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: 818-987-5000 fax: 818-776-9865

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:

Oleg Skurskiy
18375 Ventura Blvd. # 226
Tarzana, CA 91356

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: 818-987-5000

Thank you for choosing...

blue of california

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

blue of california

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

You are eligible for any Individual and Family Plan (IFP) dental plan or the dental + vision package if you are a California resident at the time of enrollment. If you had a Blue Shield IFP dental plan cancelled for any reason (by yourself or by Blue Shield), you must wait 6 months from the date of cancellation before you can reapply, unless there is no lapse in coverage between the Blue Shield dental plans. Blue Shield will not approve concurrent enrollment in two Blue Shield IFP dental plans. If you enroll in any HIPAA guaranteed-issue plan, you are not eligible for a dental plan or the dental + vision package.

Part 1 – Coverage, plan, and applicant information

Reason for application: ☐ New enrollment ☐ Plan transfer ☐ Add dependent family member to existing coverage

Dental plan or dental + vision package: (please check one below)
☐ Value Smile PPO*† ☐ Specialty Duo (dental + vision) package*† ☐ Dental PPO ☐ Dental HMO
Requested effective date: _____ **Dental HMO applicants only** – please choose a dentist from the Provider Directory at **blueshieldca.com**, or call **(800) 431-2809** for assistance.
Dental HMO provider name: _____ Dental HMO provider number: _____

Applicant information

Applicant Social Security number	Gender: ☐ Male ☐ Female	Date of birth (mo/day/yr) / /	Married: ☐ Yes ☐ No Domestic partnership: ☐ Yes ☐ No
First name	MI	Last name	
Do you currently have dental coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Dental subscriber number (if applicable)	
Do you currently have medical coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Medical subscriber number (if applicable)	
Do you currently have vision coverage through Blue Shield? ☐ Yes ☐ No	If yes, please indicate plan	Vision subscriber number (if applicable)	
Applicant business phone number	Applicant home phone number	Applicant fax number	Applicant cell number
Applicant home address (NO P.O. box)			Apt No.
City	State		ZIP code
Applicant billing address (if different from home address)			Apt No.
City	State		ZIP code
Applicant mailing address (if different from home address)			Apt No.
City	State		ZIP code
Email address	Best time to contact by phone ☐ AM ☐ PM		

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

Language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

Part 2 – Dependent information

List all dependent family members you wish to cover (dependent children must be under age 26).

1. ☐ Spouse ☐ Domestic partner (check one): ☐ Male ☐ Female			
First name	MI	Last name (if different from above)	
Social Security number		Date of birth (mo/day/yr) / /	
2. ☐ Son ☐ Daughter			
First name	MI	Last name (if different from above)	
Social Security number		Date of birth (mo/day/yr) / /	
3. ☐ Son ☐ Daughter			
First name	MI	Last name (if different from above)	
Social Security number		Date of birth (mo/day/yr) / /	
4. ☐ Son ☐ Daughter			
First name	MI	Last name (if different from above)	
Social Security number		Date of birth (mo/day/yr) / /	

* Pending regulatory approval.
† Underwritten by Blue Shield of California Life & Health Insurance Company.

Part 3 – Authorizations, terms, and conditions

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

1. **Eligibility:** I understand that Blue Shield has the right to decline my application for coverage. I also understand that I must be residing in California and not enrolled in any HIPAA guaranteed-issue medical plan in order to be eligible for enrollment in this plan/package. I will notify Blue Shield upon any change regarding my eligibility for this plan/package. I also agree to provide, or provide access to, information requested by Blue Shield to verify my eligibility, or continued eligibility, for coverage, and understand that failure to cooperate could result in cancellation of coverage.
2. **First month's dues/premium:** Blue Shield requires first month's dues/premium at the time of application submission. Find your estimated monthly dues/premium in the rate book provided to you. Refer to part 4 and 5 for details on payment options. Failure to submit full payment of dues/premium will result in a return of your application. Please note that processing of your payment does not constitute approval of your application with Blue Shield or Blue Shield Life. If your application is not approved, the dues/premium you submit with your application will not be processed. If you include a check, it will be destroyed. If you complete the payment authorization form, your credit card or checking account will not be debited.
3. **Dues/premium:** Dues/premium are to be paid by the due date. Coverage will be terminated for failure to pay dues/premium in a timely manner as set forth in the *Evidence of Coverage* and Health Service Agreement/Policy.
4. **Effective date of coverage:** If your application is approved, Blue Shield will notify you in writing 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/premium are owed, payment must be received within the time specified in the notice from Blue Shield to be enrolled. Any charges incurred for services received prior to your effective date or after termination of coverage are not covered.
5. **Acceptance of application:** You understand that only Blue Shield can accept your application and approve coverage. Your agent or broker 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 3. 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/premium payments and for the following terms and conditions for coverage. If you are not the parent of the applicant, please attach court documents that appoint you as the guardian of this minor. Mark one of the following boxes and identify the individual authorized to act on behalf of the minor (applicant):

☐ Parent or legal guardian _____ (include name and relationship); or
☐ My designee _____(include name and relationship); or
☐ Qualified medical child support order designee _____ (include name and relationship); or
☐ Mark this box if Blue Shield is to only make changes to the contract upon written request by the person identified above.

7. **Authorization for spouse/domestic partner to make changes:** If you are an applicant whose spouse/domestic partner is also applying for coverage, please specify if you authorize your spouse/domestic partner to make changes to the contract/policy on your behalf. You may discontinue this authorization at any time by sending a written request to Blue Shield. ☐ **Yes** ☐ **No**
8. **HIV or genetic testing prohibited:** No genetic information, including family medical history, and no information related to HIV testing should be provided. California law prohibits an HIV test from being required or used by a health insurance company or a healthcare service plan as a condition of obtaining health coverage.

THIS SECTION MUST BE COMPLETED BEFORE YOUR APPLICATION CAN BE PROCESSED. KEEP A COPY OF THIS APPLICATION FOR YOUR RECORDS.

I have reviewed all responses pertaining to me in this application, I have read the summary of benefits and the terms and conditions of coverage and authorizations set forth above. With my own signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided. (Important: Each adult applicant must provide their own signature.)

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

Producer information

Producer number	364698896	Telephone number	818-987-5000	Fax number	818-776-9865
Email address	oleg@findppo.com				
Producer address	18375 Ventura Blvd. # 226				
City	Tarzana	State	CA	ZIP code	91356
Super producer name		Super producer number			

Do you want the *Evidence of Coverage* and Health Service Agreement/Policy sent directly to the subscriber? ☑ Yes ☐ No

	/ /	Oleg Skurskiy
Producer signature (required)	Today's date (required)	Print name

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.

Please fax or mail the completed and signed application to:

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

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

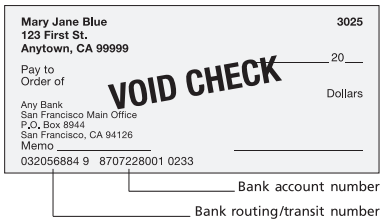
Part 4 – Billing and payment information

Calculate estimated monthly dues/premium

- Using the rate book provided to you, calculate your estimated rates or talk to your agent to get estimated rates.
- First month's dues/premium are required at the time of application submission. You can enroll in Easy$Pay℠ where automatic payments are handled via electronic transfer through your checking or savings account for the first month's dues/premium and for ongoing payments. You can also pay the first month's dues/premium via electronic check by completing section C on the Payment Authorization form or you can staple a personal check or money order to your application in an amount equal to the dues/premium for one month, payable to Blue Shield. If paying first month's dues/premium by credit card, please fill out section B of the Payment Authorization form.

Easy$Pay automatic payment option

To sign up for automatic payments, complete section A of the Payment Authorization form and return it with your application. You must provide the routing/transit number of your financial institution or staple a deposit slip or blank check marked "VOID CHECK" to your authorization form.



Part 5 –Payment Authorization form

(Dues/premium payment is required with your application. Please select Option 1 or 2.)

☐ **Option 1:** Automatic payment through checking or savings account – Easy$Pay for initial and ongoing payments (complete section A below)
☐ **Option 2:** Please choose one of the options below for both: 1) your initial payment, and 2) for ongoing payments

Initial payment with application:

☐ By check
☐ By credit card (complete section B)

Ongoing payments:

☐ By automatic payment through checking or savings account – Easy$Pay (complete section A)
☐ Monthly billing ☐ Quarterly billing

Applicant information

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

Method of payment

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

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

Payment frequency: ☐ Monthly

Bank routing/transit number

Bank account number

Name(s) on bank account

Name of financial institution

Branch address

City	State	ZIP code

Branch telephone number

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

Cardholder name

Cardholder billing address		Apt. No.
City	State	ZIP code

Credit card number

Card type: ☐ Visa ☐ MasterCard	Expiration date (mm/yyyy) _____/_____

If paying first month's dues/premium by credit card, the estimated first month's payment is:* $ _____

* This is only an estimate of monthly dues/premium. Blue Shield will provide notice of actual monthly dues/premium if my application for coverage is accepted. All dues/premium must be received prior to the original effective date for coverage to be in effect.

Authorization and signature(s)

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

Additional information if paying initial dues/premium only by credit card:
If only the first month's dues/premium box is checked, this authorization is only valid to charge the first month's dues/premium owed to Blue Shield. I understand my credit card will be charged for the estimated first month's dues/premium immediately upon receipt of my application; however, this payment does not constitute approval of my application, and if my application is accepted, a different rate may apply. If I am accepted at a different rate, the difference in dues/premium must be paid prior to the original effective date of coverage. Blue Shield will not automatically charge the difference in rate owed to the credit card without a separate authorization from the applicant.

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

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

Cardholder/Account holder signature

Print Name

Social Security number

Date

Cardholder/Account holder signature

Print Name

Social Security number

Date