INDIVIDUAL AND FAMILY HEALTH PLANS
Blue Shield of California and
Blue Shield of California Life & Health Insurance Company

blue of california

APPLICATION FOR BLUE SHIELD INDIVIDUAL AND FAMILY HEALTH PLANS

Application must be typed or completed in blue or black ink. Please make sure you answer all questions as completely and accurately as possible and initial any changes/corrections you may have to make. Fully completing the application will help avoid a delay in processing or possible return of the application. Submit ALL pages, 1 through 12, as your complete application. Call Blue Shield at (800) 431-2809 or contact your agent for help filling out the application or for the address of where to send the application.

MARKET CODE (PRODUCER USE ONLY)

REASON FOR APPLICATION ☐ New enrollment ☐ Plan Transfer ☐ Add family member to existing coverage

PART 1 – APPLICANT INFORMATION: Indicating the younger spouse/domestic partner as the primary applicant may reduce your monthly dues/payments.

Applicant's Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___

First name | MI

Last name

☐ Male ☐ Female

Married: ☐ Yes ☐ No

Domestic Partner: ☐ Yes ☐ No

Date of Birth (Mo/Day/Yr) _____/_____/_____

Height (ft. in.)

Weight (lbs.)

Choose health plan (check one box only):

Active Start Plans*
☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx

Access+ Plans ☐ HMO ☐ Value HMO

Balance Plans* ☐ 1000 ☐ 1700 ☐ 2500

Essential Plans* ☐ 1750 ☐ 3000 ☐ 4500

Shield Spectrum PPO Plans
☐ PPO Plan 500 ☐ PPO Plan 1500
☐ PPO Plan 750 ☐ PPO Plan 2000
☐ PPO Plan 5000*
☐ Blue Shield Life PPO Plan 1500*
☐ Blue Shield Life PPO Plan 2000*

Shield Savings Plans
☐ 1800/3600*
☐ 2400/4800
☐ 3500*
☐ 4000/8000*
☐ 5200*

Vital Shield Plans*
☐ 900 ☐ 2900

Vital Shield Plus Plans*
☐ 400 ☐ 400 Generic Rx
☐ 900 ☐ 900 Generic Rx
☐ 2900 ☐ 2900 Generic Rx

HMO only (visit blueshieldca.com to find a provider):
Personal Physician Name: _____
Provider #:
Med.Group/IPA #:
☐ Check if Current Patient

If applying for Guaranteed Issue ONLY, complete Parts 1-3, 8-11 only. See Part 11 for more information on Guaranteed Issue plans.

☐ Please check here if not interested in a Guaranteed Issue plan.

Payment options: ☐ Easy$Pay (complete page 12) ☐ Credit Card (complete page 12) ☐ Monthly Direct Billing ☐ Quarterly Direct Billing

Applicant's business phone # ( ) | Applicant's home phone # ( ) | Applicant's fax # ( )

Other name(s) under which you've received care | Existing subscriber #

Have you been a resident of California for the past six months? ☐ Yes ☐ No If no, where was your last residence? _____
If no, medical records documenting a complete physical exam by a California physician, within the last six months, may be required.

Home Address (no P.O. Box)

City | State | ZIP Code -

County of residence

Billing Address (if different from above)

City | State | ZIP Code -

Mailing Address (if different from home address)

City | State | ZIP Code -

Applicant's Occupation	Employer and employer's address	City	State	ZIP Code
Spouse/Domestic Partner's Occupation	Employer and employer's address	City	State	ZIP Code

To help us serve you better in the future, please indicate your language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other:

Please check your preferred method of contact:
☐ Home telephone ☐ Work telephone ☐ E-Mail ☐ Standard mail

Applicant's E-Mail Address

If you have been a Blue Shield member, indicate prior Blue Shield #:

Date cancelled (MO/DAY/YR) _____/_____/_____

Do you want your effective date to coordinate with the termination date of your short-term health insurance?
☐ Yes ☐ No ☐ N/A Short-term health termination date _____/_____/_____

Requested effective date
(see Part 10, Item 5 for instructions) _____/_____/_____

*Underwritten by Blue Shield of California Life & Health Insurance Company.

Applicant's Social Security Number
____ ____ ____ - ____ ____ - ____ ____ ____ ____

PART 2 – SUPPLEMENTAL PLAN CHOICES

You may also purchase a dental plan and/or life insurance to supplement your medical coverage. **PLEASE NOTE:** Guaranteed Issue plans are not eligible for life insurance coverage options.

Dental plan options (check one): ☐ Dental HMO (DHMO) ☐ Dental PPO (DPPO) ☐ Value Smile PPO ☐ No dental plan
If Dental HMO (visit **blueshieldca.com** to find a dental provider or for questions call (800) 431-2809):
Dental Provider name: ______________________________ Dental Provider #: |__|__|__|__|__|__|

Life Insurance options* (check one): Applicants under the age of one year are not eligible for life insurance. These options apply only to the primary applicant.
Child applicants can apply for up to a $30,000 Life Insurance option and Spouse/domestic partner can apply for up to a $90,000 Life Insurance option in Part 3 of this application.
☐ $10,000 (applicants ages 1-64) ☐ $30,000 (applicants ages 1-64) ☐ $60,000 (applicants ages 19-64) ☐ $90,000 (applicants ages 19-49) ☐ No Life Insurance
Beneficiary information applies only to the primary applicant. If you have not indicated a beneficiary, and the policy is issued, death benefits will be paid in accordance with the policy. The percentage indicated must total 100%.
Beneficiary: ____________________ Relationship__________ Age______ City/St____________________ (%)______
Beneficiary: ____________________ Relationship__________ Age______ City/St____________________ (%)______

Bridge Plan* (hospital insurance indemnity rider) ☐ (available for Shield Savings 3500, 4000/8000, and 5200)

* Underwritten by Blue Shield of California Life & Health Insurance Company.

PART 3 – DEPENDENT INFORMATION – List all family members you wish to cover. Dependent children must be under age 19, or under age 23 if full-time students and not married or in a domestic partnership. Please note: if you consider a separate medical plan for your dependents, your dependents are eligible to select any dental or life insurance plan listed below. Dependents will be considered the primary applicant for each new plan selected.

For HMO only, select a Personal Physician for each family member from the Blue Shield HMO Physician and Hospital Network for your service area. For questions, call **(800) 424-6521**. For Dental HMO: select a Dental Provider from the Dental HMO Dental Provider Directory. For questions regarding your Dental Provider selection, call **(800) 431-2809**. Visit **blueshieldca.com** to find a Personal Physician or Dental Provider.

Relation	Sex	First name	MI	Last name	Social Security Number	Date of Birth	Height (ft.in.)	Weight (lbs.)
☐ Spouse ☐ Domestic partner	☐ M ☐ F				___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____		

HMO plans only: Personal physician name: Provider #: |_|_|_|_|_|_|_|_|_| Med.group/IPA #: |_|_|_|_|_|_|_|_| Check if current patient ☐

Consider my spouse/domestic partner for a separate plan ☐ **Choose plan (check 1 box only):** **Access+ Plan:** ☐ Value HMO ☐ HMO **Balance Plan:** ☐ 1000 ☐ 1700 ☐ 2500
Essential Plan: ☐ 1750 ☐ 3000 ☐ 4500 **Vital Shield:** ☐ 900 ☐ 2900 **Vital Shield Plus:** ☐ 400 ☐ 400 Generic Rx ☐ 900 ☐ 900 Generic Rx ☐ 2900 ☐ 2900 Generic Rx
PPO Plan: ☐ 500 ☐ 750 ☐ 1500 ☐ 2000 ☐ 5000 **Shield Savings:** ☐ 1800 ☐ 2400 ☐ 3500 ☐ 4000 ☐ 5200 **Active Start Plan:** ☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx
Bridge Plan: ☐ (available for Shield Savings 3500, 4000, and 5200)
Dental Coverage: ☐ HMO ☐ PPO ☐ Value Smile PPO ☐ No dental plan **Dental HMO only**: Dental provider #: |_|_|_|_|_|_| Dental provider name: ____________________
Optional Life Insurance: ☐ $10,000 ☐ $30,000 (applicants ages 1–64) ☐ $60,000 (applicants ages 19–64) ☐ $90,000 (applicants ages 19-49)
Beneficiary ________________________________

Relation	First name	MI	Last name	Social Security Number	Date of Birth	Height	Weight
☐ Son ☐ Daughter				___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____		

HMO plans only: Personal physician name: Provider #: |_|_|_|_|_|_|_|_|_| Med.group/IPA #: |_|_|_|_|_|_|_|_| Check if current patient ☐

Consider my child for a separate plan ☐ **Choose plan (check 1 box only):** **Access+ Plan:** ☐ Value HMO ☐ HMO **Balance Plan:** ☐ 1000 ☐ 1700 ☐ 2500
Essential Plan: ☐ 1750 ☐ 3000 ☐ 4500 **Vital Shield:** ☐ 900 ☐ 2900 **Vital Shield Plus:** ☐ 400 ☐ 400 Generic Rx ☐ 900 ☐ 900 Generic Rx ☐ 2900 ☐ 2900 Generic Rx
PPO Plan: ☐ 500 ☐ 750 ☐ 1500 ☐ 2000 ☐ 5000 **Shield Savings:** ☐ 1800 ☐ 2400 ☐ 3500 ☐ 4000 ☐ 5200 **Active Start Plan:** ☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx
Bridge Plan: ☐ (available for Shield Savings 3500, 4000, and 5200)
Dental Coverage: ☐ HMO ☐ PPO ☐ Value Smile PPO ☐ No dental plan **Dental HMO only**: Dental provider #: |_|_|_|_|_|_| Dental provider name: ____________________
Optional Life Insurance: ☐ $10,000 ☐ $30,000 Beneficiary ________________________________

Relation	First name	MI	Last name	Social Security Number	Date of Birth	Height	Weight
☐ Son ☐ Daughter				___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____		

HMO plans only: Personal physician name: Provider #: |_|_|_|_|_|_|_|_|_| Med.group/IPA #: |_|_|_|_|_|_|_|_| Check if current patient ☐

Consider my child for a separate plan ☐ **Choose plan (check 1 box only):** **Access+ Plan:** ☐ Value HMO ☐ HMO **Balance Plan:** ☐ 1000 ☐ 1700 ☐ 2500
Essential Plan: ☐ 1750 ☐ 3000 ☐ 4500 **Vital Shield:** ☐ 900 ☐ 2900 **Vital Shield Plus:** ☐ 400 ☐ 400 Generic Rx ☐ 900 ☐ 900 Generic Rx ☐ 2900 ☐ 2900 Generic Rx
PPO Plan: ☐ 500 ☐ 750 ☐ 1500 ☐ 2000 ☐ 5000 **Shield Savings:** ☐ 1800 ☐ 2400 ☐ 3500 ☐ 4000 ☐ 5200 **Active Start Plan:** ☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx
Bridge Plan: ☐ (available for Shield Savings 3500, 4000, and 5200)
Dental Coverage: ☐ HMO ☐ PPO ☐ Value Smile PPO ☐ No dental plan **Dental HMO only**: Dental provider #: |_|_|_|_|_|_| Dental provider name: ____________________
Optional Life Insurance: ☐ $10,000 ☐ $30,000 Beneficiary ________________________________

Relation	First name	MI	Last name	Social Security Number	Date of Birth	Height	Weight
☐ Son ☐ Daughter				___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____		

HMO plans only: Personal physician name: Provider #: |_|_|_|_|_|_|_|_|_| Med.group/IPA #: |_|_|_|_|_|_|_|_| Check if current patient ☐

Consider my child for a separate plan ☐ **Choose plan (check 1 box only):** **Access+ Plan:** ☐ Value HMO ☐ HMO **Balance Plan:** ☐ 1000 ☐ 1700 ☐ 2500
Essential Plan: ☐ 1750 ☐ 3000 ☐ 4500 **Vital Shield:** ☐ 900 ☐ 2900 **Vital Shield Plus:** ☐ 400 ☐ 400 Generic Rx ☐ 900 ☐ 900 Generic Rx ☐ 2900 ☐ 2900 Generic Rx
PPO Plan: ☐ 500 ☐ 750 ☐ 1500 ☐ 2000 ☐ 5000 **Shield Savings:** ☐ 1800 ☐ 2400 ☐ 3500 ☐ 4000 ☐ 5200 **Active Start Plan:** ☐ 25 ☐ 25 Generic Rx ☐ 35 ☐ 35 Generic Rx
Bridge Plan: ☐ (available for Shield Savings 3500, 4000, and 5200)
Dental Coverage: ☐ HMO ☐ PPO ☐ Value Smile PPO ☐ No dental plan **Dental HMO only**: Dental provider #: |_|_|_|_|_|_| Dental provider name: ____________________
Optional Life Insurance: ☐ $10,000 ☐ $30,000 Beneficiary ________________________________

Certification for students age 19 or older (must be under age 23). I certify that my dependent listed below is currently enrolled as a full-time student (does not apply to children of legal guardians). If you have more than two dependents age 19 or older who are full-time students, please attach an additional sheet with the required information and check here. ☐

Name	Hours/week	Units	School	Address
Name	Hours/week	Units	School	Address

Applicant's Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

PART 4 – MEDICAL HISTORY – Please answer ALL questions. Remember to initial any changes/corrections you may have to make as you complete the questionnaire.

Have you or any applying family member in the past 10 years sought any professional consultation or received any treatment (including prescription medications) from a licensed health practitioner for any of the following?

All questions must be checked (✓) "Yes" or "No." Answer as completely and accurately as possible. Full details of any "Yes" answers must be given in Part 6.	**YES**	**NO**
1. *Brain or nervous system* – such as: migraine headache; seizure disorder; loss of consciousness; epilepsy; paralysis; muscular dystrophy; multiple sclerosis; stroke; cerebral palsy; mental retardation?	☐	☐
2. *Cardiovascular system* – such as: heart or valve problems; coronary artery disease; heart attack; heart murmur; pericarditis; mitral valve prolapse; heart valve regurgitation; rheumatic fever; palpitations; high blood pressure; shortness of breath; chest pains; elevated cholesterol and/or triglycerides?	☐	☐
3. *Circulatory system* – such as: varicose veins; peripheral vascular disease; phlebitis; blood clots; stroke; disease or disorder of the blood (except HIV infection); anemia; enlarged lymph nodes?	☐	☐
4. *Respiratory tract* – such as: asthma; reactive airway disease; bronchitis; allergies; sinusitis; disease, disorder or injury of the lungs or respiratory system; emphysema; tuberculosis; spitting or coughing up blood; shortness of breath; pneumonia; cystic fibrosis; pulmonary fibrosis; chronic obstructive pulmonary disease; sleep apnea? **If asthma or allergies (circle frequency): daily, weekly, monthly, seasonal Severity (circle one): mild, moderate, severe, other**	☐	☐
5. A. *Musculo-skeletal system* – such as: pain, injury, sprain, or other problems of the neck, spine, or back; sciatica; herniated or bulging disc(s); curvature of the spine; scoliosis; pain, injury, or other problems of the joints, bones, or muscles; arthritis; rheumatoid arthritis; temporo-mandibular joint syndrome (TMJ); Lyme disease; broken bones or retained hardware; dislocation of joints; bunions; hammertoe; carpal tunnel syndrome; physically handicapped; polio; amputations? **B. If any chiropractic treatment has been received, please explain reason for treatment:** _____ **Number of chiropractic treatments within the past 6 months:** _____	☐	☐
6. *Metabolic system* – such as: diabetes; gout; thyroid or adrenal disorders; hormone or growth hormone deficiencies; immune system disorders (except HIV infection) such as: lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), treatment for AIDS/ARC with AZT, HIVID or Pentamidine therapy?	☐	☐
7. *Cancer (malignancy)* – such as: leukemia; Hodgkin's; malignant melanoma; tumor/cyst; lymphoma? **Type:** _____ **If Yes, circle treatment type: chemotherapy, radiation therapy, other?**	☐	☐
8. *Congenital abnormalities, birth defects* – such as: Down's Syndrome; cerebral palsy; cleft lip or palate; clubfoot; developmental delay; or other neurological or physical abnormalities?	☐	☐
9. Alcoholism, drug dependency or substance abuse **Type:** _____	☐	☐
10. Counseling or treatment for symptoms of depression; manic depression; anxiety; panic attacks; nervousness; mental or emotional disorders; schizophrenia; behavior problems; hyperactivity; attention deficit disorder; eating disorders; bulimia; anorexia; alcohol or substance abuse; or for any other reason? **Are you currently in counseling? If yes, reason for counseling and frequency of treatment** _____	☐	☐

Have you or any applying family member in the past 5 years sought any professional consultation or received any treatment (including prescription medications) from a licensed health practitioner pertaining to any of the following?

All questions must be checked (✓) "Yes" or "No." Answer as completely and accurately as possible. Full details of any "Yes" answers must be given in Part 6.	**YES**	**NO**
11. *Male reproductive system* – such as: prostate problems; impotency; male breast problems; gynecomastia; infections; herpes; syphilis; gonorrhea; or other venereal disease (except HIV infection); or is either the applicant, spouse or domestic partner whether or not listed on the application, being treated or been treated for infertility within the last 24 months?	☐	☐
12. A. *Female reproductive system* – such as: breast problems; breast implants; adhesions; abnormal bleeding; amenorrhea; miscarriage and/or abortion; endometriosis; fibroid tumors; abnormal Pap test; problems of the ovaries, uterus and associated female organs; in-vitro fertilization; infections, genital warts, herpes, syphilis, or other venereal disease (except HIV infection); or is either the applicant, spouse or domestic partner whether or not listed on the application, being treated or been treated for infertility within the last 24 months? **Type of implants (circle one): saline or silicone**	☐	☐
B. Does any female applicant between the ages of 12-55 menstruate? 1. If yes, list the names of family member(s): _____; _____; _____ 2. Has it been more than 40 days since her/their last menstrual period? _____ 3. If Yes, list the names of family member(s): _____; _____; _____ 4. Please explain: _____	☐	☐
13. *Digestive system* – such as: disease or disorder of the mouth, tongue, esophagus or stomach; ulcer; gall bladder disorder; liver disease; cirrhosis; jaundice; ascites; pancreatitis; colon, intestinal or rectal problems; colitis; chronic diarrhea; hemorrhoids; hernia; weight or eating problems; hepatitis? **If hepatitis, type(s): A, B, C, other**	☐	☐
14. *Urinary tract* – such as: renal colic; gravel or stones; urethra, bladder, ureter or kidney problems; urinary tract infections; stricture; pyelonephritis?	☐	☐
15. *Skin conditions* – such as: skin cancer; melanoma; psoriasis; keratosis; acne; herpes; warts; birthmarks; severe burns?	☐	☐
16. *Diseases or problems of the eyes or sight, ears or hearing, nose or breathing, throat or swallowing* – such as: any infections of eyes, ears, nose or throat; crossed eyes; glaucoma; cataracts; detached retina; polyps; deviated nasal septum; excessive snoring; problems with tonsils or adenoids; sleep apnea?	☐	☐
17. *Abnormal laboratory results* – such as blood work; x-rays; EKG; nerve conduction; blood flow studies; MRI, CT, PET or other scans(s) (except HIV antibody detection tests)?	☐	☐
18. Prosthesis, implant, or retained hardware? **Type:** _____	☐	☐

Applicant's Social Security Number
____ ____ ____ - ____ ____ - ____ ____ ____ ____

PART 4 – MEDICAL HISTORY *(continued)* – Please answer ALL questions. Remember to initial any changes/corrections you may have to make as you complete the questionnaire.

All questions must be checked (✓) "Yes" or "No." Answer as completely and accurately as possible. Full details of any "Yes" answers must be given in Part 6.	**YES**	**NO**
19. Have you or any applying family member taken or been written a prescription for medication(s) in the last 12 months? If yes, please fill out Part 5 of this application.	☐	☐
20. In the past 5 years, have you or any applying family member:		
A. Been an inpatient or outpatient in a hospital, surgical center, sanitarium, or other medical facility, including an emergency room, or had surgery, including angioplasty, cosmetic/reconstructive, bypass or transplant surgery?	☐	☐
B. Had any illness, physical injury, persisting or new physical symptoms and/or health problems not mentioned elsewhere on this application that have not been evaluated or that you plan to have evaluated by a licensed health practitioner?	☐	☐
C. Been advised to have, or been referred for, a medical exam, further testing, treatment or surgery which has not yet been performed by a physician, dentist, or other licensed health practitioner?	☐	☐
D. Had any application for health or life insurance revoked, declined, deferred, postponed, or restricted in any way?	☐	☐
Family member: ____________________ Date:____/____/____		
Please explain: ____________________		
21. Are you or any applying family member presently a member of a support group? **Type:** __________ **How Long:** __________	☐	☐
22. *Males only:* Are you expecting a child with anyone, even if the birth mother is not listed on the application?	☐	☐
23. *Males and females:* Is either the applicant, spouse, domestic partner or dependent, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy?	☐	☐
24. Have or do you or any applying family member:		
A. Requested or received a pension, benefits or payment because of any injury, sickness, disability of workers' compensation?	☐	☐
B. Smoke(d) cigarettes? **Family member:** __________ **How many packs per day:** __________	☐	☐
For how many years: ______ **Have you/they stopped?** ______ **If yes, when?** __________		
C. Drink alcoholic beverages? **Family member:** __________ **Number of drinks per week:** __________	☐	☐
For how many years: ______ **Have you/they stopped?** ______ **If yes, when?** __________		

PART 5 – CURRENT OR RECENT PRESCRIPTION MEDICATIONS

If you answered "YES" to question 19 in Part 4, please provide the details of the current and previous medications. If additional space is necessary to provide complete information, please attach an additional sheet of paper. Be sure to identify the family member, include all information requested and **sign and date every attachment**. Check here for attachment. ☐

Name of family member			Dates from: ____/____/____ to: ____/____/____		
Medication	Reason for Rx		Dosage		Frequency
Physician Name	Phone number		Medical group		Physician specialty
Address	Ste #	City	State	ZIP	
Name of family member			Dates from: ____/____/____ to: ____/____/____		
Medication	Reason for Rx		Dosage		Frequency
Physician Name	Phone number		Medical group		Physician specialty
Address	Ste #	City	State	ZIP	
Name of family member			Dates from: ____/____/____ to: ____/____/____		
Medication	Reason for Rx		Dosage		Frequency
Physician Name	Phone number		Medical group		Physician specialty
Address	Ste #	City	State	ZIP	

Applicant's Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

PART 6 – MEDICAL CONDITION DETAILS – If you answered "YES" to any of questions 1–24 with the exception of 19, 20D, 24B and 24C in Part 4, give full details below for each condition.

If additional space is necessary to provide complete information, please attach an additional sheet of paper. Be sure to identify the family member, the section and the question number, as appropriate, include all information requested in Part 6 and **sign and date every attachment**. Check here for attachment. ☐

List question number

Family member name and name used on doctor's records:
First:
Last:

Diagnosis:

Treatment:

Dates of treatment:
Began: ____ /____ (MO/YR) Ended: ____ /____ (MO/YR)

Does the condition still exist? ☐ Yes ☐ No

Condition's present status:

Medical ID card # (if available)

Hospitalized? ☐ Yes ☐ No Dates:

ER visits? ☐ Yes ☐ No Dates:

Full name and address of every physician, clinic or hospital (include ZIP code). For physicians who belong to a medical group, please list the medical group as well.

Name: | Phone number: ( ) | Medical group

Address: | Ste #

City | State | ZIP

List question number

Family member name and name used on doctor's records:
First:
Last:

Diagnosis:

Treatment:

Dates of treatment:
Began: ____ /____ (MO/YR) Ended: ____ /____ (MO/YR)

Does the condition still exist? ☐ Yes ☐ No

Condition's present status:

Medical ID card # (if available)

Hospitalized? ☐ Yes ☐ No Dates:

ER visits? ☐ Yes ☐ No Dates:

Full name and address of every physician, clinic or hospital (include ZIP code). For physicians who belong to a medical group, please list the medical group as well.

Name: | Phone number: ( ) | Medical group

Address: | Ste #

City | State | ZIP

List question number

Family member name and name used on doctor's records:
First:
Last:

Diagnosis:

Treatment:

Dates of treatment:
Began: ____ /____ (MO/YR) Ended: ____ /____ (MO/YR)

Does the condition still exist? ☐ Yes ☐ No

Condition's present status:

Medical ID card # (if available)

Hospitalized? ☐ Yes ☐ No Dates:

ER visits? ☐ Yes ☐ No Dates:

Full name and address of every physician, clinic or hospital (include ZIP code). For physicians who belong to a medical group, please list the medical group as well.

Name: | Phone number: ( ) | Medical group

Address: | Ste #

City | State | ZIP

List question number

Family member name and name used on doctor's records:
First:
Last:

Diagnosis:

Treatment:

Dates of treatment:
Began: ____ /____ (MO/YR) Ended: ____ /____ (MO/YR)

Does the condition still exist? ☐ Yes ☐ No

Condition's present status:

Medical ID card # (if available)

Hospitalized? ☐ Yes ☐ No Dates:

ER visits? ☐ Yes ☐ No Dates:

Full name and address of every physician, clinic or hospital (include ZIP code). For physicians who belong to a medical group, please list the medical group as well.

Name: | Phone number: ( ) | Medical group

Address: | Ste #

City | State | ZIP

Applicant's Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

PART 7 – LIST YOUR HEALTH PRACTITIONER VISITS

Have you and/or any applying family member visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist, or other licensed health practitioner in the past 5 years? If Yes, enter the details below. If No, check here ☐ and go to Part 8.
Note: Exams for children under 5 years of age are required. Medical Records will be requested for ALL children age seven (7) months and younger.

Name of applicant	Date of visit: ____/____/_____	Reason for exam		Results	Present status
Physician name		Phone number		Medical group	Physician specialty
Address		Ste #	City	State	ZIP
Name of spouse/domestic partner	Date of visit: ____/____/_____	Reason for exam		Results	Present status
Physician name		Phone number		Medical group	Physician specialty
Address		Ste #	City	State	ZIP
Name of dependent	Date of visit: ____/____/_____	Reason for exam		Results	Present status
Physician name		Phone number		Medical group	Physician specialty
Address		Ste #	City	State	ZIP
Name of dependent	Date of visit: ____/____/_____	Reason for exam		Results	Present status
Physician name		Phone number		Medical group	Physician specialty
Address		Ste #	City	State	ZIP

PART 8 – PRIOR MEDICAL COVERAGE – **Please answer each question.**

1. Did you or any applying family member have other health coverage (insurance) within the last 63 days? ☐ YES ☐ NO

   If **NO**, go to Part 9
   If **YES**, complete the following:

	Type of Coverage	Effective date:	Cancel date:	Health plan carrier or COBRA administrator:
2. Applicant _____	☐ Group ☐ COBRA ☐ Individual ☐ Other	____/____/____	____/____/____	_____
Spouse/Domestic Partner/Dependent _____	☐ Group ☐ COBRA ☐ Individual ☐ Other	____/____/____	____/____/____	_____

3. If you are applying for a plan other than an HMO, did you have a prior health plan that covered any of the conditions checked yes in Part 4? ☐ Yes ☐ No
   If that plan terminated within 63 days of the Blue Shield receipt date of this application, please check here ☐ and submit a certificate of creditable coverage from your previous health carrier. If your application is approved, we will apply your prior creditable coverage to reduce any waiting period on your pre-existing condition exclusion with this plan. See the Summary of Benefits booklet for more on pre-existing conditions. You can call Blue Shield at **(800) 431-2809** for assistance obtaining a certificate.

4. If you are applying for an HMO Plan, please note that pregnancy is a Waivered Condition. Benefits for pregnancy and maternity services are not covered during the six (6)-month period beginning as of the effective date of coverage if you received pregnancy-related medical advice, diagnosis, care or treatment, including prescription drugs, from a licensed health practitioner during the six months immediately preceding the effective date of coverage, with the exception of services required to treat involuntary complications of pregnancy. However, if you have prior creditable coverage, and you apply for coverage within 63 days after termination of the prior coverage, Blue Shield will credit the length of time you were covered on your previous health plan toward the six-month period. See the Summary of Benefits booklet for more on waivered conditions. You can call Blue Shield at **(800) 431-2809** for assistance obtaining a certificate.

STOP!! WANT TO EXPEDITE THIS APPLICATION? WANT TO AVOID POSSIBLE ERRORS WHICH CAUSE DELAYS IN ACCEPTANCE? TALK TO YOUR AGENT ABOUT COMPLETING THIS FORM ONLINE!

ENROLL IN AUTOMATIC PAYMENT AND STOP WORRYING ABOUT PAYING YOUR BILL ON TIME! HAVE YOUR DUES/PREMIUM DEBITED DIRECTLY FROM YOUR CHECKING ACCOUNT OR SAVINGS ACCOUNT OR CHARGED DIRECTLY TO YOUR CREDIT CARD.

Applicant's Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

DON'T FORGET – YOUR SIGNATURE AND TODAY'S DATE ARE REQUIRED AT THE END OF PART 9 AND 10 OF THIS APPLICATION

PART 9 – AUTHORIZATION FOR RELEASE OF INFORMATION

By signing this form you are authorizing the release of your and/or your dependents' health care 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. The healthcare information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under the federal health information privacy laws.

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.

Applicant/Parent (or legal guardian) — Today's date

X_____ _____/_____/_____

Applicant's spouse/domestic partner — Today's date

X_____ _____/_____/_____

Applicant age 18 and over — Today's date

X_____ _____/_____/_____

Applicant age 18 and over — Today's date

X_____ _____/_____/_____

Applicant's Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

PART 10 – AUTHORIZATIONS, TERMS & CONDITIONS

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

1. **Application for Coverage**: It is important to know that Blue Shield of California or Blue Shield of California Life & Health Insurance Company (as applicable) has the right to decline your application for coverage. **Note:** I understand that Blue Shield may use any medical information in reviewing my application, including any medical condition which occurs after the signature and submission of the application and before a decision by Underwriting is made.
2. **First Month's Dues/Premiums**: Attach a personal check or money order to this application in an amount equal to one month's Dues/Premiums. Find your estimated monthly dues/premiums in the rate book provided to you. Failure to submit full payment of Dues/Premiums may delay processing and the effective date of coverage. Please note that cashing of your check does not constitute approval of your application with Blue Shield or Blue Shield Life. If your application is not approved, this amount will be refunded to you.
3. **Dues/Premiums**: Dues/Premiums are to be paid by the first day of the billing period. Coverage will be terminated for failure to pay Dues/Premiums in a timely manner as set forth in the Health Service Agreement/Policy.
4. **Effective Date of Coverage**: If your application is approved, 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 your requested date, coverage will begin as soon as possible. If additional Dues/Premiums are owed, payment must be received within the time specified in the notice from Blue Shield to avoid changing the effective date. Any charges incurred for services received prior to your effective date or after termination of coverage are not covered.
5. **Entire Agreement**: If approved, this application (including the health questionnaire), together with the evidence of coverage and health services agreement/policy for individuals and families, any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage. Your agent cannot approve this application 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 10. 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 the 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 only:_____ (name) or,

   ☐ My designee_____ (include name and relationship) or,

   ☐ Qualified Medical Child Support Order designee_____ (include name and relationship).

   ☐ 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 additions or changes to the application/contract/policy on your behalf. ☐ Yes. ☐ No. **Note**: You may discontinue this authorization at any time by sending a written request to Blue Shield.
8. **Response to Requested Information:** You agree to cooperate with Blue Shield (or Blue Shield Life, as applicable) by providing, or by providing access to, documents and other information requested to corroborate information provided in this application for coverage. You acknowledge and agree that failure or refusal to provide these documents or information, may be cause to rescind or cancel your coverage.
9. **HIV Testing Prohibited: California law prohibits an HIV test from being required or used by a health insurance company or health care service plan as a condition of obtaining health coverage.**

ALL APPLICANTS AGE 18 AND OLDER MUST SIGN AND DATE THIS APPLICATION. KEEP A COPY OF THIS APPLICATION FOR YOUR RECORDS.

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 application. I understand that neither I, nor any family members, will be eligible for coverage if any information is false or incomplete. I also understand that if coverage is issued, it may be cancelled or rescinded upon such a finding.

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

Applicant's Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

PART 11 — STATEMENT OF GUARANTEED ISSUE ELIGIBILITY

If you have a pre-existing condition and are concerned about obtaining health care coverage, Blue Shield offers an alternative that you may want to consider.

The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. Depending on your responses to the statements below, you may be eligible for guaranteed issue in accordance with HIPAA, and Blue Shield will automatically accept your application for one of its guaranteed issue plans. Each person on the application must meet HIPAA eligibility requirements to qualify for a guaranteed issue plan.

If you are applying for coverage on behalf of any dependents who are not eligible for guaranteed issue, their coverage will be subject to medical underwriting, except for children who were enrolled under any prior creditable coverage within 30 days of the birth or placement for adoption. A dependent child who is 18 years of age or younger or a dependent spouse applying for guaranteed issue must complete a separate Statement of Guaranteed Issue Eligibility (Blue Shield will accept copies of the Statement of Guaranteed Issue Eligibility). For additional applications or current guaranteed issue rates, please contact your Blue Shield agent or call Blue Shield at **(800) 431-2809**.

STATEMENT OF GUARANTEED ISSUE ELIGIBILITY & CHECKLIST

Please complete the following questionnaire if you are interested in a Guaranteed Issue policy so that your eligibility for Guaranteed Issue coverage may be verified.

☐ Yes ☐ No 1. I have had a total of at least 18 months of health care coverage (including COBRA or Cal-COBRA, if applicable) without a lapse in coverage of more than 63 days (excluding employer-imposed waiting periods).

☐ Yes ☐ No 2. My most recent coverage was through an employer-sponsored health plan (COBRA and Cal-COBRA are considered employer-sponsored coverage).

☐ Yes ☐ No 3. I accepted and exhausted any available COBRA and/or Cal-COBRA coverage. (If COBRA/Cal-COBRA were not available, check "yes").

COBRA/Cal-COBRA coverage dates ___/___/_____ through ___/___/_____

COBRA Administrator _____ Telephone _____

Insurance Carrier _____ Telephone _____

If your most recent coverage was employer-sponsored and you were not eligible for COBRA and/or Cal-COBRA coverage, please explain: _____

☐ Yes ☐ No 4. I am currently eligible for coverage under a group or employer sponsored health plan, Medicare or Medicaid.

☐ Yes ☐ No 5. My most recent coverage terminated because of nonpayment of dues/premium or fraud.

If your answers to statements 1, 2 & 3 are "yes," and your answers to statements 4 & 5 are "no," please complete the remaining sections below to apply for a guaranteed issue plan.

GUARANTEED ISSUE COVERAGE OPTIONS (PLEASE SELECT ONE)

A. If you know that you will not qualify for coverage, or do not want to apply for an underwritten plan, check this box:

☐ Issue the Guaranteed Issue Plan only. Since I have chosen this option, I understand that I will not be considered for an underwritten plan.

B. If you are applying for both Guaranteed Issue and an underwritten plan, select one of the following:

☐ Guaranteed Issue coverage at the earliest effective date, so that I am covered during the underwriting process of the individual plan. (I understand that if my application for the underwritten plan is approved, I will automatically be transferred to the underwritten plan. If it is not approved, I will continue to receive Guaranteed Issue.)

☐ Issue the Guaranteed Issue plan only if I am not approved for the underwritten plan. (I understand that I will not have any coverage until my application for the underwritten plan is processed and either approved or declined.)

GUARANTEED ISSUE PLAN OPTIONS (PLEASE SELECT ONE)

☐ PPO Plan 1500 ☐ PPO Plan 2000

☐ Blue Shield Life PPO Plan 1500 ☐ Blue Shield Life PPO Plan 2000

By signing this statement I verify that I have read and understood the eligibility conditions listed above and that all of the information is true and correct.

Signature of applicant or legal guardian	Today's date (required)	Print name
X _____	_____/_____/_____	_____

Applicant's Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

PART 12 — PRODUCER INFORMATION — Must be completed by Producer.

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. Did you see the applicant? ☐ Yes ☐ No

5. Are you aware of any information not disclosed in this application of health, which may have a bearing on this risk?
☐ Yes, attach explanation ☐ No

6. Review and select one of the following:

☐ I did not assist the applicant in any way in completing or submitting this application. All information was completed by the applicant with no assistance or advice of any kind from me.

☐ I assisted the applicant in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to $10,000.

7. Do you want the service agreement/policy sent directly to the subscriber? ☐ Yes ☐ No

Producer number:	Telephone number:	Fax number:
____ ____ ____ ____ ____ ____ ____ ____ ____	( ) ☐ Update	( ) ☐ Update

Producer name:

Email Address: ☐ Update

Producer address:

☐ Update

City | State | ZIP Code -

Super producer name:	Super producer number
	____ ____ ____ ____ ____ ____ ____ ____ ____

Today's date (required) **Producer signature (required)** **Print name**

____/____/_____ X_____ _____

NOTICE: 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. IFP Applications can be faxed toll-free 24 hours a day, 7 days a week, to **(888) 386-3420**.

Application Checklist

Before you send in your application for processing, we suggest you go through this checklist. Make sure each box is checked off so that your application is processed as quickly as possible.

Make sure you and each applying family member have:

- ☐ Answered every question, even if you are not sure it applies to you.
- ☐ Printed clearly in blue or black ink.
- ☐ Selected a Personal Physician only if you are applying for Access+ HMO or Access+ Value HMO; selected a Dental provider only if you are applying for Dental HMO.
- ☐ Indicated your payment option in Part 1 of the application. If you chose credit card payments or Easy$Pay, you must complete the authorization form on the reverse side of this page and send it in when you submit your application to Blue Shield.
- ☐ Stapled a personal check or money order to your application in an amount equal to the dues/premiums for the first month of coverage.
- ☐ Signed Part 9 and 10 of the application. Signatures by all applicants (age 18 and over) are required.
- ☐ Returned the application within 30 days of your date and signature.

General Information

You are eligible for any Individual & Family Health Plan if you: are a California resident, are ineligible for Medicare, and are not age 65 or over.

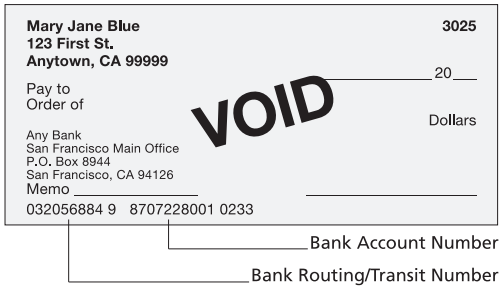
If your application is approved, you may be eligible to receive Access+ HMO or Access+ Value HMO benefits on the first of the month following Blue Shield's approval date, and on any day of the month, except for the 29th, 30th or 31st of the month following Blue Shield's approval date for any IFP PPO Plan.

Your spouse or Domestic Partner (under age 65) and unmarried dependent children (under age 19, or under age 23 if a full-time student), are eligible to apply for dependent coverage. If your children are under 19, you may also apply for separate child plans, which may cost you less overall. Call Blue Shield at **(800) 351-2465** or talk to your agent to find out which option is best for you.

Process to Authorize Blue Shield to Release Personal Information to Others: If you would like to authorize your spouse, domestic partner or a third party to access your personal health information, please complete the form titled *Authorization for Blue Shield to Disclose Personal & Health Information to a Third Party*. To obtain this form go to **blueshieldca.com** or call **(800) 431-2809**.

Billing Information

- Using the rate book provided to you, calculate your rates or talk to your agent to get estimated rates. You may receive rates higher than your agent quoted you based on Underwriting determination.
- For the first month's dues/premium staple a personal check or money order to your application in an amount equal to the dues/premiums for for one month, payable to Blue Shield. If paying first month's dues/premium by credit card please fill out the required information on Page 12.



Payment Options

Subsequent dues/premiums must be paid in advance. Blue Shield offers four payment methods. Please select a billing option below:

1. Easy$Pay Monthly Payment – monthly payments are handled automatically, via electronic transfer from your checking or savings account.
2. Credit Card Payment – monthly/ quarterly (select frequency on following page) payments are handled automatically, via electronic charging to your credit card.
3. Monthly (30 days) direct billing
4. Quarterly (90 days) direct billing

Easy$Pay and Credit Card Payment Options

To sign up for Automatic Payments: Complete the authorization form on the next page and return it with your application. If you have selected Easy$Pay as your payment option please staple a deposit slip or blank check marked "VOID" to your authorization form **in addition to your initial dues/premiums check**. If you prefer not to attach a voided check or deposit slip, you must provide the routing/ transit number of your financial institution.

If paying first month's dues/premium by credit card please fill out the required information below.

Automatic Payment Authorization Form

I AM: ☐ A new Automatic Payment applicant	☐ A current Automatic Payment user reporting a change (requires 30-day notice)
METHOD OF AUTOMATIC PAYMENT:	☐ Easy$Pay (complete Parts A and C only): Checking Account Savings Account (circle one) ☐ Credit Card* (complete Parts B and C only)

PART A (Complete for checking/savings account debits only.)

Payment Date (choose one): HMO and Dental HMO Subscribers must use 1st of month. ☐ 1st of month, or ☐ 15th of month

Bank routing/transfer number | Bank account number

Name of Financial Institution

Name(s) on Bank account

Branch Address

City | State | ZIP Code -

Branch Telephone Number

PART B (Complete for credit card charges only. Visa or MasterCard only.) ☐ Payment for first month's dues/premium only

Payment Date (choose one): ☐ Monthly ☐ Quarterly

Credit card number | Card Type: ☐ Visa ☐ MasterCard | Expiration Date (MM/YYYY)

Cardholder First Name | MI

Last Name

Cardholder Billing Address

City | State | ZIP Code -

PART C (All Automatic Payment applicants must complete.)

Name of subscriber | Subscriber's daytime phone number ( )

Mailing Address Street

City | State | ZIP Code -

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company as applicable, to initiate debits/charges (and/or corrections to previous debits/charges) from my account with the financial institution identified by me on this form for payment of my Blue Shield dues/premium, as well as for the dues/premium of the following covered individuals (my dependents):

_____ _____ _____ - _____ _____ - _____ _____ _____ _____
Social Security Number

_____ _____ _____ - _____ _____ - _____ _____ _____ _____
Spouse/Domestic Partner Social Security Number

_____ _____ _____ - _____ _____ - _____ _____ _____ _____
Dependent Social Security Number

_____ _____ _____ - _____ _____ - _____ _____ _____ _____
Dependent Social Security Number

I also authorize that financial institution to reduce/charge my account by the amount of those debits/charges (and/or corrections to previous debits/charges) on the agreed upon schedule. This authorization will remain in effect until I provide notice revoking the authorization, at least 10 days before my account is to be debited/charged.

Authorized Signature(s) – as it/they appear in the financial institution's records. If the account is listed as a joint account, both account holders must sign. If the holder of the account is not an individual, the one signing on behalf of a company/ partnership/etc. must identify him/herself and his/her relationship to the company/partnership.

Signature | Date

Print name | Relationship

Signature | Date

Print name | Relationship

* You will be charged the amount owed for dues/premium until you choose to cancel your automatic payment schedule. If you chose to cancel your automatic payment, or if changes are made to the account being charged, please contact IFP Customer Service at **(800) 431-2809**. Credit card charges may occur 1 to 2 days prior to payment date.