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: 877-566-5454 fax: 760-433-0304

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:

Barricks Insurance Services

276 N El Camino Real #6

Oceanside, CA 92058

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: 877-566-5454

Thank you for choosing...

blue of california

2017 Blue Shield 65 Plus Optional Supplemental Dental HMO or PPO Plan Enrollment Request Form

blue of california

Please contact Blue Shield of California if you need information in another language or format (Braille). Call **(800) 776-4466 [TTY: 711]** 8 a.m. to 8 p.m., seven days a week, from October 1 through February 14, and 8 a.m. to 8 p.m., weekdays, from February 15 through September 30.
Please fax or mail your completed enrollment form to:
Fax: (877) 251-3660
Mail: Blue Shield of California, P.O. Box 948, Woodland Hills, CA 91365-9856

If you are already a Blue Shield 65 Plus℠ (HMO) or Blue Shield 65 Plus Choice Plan (HMO) member, and would like to enroll in the optional supplemental dental HMO or PPO plan, please provide the following information:

Please check which plan you want to enroll in.

☐ Optional supplemental dental HMO plan $12.90 per month (Note: The dental HMO plan is not available to members in San Luis Obispo and Santa Barbara counties.)

☐ Optional Supplemental Dental PPO Plan $33.40 per month

Blue Shield 65 Plus Member ID No.

Last name:	First name:	MI	☐ Mr. ☐ Mrs. ☐ Ms.

Birth date: (____/____/____) MM DD YYYY	Sex: ☐ Male ☐ Female	Home phone number: ( )

Permanent residence street address (P.O. Box is not allowed):

City:	State:	ZIP code:

Mailing address (only if different from your permanent residence address):

City:	P.O. Box:	State:	ZIP code:

Emergency contact:	**Phone number:** ( )	**Relationship to you:**

Optional supplemental dental HMO plan ONLY. If you're enrolling in the Dental PPO plan, you do not need to provide a dentist name or ID.

Name of dentist	Provider ID No.

If you do not select a dentist, you will be assigned a dentist at the time of enrollment.

Paying your plan premium

Your premium for the next month's coverage is due by the last day of the current month.

You can pay your monthly optional supplemental dental HMO or PPO plan premium by mail or by electronic funds transfer (EFT) each month. You can also choose to pay your premium by automatic deduction from your Social Security or Railroad Retirement Board (RRB) benefit check each month.

If you don't select a payment option, you will receive a bill each month.

Please select a plan premium payment option:

☐ Get a monthly bill.

☐ Electronic funds transfer (EFT) from your bank account each month. Please enclose a VOIDED check or provide the following:

Account holder name:

Bank routing number: | Bank account number:

Account type: ☐ Checking ☐ Savings

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check. (The Social Security or RRB deduction may take two or more months to begin after Social Security or RRB approves the deduction. In most cases, if Social Security or RRB accepts your request for automatic deduction, the first deduction from your Social Security or RRB benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security or RRB does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

Please note: If your Blue Shield 65 Plus plan has a monthly premium, or if you currently pay a late enrollment penalty, whatever plan premium option you select now will be applicable to ALL components of your plan premium.

If you do not make your premium payment according to the payment option you selected, you will receive a written notice and will be given three months from the payment due date to pay all amounts due to Blue Shield. If you do not pay all amounts due within that time, Blue Shield of California will disenroll you from the optional supplemental dental HMO or PPO plan.

Once you have enrolled in the optional supplemental dental HMO or PPO plan, your membership will continue as long as you pay your premiums as specified by the plan and remain enrolled as a Blue Shield 65 Plus member.

You must be a member of Blue Shield 65 Plus in order to be eligible to enroll in the optional supplemental dental HMO or PPO plan. If you disenroll from Blue Shield 65 Plus, you will also be disenrolled from the optional supplemental dental HMO or PPO plan. If you disenroll from the optional supplemental dental HMO or PPO plan only and wish to re-enroll at a later date, you must wait six months from the disenrollment date and pay any premium amount owed before you will be allowed to re-enroll in the Optional Supplemental Dental HMO or PPO plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State of California) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under the State of California's law to complete this enrollment and 2) documentation of this authority is available upon request from Medicare.

Signature

Today's date

If you are the legally authorized representative (i.e., power of attorney or legal guardian – see description above), you must sign above and provide the following information:

Name

Address

Phone number
( )

Relationship to enrollee

Producer information: Producer name and ID or NPN is required

TMO/GMO/Agency name _____
(please print appointed agency name)

TMO/GMO/Agency ID No. _____
(please print agency ID)

Producer name JAMES BARRICKS
(please print writing agent name)

Producer ID No. 06328758
(please print agent ID number or NPN)

Producer phone number (760) 433-0300

Producer email address INSURE@BARRICKSINSURANCE.COM

Date application received by producer _____

Producer signature _____

With my signature, I hereby certify that I have read and understand the CMS Medicare Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete pre-sale kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.

Blue Shield of California is an HMO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.