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: fax:

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:

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:

Thank you for choosing...

Blue Shield of California Life & Health Insurance Company
Dental plan application

blue of california

This form is to be used by applicants applying for a Smile[SM] PPO* or Value Smile[SM] PPO* dental plan.

You are eligible for any Individual & Family (IFP) Dental Plan if you are a California resident and under age 65 at the time of enrollment. If you had a Blue Shield Individual & Family Dental Plan cancelled for any reason (by yourself or by Blue Shield), you must wait 12 months from the date of cancellation before you can reapply, unless there is no lapse in coverage between Blue Shield dental plans. Blue Shield will not approve concurrent enrollment in two Blue Shield IFP dental plans.

Part 1 – Coverage, plan, and applicant information

Coverage Options: ☐ New enrollment ☐ Add dependent family member to existing coverage

Dental plan: (please check one below)
☐ Smile PPO* ☐ Value Smile PPO* Requested effective date: ______________________
To find a Blue Shield dental provider by name location and specialty, go to our website **blueshieldca.com**.

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)	
Applicant business phone number	Applicant home phone number	Applicant fax number	
Applicant home address	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	
E-mail address	Best time to contact by phone		

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

Payment options: ☐ Monthly direct billing ☐ Quarterly direct billing

Part 2 – Dependent information

List all dependent 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).

1. ☐ Husband ☐ Wife ☐ Domestic partner (circle 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)	

* Pending regulatory approval.

An Independent Licensee of the Blue Shield Association C36143-FF (9/10)

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 in order to be eligible for enrollment in this dental plan. I will notify Blue Shield upon any change regarding my eligibility for this plan. 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 payment of premium**: Attached is my personal check or money order in an amount equal to one month's premium made payable to Blue Shield of California Life & Health Insurance Company. I understand cashing of my check by Blue Shield does not constitute enrollment in the dental plan. If I am not eligible, the amount of prepaid premium will be refunded to me.
3. **Premium payments: This Blue Shield dental plan is a prepaid premium plan** and payment is due in full prior to the first day of the billing period. Coverage will be cancelled for failure to pay premium in a timely manner as set forth in the Policy. If my dental coverage is cancelled for late payment, I may apply for reinstatement within 15 days.
4. **Effective date of coverage**: If my application is approved, Blue Shield will inform me in writing of the effective date of coverage for me and any enrolling dependents. If Blue Shield cannot honor my requested effective date, or is unable to issue coverage before my requested date, coverage will begin as soon as possible. **Charges incurred before my effective date or after termination of coverage are not covered.**
5. **Entire agreement**: If approved, this application, together with the Policy, any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for dental coverage with Blue Shield. My agent cannot approve this application for coverage or change any terms or conditions of coverage.
6. **If the applicant is a minor:** The parent or legal guardian must sign on behalf of the any minor under the age of 18. The parent or legal guardian is identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, the parent or legal guardian will assume all responsibility for premium payments and for following the terms and conditions of coverage. Please indicate the relationship to the minor:
   - ☐ A. Parent
   - ☐ B. Legal guardian (attach copy of court documents)
7. **Authorization for dependent spouse/domestic partner to make changes:** If my dependent spouse/domestic partner is enrolling for dental plan coverage, I authorize my spouse/domestic partner changes to the contract on my behalf. ☐ **Yes** ☐ **No**
   I may discontinue this authorization at any time by sending a written request to Blue Shield.
8. **HIV testing prohibited:** 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	Today's date (required)	Print name
Signature of spouse/domestic partner	Today's date (required)	Print name
Signature of dependents age 18 or over (if applying)	Today's date (required)	Print name
Signature of dependents age 18 or over (if applying)	Today's date (required)	Print name

Producer information

Producer number	Telephone number	Fax number
E-mail address		
Producer address		
City	State	ZIP code
Super producer name	Super producer number	
Do you want the Policy sent directly to the subscriber? ☐ Yes ☐ No		

Producer signature	Today's date	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 Life & Health Insurance Company
P.O. Box 3008
Lodi, CA 95241-1912
Fax: **(209) 367-6490**

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