blue of california

LIST BILL TRANSMITTAL FORM

Thank you for your interest in our List Billing option.

To qualify for a List Bill option, three or more individual subscribers must be included.

Please complete the following information and return a signed Agreement for Payment form for each Subscriber listed below that is to be included in the List Bill. **Please note that participation in Blue Shield's List Billing option requires that premiums be paid in advance.**

Requested Effective Date: (must be first day of the month) _____

Producer Name: _____Producer Phone: _____

Address: _____Producer No: _____

_____

Designated Administrator/Employer Group: _____

Contact Person:_____ Phone #:_____

Billing Address: _____

_____

List Bill Account # _____(If a list bill is already established for this administrator)

Subscriber Name	Subscriber ID Number

Please copy this form for additional Subscribers.

Please return forms to:
Blue Shield of California
IFP List Bill Team
P.O. Box 3008
Lodi, CA 95241-1912

Fax: (855) 808-8591