married or in a domestic partnership, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin), and name someone other than your spouse/domestic partner as beneficiary, it is possible that payment of benefits will be delayed or disputed unless your spouse/domestic partner also signs the beneficiary designation.
I agree to the above-stated beneficiary designation(s).

Spouse/domestic partner signature	Print name	Date signed

Part 5 – Agreements and authorization, terms and conditions

Please read the following terms and conditions carefully. Your authorization and signature is required below.

I have read and agree that the above statements are complete, true, and correctly recorded to the best of my knowledge and belief. Further, I understand that Blue Shield Life shall not be liable for any claim on account of death or disability occurring or arising prior to the date of approval of this application at the Home Office of the Company.

I hereby authorize Blue Shield Life or its reinsurers to make a brief report on the statements herein to the Medical Information Bureau, Inc. ("MIB"), a not-for-profit membership organization of life insurance companies which operates as an information exchange on behalf of its members. Blue Shield Life or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits has been submitted.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the MIB, or investigative reporting services that has any records or knowledge of me or my health, to give to Blue Shield Life or its reinsurers any such information, including drug or alcohol use or abuse, mental illness, AIDS, or other sexually transmitted diseases. This authorization is valid for 30 months from the date it is signed.

I agree that a photocopy of this authorization shall be as valid as the original. I acknowledge that I have received the Application Notice which precedes this application form and understand that coverage will not become effective until the first of the month following date of approval. I understand that failure to completely and correctly disclose my medical history will result in coverage being voided from the approval date of coverage.

THIS SECTION MUST BE COMPLETED BEFORE YOUR APPLICATION CAN BE PROCESSED. KEEP A COPY OF THIS APPLICATION FOR YOUR RECORDS.
I have reviewed all responses pertaining to me in this application, I have read the agreements and authorization, and terms and conditions 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. (Important: Each adult applicant must provide their own signature.)

Signature of applicant (parent/guardian if applicant is a minor)	Today's date (required)	Print name (and your relationship if applicant is a minor)
	____/____/_____	

Blue Shield of California Life & Health Insurance Company
Payment Authorization Form for Individual Term Life Insurance Coverage

Payment authorization

Payment information is required with your application for your first month's premium. In the event that you are not approved for coverage, your credit card will not be charged. If you are approved, your payment will be processed and you will be billed monthly for ongoing payments, which will be due the 1st of the month.

Please complete this form in black or blue ink.

Credit Card ☐ VISA ☐ MasterCard

Cardholder name	Cardholder billing address

Credit card number	Expiration date

I authorize Blue Shield of California Life & Health Insurance Company ("Blue Shield") to charge (and/or apply credits, if correcting errors to previous charges) the credit card identified on this form for the initial payment of premium. If the credit card transaction fails (e.g., over limit, expired), my enrollment will be delayed until such time that the initial payment can be processed successfully. This authorization is only valid to charge the first month's premium owed to Blue Shield.

Signature of applicant (parent/guardian if applicant is a minor)	Today's date (required)	Print name (and your relationship if applicant is a minor)

Additional Contact Designation Form:
Notice of Lapse or Termination of Life Insurance Policy for Non-Payment of Premium

Blue Shield Life will send you a notice of lapse or termination of your life insurance policy if your life insurance premium is not paid. This notice will be mailed to you at least 30 days prior to the termination of your policy. You have the right to designate an additional contact person(s) to receive these notices. If you do not wish to specify an additional contact person(s) at this time, no action is required.

Blue Shield will send you an annual reminder of your right to designate an additional contact person(s) to be notified in the event of a lapse or termination of your life insurance policy. Be advised, however, that you have the right to designate, update, or remove an additional contact person(s) at any time by calling Customer Service at **(888) 800-2742**.

☐ I would like to make a designation of an additional person(s) to receive the 30-day notice of lapse or policy termination from Blue Shield Life.

Contact Person #1

First name:	Last name:	Phone number:

Mailing address:	City:	State:	ZIP code:

Contact Person #2

First name:	Last name:	Phone number:

Mailing address:	City:	State:	ZIP code:

Signature of applicant (parent/guardian if applicant is a minor)	Date

Blue Shield of California Life & Health Insurance Company
Acknowledgement of Life Insurance Replacement Coverage

All applicants applying for term life insurance must complete this form. Please complete and submit **a copy of this form** along with the Application for Individual Term Life Insurance Coverage, Payment Authorization Form for Individual Term Life Insurance Coverage, Producer Information Form for Term Life Insurance (if applicable), and the Additional Contact Designation Form. **You must keep the original signed form.**

This form must be completed in black or blue ink.

Part 1 – Disclosure of existing life insurance policy (this section to be completed by the applicant)

Applicant's first name (please print)	Applicant's last name (please print)	Date of birth (mm/dd/yyyy):
		____/____/_____

Are you purchasing life insurance to replace an existing life insurance policy?
☐ Yes, I am replacing an existing life insurance policy (Complete Part 2 (if applicable), Part 3, and Part 4)
☐ No, I am not replacing an existing life insurance policy (Sign Part 1 only, skip Parts 2, 3, 4)

Signature of applicant (parent/guardian if applicant is a minor)	First name (please print)	Last name (please print)

Part 2 – Agent declaration

If your Blue Shield Life life insurance coverage is being purchased through an agent, the agent must complete and sign this section.

I, _____(print agent name), acknowledge that an individual life insurance replacement is or may be involved in the transaction for my client, named above, to obtain individual life insurance from Blue Shield of California Life & Health Insurance Company.

Agent signature | Date signed

Part 3 – Notice regarding replacement

If you are thinking about replacing an existing life insurance policy, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing benefits and the proposed benefits. Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it. Hear both sides before you decide. This way, you can be sure you are making a decision that is in your best interest.

We are required by law to notify your existing company that you may be replacing their policy.

Signature of applicant (parent/guardian if applicant is a minor) | Today's date (required) ___/___/___ | Print name (and your relationship if applicant is a minor)

Part 4 – Existing life insurance policy information

If you answered "Yes" in Part 1 above, please provide existing life insurance policy information below:

Existing life insurance company name	Address, city, state, ZIP	Contract/policy number*	Coverage amount

* If no contract or policy number has been assigned by the existing insurer, list alternative identification, such as an application number or receipt number.

Blue Shield of California Life & Health Insurance Company
Producer Information Form for Term Life Insurance Coverage
(To be completed by the producer only when purchasing coverage through 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? If No, provide explanation:	☐ Yes ☐ No
4. Do you want the policy sent directly to the applicant?	☐ Yes ☐ No

Producer information

Producer name		Producer number	
Email address			☐ Update email
Telephone number ( )	☐ Update phone	Fax number ( )	☐ Update fax
Producer address line 1			☐ Update address
Producer address line 2			
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 or its authorized representatives may contact your applicant directly to obtain complete information.

Mail the completed application to: Blue Shield of California Life & Health Insurance Company
c/o HOVIN Underwriting Partners, Inc.
P.O. Box 249
Simsbury, CT 06070