Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: 323-936-6310 fax: 323-936-9337

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

GrossmanInsuranceServices.com
7162 Beverly blvd #582
Los Angeles, CA 90036

Please make your check payable to: Blue Shield of California

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at: 323-936-6310

Thank you for choosing...

BlueShield of California

Blue Shield of California

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

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. Fully completing the application will help avoid a delay in processing or possible return of the application. Call Blue Shield at **(800) 660-3007** 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. Domestic Partners must submit an affidavit called "Statement for Domestic Partnership". Please call Blue Shield Member Services at (800) 431-2809 to request the form and instructions for submission.

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.)
			___/___/___		

APPLICANT'S BUSINESS PHONE #	APPLICANT'S HOME PHONE #	APPLICANT'S FAX #	OTHER NAME(S) UNDER WHICH YOU'VE RECEIVED CARE	EXISTING SUBSCRIBER #
( )	( )	( )		

HOME ADDRESS	CITY	STATE	ZIP CODE	COUNTY OF RESIDENCE

BILLING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE

MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE

APPLICANT'S OCCUPATION	EMPLOYER AND EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

SPOUSE'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 ☐ OTHER:

PLEASE CHECK YOUR PREFERRED METHOD OF CONTACT: ☐ HOME TELEPHONE ☐ WORK TELEPHONE ☐ EMAIL ☐ STANDARD MAIL — APPLICANT'S EMAIL ADDRESS

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.

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 9, ITEM 5 FOR INSTRUCTIONS) _____/_____/_____

PART 2 – PLAN CHOICES

CHOOSE HEALTH PLAN (CHECK ONE BOX ONLY):	☐ ACTIVE CHOICE PLAN 600*	SHIELD SPECTRUM PPO PLANS	SHIELD SPECTRUM PPO SAVINGS PLANS	BLUE SHIELD HMO PLAN
		☐ PPO PLAN 500 ☐ PPO PLAN 2000 ☐ PPO PLAN 1500 (BSL)* ☐ PPO PLAN 750 ☐ PPO PLAN 5000* ☐ PPO PLAN 2000 (BSL)* ☐ PPO PLAN 1500	☐ PPO SAVINGS PLAN 2400 (INDIVIDUAL) ☐ PPO SAVINGS PLAN 4800 (FAMILY)	☐ ACCESS+ HMO PLAN

ACCESS+ HMO ONLY:
PERSONAL PHYSICIAN NAME: _____ PROVIDER #: _____ MED.GROUP/IPA #: _____ ☐ CHECK IF CURRENT PATIENT

IF APPLYING FOR GUARANTEED ISSUE ONLY, CHECK ONE BOX BELOW AND COMPLETE PARTS 1-3, 7-10 ONLY. SEE PART 10 FOR MORE INFORMATION.

☐ PPO PLAN 1500 (GUARANTEED ISSUE) ☐ PPO PLAN 2000 (GUARANTEED ISSUE) ☐ PPO PLAN 1500 (BSL) (GUARANTEED ISSUE)* ☐ PPO PLAN 2000 (BSL) (GUARANTEED ISSUE)*
☐ PLEASE CHECK HERE IF NOT INTERESTED IN A GUARANTEED ISSUE PLAN.

YOU MAY ALSO PURCHASE A DENTAL PLAN AND/OR LIFE INSURANCE TO SUPPLEMENT YOUR MEDICAL COVERAGE. IF YOU ARE APPROVED FOR A HEALTH PLAN, YOU MAY ALSO QUALIFY FOR DENTAL/LIFE AS WELL.

DENTAL PLAN OPTIONS (CHECK ONE): ☐ DENTAL HMO (DHMO) ☐ DENTAL PPO (DPPO) ☐ NO DENTAL PLAN
IF DENTAL HMO: DENTAL CENTER #: _____ IF DENTAL HMO: DENTAL CENTER NAME: _____

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. YOUTHCARE APPLICANTS CAN APPLY FOR $10,000 AND $30,000 LIFE INSURANCE OPTIONS 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_____ _____(%)

*NOTE: UNDERWRITTEN BY BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY.

BILLING OPTIONS: ☐ EASY$ PAY (AUTOMATIC MONTHLY BILLING – COMPLETE REQUIRED FORM) ☐ MONTHLY BILLING ☐ QUARTERLY BILLING

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.)

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 Center from the Dental HMO Dental Center Directory. For questions regarding your Dental Center selection, call (800) 431-2809.

RELATION	FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT (FT.IN.)	WEIGHT (LBS.)	DENTAL
☐ HUSBAND ☐ WIFE ☐ DOMESTIC PARTNER				___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/___			☐ HMO ☐ PPO

ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME: PROVIDER #: MED.GROUP/IPA #: ☐ CHECK IF CURRENT PATIENT

DENTAL HMO ONLY: DENTAL CENTER #: DENTAL CENTER NAME:

APPLICANT'S SOCIAL SECURITY NUMBER
___ ___ ___ - ___ ___ - ___ ___ ___ ___

PART 3 – DEPENDENT INFORMATION – (continued)

RELATION	FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT (FT.IN.)	WEIGHT (LBS.)	DENTAL
☐ SON ☐ DAUGHTER				___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/___			☐ HMO ☐ PPO

ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME: PROVIDER #: MED.GROUP/IPA #: ☐ CHECK IF CURRENT PATIENT

DENTAL HMO ONLY: DENTAL CENTER #: DENTAL CENTER NAME:

CONSIDER MY CHILD FOR SEPARATE YOUTHCARE RATES ☐
CHOOSE PLAN (CHECK 1 BOX ONLY): ☐ ACTIVE CHOICE 600 PLAN ☐ PPO PLAN 500 ☐ PPO PLAN 750 ☐ PPO PLAN 1500 ☐ PPO PLAN 2000 ☐ PPO PLAN 5000 ☐ PPO SAVINGS PLAN 2400 ☐ ACCESS+ HMO PLAN
OPTIONAL LIFE INSURANCE FOR YOUTHCARE APPLICANTS: ☐$10,000 LIFE INSURANCE ☐$30,000 LIFE INSURANCE

RELATION	FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT (FT.IN.)	WEIGHT (LBS.)	DENTAL
☐ SON ☐ DAUGHTER				___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/___			☐ HMO ☐ PPO

ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME: PROVIDER #: MED.GROUP/IPA #: ☐ CHECK IF CURRENT PATIENT

DENTAL HMO ONLY: DENTAL CENTER #: DENTAL CENTER NAME:

CONSIDER MY CHILD FOR SEPARATE YOUTHCARE RATES ☐
CHOOSE PLAN (CHECK 1 BOX ONLY): ☐ ACTIVE CHOICE 600 PLAN ☐ PPO PLAN 500 ☐ PPO PLAN 750 ☐ PPO PLAN 1500 ☐ PPO PLAN 2000 ☐ PPO PLAN 5000 ☐ PPO SAVINGS PLAN 2400 ☐ ACCESS+ HMO PLAN
OPTIONAL LIFE INSURANCE FOR YOUTHCARE APPLICANTS: ☐$10,000 LIFE INSURANCE ☐$30,000 LIFE INSURANCE

RELATION	FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	HEIGHT (FT.IN.)	WEIGHT (LBS.)	DENTAL
☐ SON ☐ DAUGHTER				___ ___ ___ - ___ ___ - ___ ___ ___ ___	___/___/___			☐ PPO

ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME: PROVIDER #: MED.GROUP/IPA #: ☐ CHECK IF CURRENT PATIENT

DENTAL HMO ONLY: DENTAL CENTER #: DENTAL CENTER NAME:

CONSIDER MY CHILD FOR SEPARATE YOUTHCARE RATES ☐
CHOOSE PLAN (CHECK 1 BOX ONLY): ☐ ACTIVE CHOICE 600 PLAN ☐ PPO PLAN 500 ☐ PPO PLAN 750 ☐ PPO PLAN 1500 ☐ PPO PLAN 2000 ☐ PPO PLAN 5000 ☐ PPO SAVINGS PLAN 2400 ☐ ACCESS+ HMO PLAN
OPTIONAL LIFE INSURANCE FOR YOUTHCARE APPLICANTS: ☐$10,000 LIFE INSURANCE ☐$30,000 LIFE INSURANCE

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:

IF YOU HAVE MORE THAN TWO DEPENDENTS OVER AGE 18 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

PART 4 – MEDICAL HISTORY – Please answer ALL questions.

Have you or any applying family member in the past 20 years received any professional advice or treatment, including prescription medications, from a Licensed health practitioner or had any symptoms 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 5.**

	YES	NO
1. ***Brain or nervous system*** – such as: dizziness, 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, mitral regurgitation, rheumatic fever, palpitations, high blood pressure, shortness of breath, chest pains?	☐	☐
3. ***Circulatory system*** – such as: varicose veins, peripheral vascular disease, phlebitis, blood clots, stroke, bleeding problems, blood disorder (except HIV infection), anemia, enlarged lymph nodes?	☐	☐
4. ***Respiratory tract*** – such as: asthma, reactive airway disease, bronchitis, hayfever, allergies, sinusitis, lung/chest problems of any kind, 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. ***Digestive system*** – such as: mouth, tongue, esophagus or stomach problems, 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**	☐	☐
6. ***Urinary tract*** – such as: renal colic, gravel or stone, urethra, bladder, ureter or kidney problems, infections, stricture, pyelonephritis?	☐	☐
7. ***Male reproductive system*** – such as: prostate problems, impotency, male breast problems, gynecomastia, infections, herpes, syphilis, gonorrhea, or other venereal disease, or is either the applicant or spouse, whether or not listed on the application, currently being treated for infertility?	☐	☐
8. A. ***Female reproductive system*** – such as: breast problems, breast implants, adhesions, abnormal bleeding, amenorrhea, 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, or is either the applicant or spouse, whether or not listed on the application, currently being treated for infertility? **TYPE OF IMPLANTS (CIRCLE ONE): SALINE OR SILICONE**	☐	☐
B. Does any female applicant between the ages of 12-60 menstruate? a. IF YES, LIST THE NAMES OF FAMILY MEMBER(S): _____; _____; _____ b. HAS IT BEEN MORE THAN 40 DAYS SINCE HER/THEIR LAST MENSTRUAL PERIOD? _____ c. IF YES, LIST THE NAMES OF FAMILY MEMBER(S): _____; _____; _____ d. PLEASE EXPLAIN: _____	☐	☐
9. 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?	☐	☐
10. **Males only:** are you expecting a child with anyone, even if the birth mother is not listed on the application?	☐	☐
11. ***Musculo-Skeletal system*** – such as: neck, spine/back sprain, pain, injury, sciatica, herniated or bulging disc(s), or problems; curvature of the spine, scoliosis; any pain, injuries, or problems of the joints, bones, or muscles; arthritis; rheumatoid arthritis, temporo-mandibular joint syndrome (TMJ), Lyme disease, fractures/residual hardware, dislocations, bunions, hammertoe, carpal tunnel syndrome, physically handicapped, polio, amputations? **IF CHIROPRACTIC TREATMENT, PLEASE EXPLAIN REASON FOR TREATMENT:** _____ **NUMBER OF CHIROPRACTIC TREATMENTS WITHIN THE PAST 6 MONTHS:** _____	☐	☐
12. ***Skin conditions*** – such as: skin cancer, melanoma, psoriasis, keratosis, herpes, warts, birthmarks, burns?	☐	☐

APPLICANT'S SOCIAL SECURITY NUMBER
_____ _____ _____ - _____ _____ - _____ _____ _____ _____

PART 4 – MEDICAL HISTORY – Please answer ALL questions.

	YES	NO
13. *Metabolic system* – such as: diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, or immune system disorders (except HIV infection) such as: lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), or treatment for AIDS/ARC with AZT, HIVID or Pentamidine therapy?	☐	☐
14. Diseases or problems of the eyes or sight, ears or hearing, nose or breathing, throat or swallowing – such as: any infections, crossed eyes, glaucoma, cataracts, detached retina, polyps, deviated nasal septum, excessive snoring, problems with tonsils or adenoids, sleep apnea?	☐	☐
15. Cancer (malignancy) – such as: leukemia, Hodgkin's, tumor/cyst, lymphoma? Type ______________ **IF YES, CIRCLE TREATMENT TYPE: CHEMOTHERAPY, RADIATION THERAPY, OTHER?**	☐	☐
16. Alcoholism, drug dependency or substance abuse? **TYPE:** ______________	☐	☐
17. Presently a member of a support group? **TYPE:** ______________ **HOW LONG:** ______________	☐	☐
18. Congenital abnormalities, birth defects – such as: Down's Syndrome, cerebral palsy, cleft lip or palate, clubfoot, developmental delay, or other neurological or physical abnormalities?	☐	☐
19. 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** ______________	☐	☐
20. 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?	☐	☐
21. Abnormal laboratory results - such as: blood work, x-rays, EKG, nerve condition, blood flow studies, MRI, CT, PET or other scan(s) (except HIV antibody detection tests)?	☐	☐
22. Prosthesis, implant, or retained hardware? **TYPE:** ______________	☐	☐
23. Diagnoses, symptoms and/or health problems not mentioned elsewhere on this application, or that have not been evaluated by a physician, or have any complications or residuals remaining following any treatment, or been advised to have a physician exam, further testing, treatment, or surgery which has not yet been performed by a physician, dentist, or other health care provider?	☐	☐
24. Requested or received a pension, benefits or payment because of any injury, sickness, disability or workers' compensation?	☐	☐
25. Taken or been ordered to take prescription medication(s) in the last 12 months? If yes, please fill out Part 6 of this application.	☐	☐
26. Smoked cigarettes? **FAMILY MEMBER:** ______________ **NUMBER OF PACKS PER DAY** ______________ **FOR HOW MANY YEARS:** ______________ **WHEN DID YOU/THEY STOP?** ______________	☐	☐
27. Drink alcoholic beverages? **FAMILY MEMBER:** ______________ **NUMBER OF DRINKS PER WEEK** ______________ **FOR HOW MANY YEARS:** ______________ **WHEN DID YOU/THEY STOP?** ______________	☐	☐
28. Had any application for health or life insurance revoked, declined, deferred, postponed, or restricted in any way? **FAMILY MEMBER:** ______________ **DATE:**_____/_____/_____ **PLEASE EXPLAIN:** ______________	☐	☐

PART 5 – MEDICAL CONDITION DETAILS – **If you answered "YES" to any of questions 1–24 in PART 4, give details below.**

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 5 and **sign and date every attachment**. Check here for attachment. ☐

	FAMILY MEMBER NAME AND NAME USED ON DOCTOR'S RECORDS	DIAGNOSIS AND PRESENT STATUS		DATES OF TREATMENT, HOSPITALIZATION	
LIST QUESTION NUMBER	NAME	DIAGNOSIS AND TREATMENT		BEGAN: ____ /____ (MO/YR) ENDED: ____ /____ (MO/YR)	
	DOES THE CONDITION STILL EXIST? ☐ YES ☐ NO	PRESENT STATUS:			
	MEDICAL ID CARD #. (IF AVAILABLE)	HOSPITALIZED? ☐ YES ☐ NO	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	NAME	DIAGNOSIS AND TREATMENT		BEGAN: ____ /____ (MO/YR) ENDED: ____ /____ (MO/YR)	
	DOES THE CONDITION STILL EXIST? ☐ YES ☐ NO	PRESENT STATUS:			
	MEDICAL ID CARD #. (IF AVAILABLE)	HOSPITALIZED? ☐ YES ☐ NO	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	NAME	DIAGNOSIS AND TREATMENT		BEGAN: ____ /____ (MO/YR) ENDED: ____ /____ (MO/YR)	
	DOES THE CONDITION STILL EXIST? ☐ YES ☐ NO	PRESENT STATUS:			
	MEDICAL ID CARD #. (IF AVAILABLE)	HOSPITALIZED? ☐ YES ☐ NO	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 5 – MEDICAL CONDITION DETAILS (continued)

LIST QUESTION NUMBER	NAME	DIAGNOSIS AND TREATMENT		BEGAN: ____ /____ (MO/YR) ENDED: ____ /____ (MO/YR)	
	DOES THE CONDITION STILL EXIST? ☐ YES ☐ NO	PRESENT STATUS:			
	MEDICAL ID CARD #. (IF AVAILABLE)	HOSPITALIZED? ☐ YES ☐ NO	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

PART 6 – CURRENT OR RECENT PRESCRIPTION MEDICATIONS

If you answered "YES" to question 25 in PART 4, please provide the details of the current and previous medications.

NAME OF FAMILY MEMBER			DATES FROM :_____/_____/_____		TO :_____/_____/_____
MEDICATION	DOSAGE		CONDITION		FREQUENCY
PHYSICIAN NAME	PHONE NUMBER		MEDICAL GROUP		PHYSICIAN SPECIALTY
ADDRESS	STE #	CITY		STATE	ZIP
NAME OF FAMILY MEMBER			DATES FROM :_____/_____/_____		TO :_____/_____/_____
MEDICATION	DOSAGE		CONDITION		FREQUENCY
PHYSICIAN NAME	PHONE NUMBER		MEDICAL GROUP		PHYSICIAN SPECIALTY
ADDRESS	STE #	CITY		STATE	ZIP
NAME OF FAMILY MEMBER			DATES FROM :_____/_____/_____		TO :_____/_____/_____
MEDICATION	DOSAGE		CONDITION		FREQUENCY
PHYSICIAN NAME	PHONE NUMBER		MEDICAL GROUP		PHYSICIAN SPECIALTY
ADDRESS	STE #	CITY		STATE	ZIP

PART 7 – LIST YOUR **LAST PHYSICIAN VISIT**

Please provide details regarding the last physician visit you and/or any applying family member has had, regardless of the date (includes check-ups).
A complete physical examination is required for any family member age 55 years or older. This examination must be within the last two years. Medical records will be requested for children under one year of age.

NAME OF APPLICANT	DATE OF VISIT : _____/_____/_____	REASON FOR EXAM/CHECK-UP		FINDINGS	PRESENT STATUS
PHYSICIAN NAME		PHONE NUMBER		MEDICAL GROUP	PHYSICIAN SPECIALTY
ADDRESS		STE #	CITY	STATE	ZIP
NAME OF SPOUSE	DATE OF VISIT : _____/_____/_____	REASON FOR EXAM/CHECK-UP		FINDINGS	PRESENT STATUS
PHYSICIAN NAME		PHONE NUMBER		MEDICAL GROUP	PHYSICIAN SPECIALTY
ADDRESS		STE #	CITY	STATE	ZIP
NAME OF DEPENDENT	DATE OF VISIT : _____/_____/_____	REASON FOR EXAM/CHECK-UP		FINDINGS	PRESENT STATUS
PHYSICIAN NAME		PHONE NUMBER		MEDICAL GROUP	PHYSICIAN SPECIALTY
ADDRESS		STE #	CITY	STATE	ZIP
NAME OF DEPENDENT	DATE OF VISIT : _____/_____/_____	REASON FOR EXAM/CHECK-UP		FINDINGS	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
2. IF **YES**, COMPLETE THE FOLLOWING:

	TYPE OF COVERAGE	EFFECTIVE DATE	CANCEL DATE:	HEALTH PLAN CARRIER OR COBRA ADMINISTRATOR
APPLICANT ______________________	☐ GROUP ☐ COBRA ☐ INDIVIDUAL ☐ OTHER	____/____/____	____/____/____	______________________
SPOUSE/DEPENDENT ______________________	☐ GROUP ☐ COBRA ☐ INDIVIDUAL ☐ OTHER	____/____/____	____/____/____	______________________

3. If you are applying for a plan other than Access+ 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 the Access+ 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, 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.

DON'T FORGET – YOUR SIGNATURE AND TODAY'S DATE ARE REQUIRED IN PART 9 OF THIS APPLICATION

APPLICANT'S SOCIAL SECURITY NUMBER
____ ____ ____ - ____ ____ - ____ ____ ____ ____

PART 9 – AUTHORIZATIONS, TERMS & CONDITIONS – Please read the following terms and conditions carefully. Your authorization and signature is 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.
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. **Short Term Health Applicants:** If you are applying for a Blue Shield Life short-term health insurance policy, you are not required to submit your first month's Dues/Premiums with your Individual and Family Plan application. Submit your short-term health application directly to Blue Shield Life at the address located on the short-term health application.
4. **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.
5. **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.
6. **Entire Agreement:** If approved, this application (including the health questionnaire), together with the evidence of coverage and health services agreement/certificate of insurance and policy, 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.
7. **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 9. 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.
8. **Authorization for Spouse to Make Changes:** If you are an applicant whose spouse is also applying for coverage, please specify if you authorize your spouse to make changes to the contract/policy on your behalf. ☐ Yes. ☐ No. **Note:** You may discontinue this authorization at any time by sending a written request to Blue Shield.
9. **Authorization for Disclosure of Personal Information:** By signing below, you authorize any "provider of care," insurer, health plan, or your Blue Shield agent or broker, to disclose to Blue Shield of California or Blue Shield of California Life & Health Insurance Company (individually or collectively referred to as "Blue Shield"), or its representatives, and vice versa, all "medical information" (as those terms are defined in the California Civil Code) regarding you and your applying family members, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for the purposes of evaluating this application, determining eligibility and claims for benefits, quality assurance, peer review, or administrative functions reasonably related to executing and managing this Agreement/Policy. In addition, you authorize Blue Shield to obtain personal and medical record information (as those terms are defined in the California Insurance Code) from an institutional source or an insurance support organization that gathers this type of information, for the purposes of determining eligibility for coverage. This authorization will remain valid as follows: (1) for 30 months from the date of authorization for the purposes of processing the application, a policy reinstatement, or a request for change in policy benefits; and (2) for all other activities under the policy, for the term of the coverage or for as long as may be necessary for processing of claims incurred during the term of coverage. I understand that I am entitled to a copy of this form and that a photocopy is as valid as the original.
10. **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.
11. **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.

TODAY'S DATE (REQUIRED)	SIGNATURE OF APPLICANT (OR LEGAL GUARDIAN)	PRINT NAME (AND RELATIONSHIP IF APPLICANT IS A MINOR)
____/____/____	X_____	_____
TODAY'S DATE (REQUIRED)	**SIGNATURE OF APPLICANT'S SPOUSE/DOMESTIC PARTNER (IF APPLYING)**	**PRINT NAME**
____/____/____	X_____	_____
TODAY'S DATE (REQUIRED)	**SIGNATURE OF FAMILY MEMBER AGE 18 AND OVER (IF APPLYING)**	**PRINT NAME**
____/____/____	X_____	_____
TODAY'S DATE (REQUIRED)	**SIGNATURE OF FAMILY MEMBER AGE 18 AND OVER (IF APPLYING)**	**PRINT NAME**
____/____/____	X_____	_____

APPLICANT'S SOCIAL SECURITY NUMBER
____ ____ ____ - ____ ____ - ____ ____ ____ ____

PART 10 — 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. If you meet every condition below, you are eligible for guaranteed issue in accordance with HIPAA, and Blue Shield will automatically accept your application for the PPO Plan 1500, PPO Plan 2000, PPO Plan 1500 (BSL), or PPO Plan 2000 (BSL).

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 answer "yes" or "no" to each of the following statements.

1. I HAVE HAD A TOTAL OF AT LEAST 18 MONTHS OF HEALTH CARE COVERAGE (INCLUDING COBRA OR CAL-COBRA, IF APPLICABLE) WITHOUT MORE THAN A 63-DAY BREAK (EXCLUDING ANY EMPLOYER-IMPOSED WAITING PERIODS) IN COVERAGE. ☐ 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. IF YOU BECAME ELIGIBLE FOR COBRA OR CAL-COBRA BEFORE JANUARY 1, 2003, RESPOND TO THIS STATEMENT. IF YOU BECAME ELIGIBLE FOR COBRA OR CAL-COBRA ON OR AFTER JANUARY 1, 2003, PROCEED TO # 4.

   I ACCEPTED COBRA OR CAL-COBRA COVERAGE AND EXHAUSTED ALL OF ITS BENEFITS, OR WAS NOT ELIGIBLE FOR COBRA OR CAL-COBRA. ☐ YES ☐ NO

   IF YES, PLEASE LIST THE DATE THAT COBRA OR CAL-COBRA WAS EXHAUSTED: _____/_____/_____ IF NO, PLEASE EXPLAIN: _____
4. IF YOU BECAME ELIGIBLE FOR COBRA OR CAL-COBRA ON OR AFTER JANUARY 1, 2003, YOU WERE ELIGIBLE FOR A MAXIMUM OF 36 MONTHS OF COVERAGE UNDER COBRA OR CAL-COBRA OR A COMBINATION OF COBRA AND CAL-COBRA. PLEASE RESPOND TO THIS STATEMENT:

   I ACCEPTED COBRA AND/OR CAL-COBRA AND EXHAUSTED 36 MONTHS OF COVERAGE. ☐ YES ☐ NO

   IF "YES", PLEASE LIST THE DATE THAT COBRA/CAL-COBRA WAS EXHAUSTED: _____/_____/_____ IF NO, PLEASE EXPLAIN: _____

IF YOU ANSWERED "YES" TO STATEMENTS 1, 2, 3 OR 4, PLEASE PROCEED TO NUMBERS 5 AND 6 . IF YOU ANSWERED "NO" TO ANY OF THE ABOVE STATEMENTS, DO NOT PROCEED. YOU ARE NOT ELIGIBLE FOR GUARANTEED ISSUE.

5. I AM CURRENTLY ELIGIBLE FOR COVERAGE UNDER A GROUP OR EMPLOYEE SPONSORED HEALTH PLAN, MEDICARE OR MEDICAID? ☐ YES ☐ NO
6 . MY MOST RECENT COVERAGE TERMINATED BECAUSE OF NONPAYMENT OF DUES/PREMIUM OR FRAUD? ☐ YES ☐ NO

IF YOU ANSWERED "NO" TO QUESTIONS 5 AND 6 AND "YES" TO STATEMENTS 1, 2, 3 OR 4, THEN YOU ARE ELIGIBLE FOR GUARANTEED ISSUE.

GUARANTEED ISSUE COVERAGE OPTIONS YOU MUST SELECT ONE OF THE BOXES BELOW TO PROCESS YOUR APPLICATION.

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.)

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.

TODAY'S DATE (REQUIRED)	SIGNATURE OF APPLICANT OR LEGAL GUARDIAN	PRINT NAME
_____/_____/_____	_____	_____

PART 11 — 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. DO YOU WANT THE SERVICE AGREEMENT SENT DIRECTLY TO THE SUBSCRIBER? ☐ YES ☐ NO

PRODUCER NUMBER:	TELEPHONE NUMBER: **323-936-6310**	FAX NUMBER: **323-936-9337**
PRODUCER NAME: **Phil Grossman**	EMAIL ADDRESS:	
PRODUCER ADDRESS: **7162 Beverly blvd #582**	**Los Angeles, CA 90036**	
SUPER PRODUCER NAME:	SUPER PRODUCER NUMBER	

TODAY'S DATE (REQUIRED)	PRODUCER SIGNATURE (REQUIRED)	PRINT NAME
_____/_____/_____	X_____	_____

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.
- ☐ Stapled a personal check or money order to your application in an amount equal to one month's dues/premiums.
- ☐ Indicated your billing choice at the top of the application. If you chose Easy$Pay, you must complete the Easy$Pay authorization form on the reverse side of this page and send it in when you submit your application to Blue Shield.
- ☐ Signed Part 9 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 over the age of 65.

If your application is approved, you may be eligible to receive Access+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 YouthCare plans, which may cost you less overall. Call Blue Shield at **(800) 660-3007** 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 **mylifepath.com** or call **1-800-431-2809**.

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.
- Staple a personal check or money order to your application in an amount equal to one month's dues/premiums, payable to Blue Shield.

Dues/premiums must be paid in advance. Blue Shield offers three payment methods. Please make sure you selected a billing method in the box at the top of the application.

1. Monthly (30 days) Billing
2. Quarterly (90 days) Billing
3. Easy$Pay Monthly Billing – monthly payments are handled automatically, via electronic transfer from your checking or savings account.

To sign up for Easy$Pay: Complete the authorization form on the next page and return it with your application. Staple a blank check marked "VOID" to your authorization form **in addition to your initial dues/premiums check**.

Easy$Pay Authorization Form

I AM: ☐ A NEW EASY$PAY APPLICANT
☐ A CURRENT EASY$PAY USER REPORTING A CHANGE IN MY BANK OR ACCOUNT NUMBER (REQUIRES 30-DAY NOTICE)

TYPE OF ACCOUNT: ☐ CHECKING ☐ SAVINGS

DEBIT DATE: ☐ 1ST OF MONTH ☐ 15TH OF MONTH

(HMO AND DENTAL HMO SUBSCRIBERS MUST USE 1ST OF MONTH.)

NAME OF FINANCIAL INSTITUTION

NAME(S) ON BANK ACCOUNT

BRANCH TELEPHONE NUMBER

NAME OF SUBSCRIBER

SUBSCRIBER'S DAYTIME PHONE NUMBER

MAILING ADDRESS 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 (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Shield dues/premium, as well as for the dues/premium of the following subscribers (my dependents):

___ ___ ___ ___ ___ ___ ___ ___ ___
SOCIAL SECURITY NUMBER

___ ___ ___ ___ ___ ___ ___ ___ ___
SPOUSE SOCIAL SECURITY NUMBER

___ ___ ___ ___ ___ ___ ___ ___ ___
DEPENDENT SOCIAL SECURITY NUMBER

___ ___ ___ ___ ___ ___ ___ ___ ___
DEPENDENT SOCIAL SECURITY NUMBER

I also authorize that financial institution to reduce the balance of my account by the amount of those debits (and/or corrections to previous debits). This authorization will remain in effect until I revoke the authorization indicated, at least 10 days before my account is to be debited.

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 bank 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

Authorization for Blue Shield of California to Disclose Personal & Health Information to a Third Party

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

You May Refuse To Sign This Authorization

This form is used to authorize Blue Shield of California to release personal and health information for the purpose stated below.

SECTION A: THIS AUTHORIZATION IS FOR THE RELEASE OF THE FOLLOWING TYPE OF PERSONAL AND HEALTH INFORMATION (check all that apply):

- ❒ Dues payment and billing and information
- ❒ Medical care and treatment (not including mental health/ substance abuse/ HIV care)
- ❒ Vision care and treatment
- ❒ Dental care and treatment
- ❒ *Mental health/substance abuse care and treatment (if selected, no other boxes may be checked)
- ❒ *Mental health – protected by the Lanterman-Petris-Short Act (LPS) on involuntary treatment of mental illness (if selected, no other boxes may be checked)
- ❒ *HIV care, HIV results, and treatment (if selected, no other boxes may be checked)

* *If this authorization is for mental health/substance abuse or HIV information, a separate completed authorization form will be necessary for the release of other types of personal and health information and for each release of records (1) protected by the LPS Act or (2) containing HIV results. Further, the LPS Act often requires that both the patient's treating physician and the patient sign the authorization form before information may be released.*

SECTION B: MEMBER INFORMATION – THIS AUTHORIZATION TO RELEASE INFORMATION RELATES TO THE PERSONAL AND HEALTH INFORMATION OF THE FOLLOWING MEMBER:

Member Information

Name: _____

Date of birth: _____

Telephone: _____

Subscriber Information (contract holder)

Complete only sub. no. if member is the subscriber

Name: _____

Date of birth: _____

Subscriber number: _____

SECTION C: PERSONS OR ENTITIES AUTHORIZED TO RECEIVE AND USE MEMBER INFORMATION

The persons and/or organizations (or the classes of persons and/or organizations) to whom you are authorizing Blue Shield to disclose the personal and health information described above are:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

SECTION D: DISCLOSURE AND USE OF MEMBER INFORMATION – PLEASE READ AND COMPLETE THE FOLLOWING STATEMENTS CAREFULLY

Note: This authorization is voluntary. Blue Shield places no conditions on our payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits because you have given this authorization.

Personal and Health Information to be Disclosed: The specific personal and health information you are authorizing "Blue Shield" to disclose includes the following:

_____

_____

Purposes of this authorization: By signing this form, you authorize the use of your personal and health information by a third party for the following purposes:

_____

_____

Limitations to the use of Personal and Health information:
Blue Shield will obtain specific written authorization for disclosure of any personal and health information, beyond those necessary to provide treatment, facilitate payment, perform the operations of the health plan, or as permitted by law. Blue Shield recognizes your right to specifically approve or to deny the release of information. Blue Shield will only disclose that information which is reasonably necessary to achieve the purpose of the request for release.

SECTION E: EXPIRATION AND REVOCATION

This authorization for the release of your personal and health information may be revoked or withdrawn at any time and a revocation or withdrawal will apply to all information not previously released pursuant to this authorization. No other personal or health information may be disclosed without your authorization, unless permitted by law. Request for revocation must be made in writing, unless Blue Shield has taken action in reliance on this authorization or it was obtained as a condition of obtaining healthcare plan coverage. This authorization for the release of your personal and health information will expire in one year or on the date you specify.

Note: *if this authorization is for the release of the personal and health information of a minor the expiration date cannot exceed the 18th birthday of the minor.*

Expiration: This authorization will expire (specify one):

❒ On _____/_____/_____

❒ One year from the signature date

SECTION F: SIGNATURE – YOU MAY REFUSE TO SIGN THIS AUTHORIZATION

I,_____ , have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization that "Blue Shield" may use and/or disclose to the persons and/or organizations named in this form the personal and health information described in this form for the purposes stated in this form. I understand that, if the persons or organizations I authorize to receive and/or use the personal and health information described in this form are not health plans, covered health care providers or health care clearinghouses subject to federal health information privacy laws, they may further disclose the personal and health information and it may no longer be protected by federal health information privacy laws.

Signature: _____ Date: _____

Print Name: _____

Person or Entity Authorizing Disclosure of Information: If you are signing on behalf of the member, please indicate your relationship to the member and provide copies of verification of your legal right to authorize the disclosure of the member's personal and health information.

❒ Parent or guardian of minor patient (to the extent minor could not have consented to the care)

❒ Court appointed guardian, legal conservator, legal representative or an individual with Power of Attorney to disclose the member's personal and health information

❒ Durable Power of Attorney for Health Care

❒ Beneficiary or personal representative of deceased patient

❒ Spouse or person financially responsible (where information is solely for purpose of processing an application for enrollment)

❒ Treating Physician (signature may be necessary if related to mental health or HIV care)

Physician Signature _____ Date: _____

Print Name _____

You can request a copy of this authorization after you sign it. A copy of this authorization shall be considered as effective and valid as the original. Additionally, you may inspect or copy the protected health information to be used or disclosed.