

ALLPOINTE Insurance Services

Application Instructions For Blue Shield of California

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to ALLPOINTE Insurance Services for review along with the completed application. If you do not have access to a fax machine, send the completed application to ALLPOINTE Insurance Services along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also sign and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to Blue Shield of California** if you are not paying by credit card.

Mail completed application and check to:

ALLPOINTE Insurance Services

Attn: New Enrollment

290 Missouri Street

San Francisco, CA 94107

ALLPOINTE Insurance Services will review your application for completeness and accuracy before we submit it to Blue Shield of California for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 1-888-992-2244 or e-mail us at mybroker@allpointe-is.com.

ALLPOINTE Insurance Services

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

ALLPOINTE Insurance Services

FAX# 415-520-5554

Dear ALLPOINTE Insurance Services,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

I will contact ALLPOINTE Insurance Services at 1-888-992-2244 to verify receipt of my application.

****I understand that ALLPOINTE Insurance Services will not review this application until the following weekday morning if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to ALLPOINTE Insurance Services. I will mail the original signed application to :

ALLPOINTE Insurance Services

Attn: New Enrollment

290 Missouri Street

San Francisco, CA 94107

I will send the original application as soon as I have been contacted by ALLPOINTE Insurance Services with confirmation that my application has been received by fax and reviewed for completeness.

Signature: _____

Date: _____



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) 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 <input type="checkbox"/> NEW ENROLLMENT <input type="checkbox"/> PLAN TRANSFER <input type="checkbox"/> ADD FAMILY MEMBER TO EXISTING COVERAGE	PART 1 – APPLICANT INFORMATION – Please provide the following: (If married, indicating the younger spouse as the primary applicant may reduce your monthly dues/payments)					
	APPLICANT'S SOCIAL SECURITY NUMBER _____ - _____ - _____		FIRST NAME _____		MI _____	LAST NAME _____
	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARRIED: <input type="checkbox"/> YES <input type="checkbox"/> 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: <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> CHINESE <input type="checkbox"/> OTHER:						
PLEASE CHECK YOUR PREFERRED METHOD OF CONTACT: <input type="checkbox"/> HOME TELEPHONE <input type="checkbox"/> WORK TELEPHONE <input type="checkbox"/> EMAIL <input type="checkbox"/> STANDARD MAIL					APPLICANT'S E-MAIL ADDRESS _____	
HAVE YOU BEEN A RESIDENT OF CALIFORNIA FOR THE PAST SIX MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> 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):	<input type="checkbox"/> ACTIVE CHOICE PLAN 600*	SHIELD SPECTRUM PPO PLANS <input type="checkbox"/> PPO PLAN 500 <input type="checkbox"/> PPO PLAN 2000 <input type="checkbox"/> PPO PLAN 1500 (BSL)* <input type="checkbox"/> PPO PLAN 750 <input type="checkbox"/> PPO PLAN 5000* <input type="checkbox"/> PPO PLAN 2000 (BSL)* <input type="checkbox"/> PPO PLAN 1500	SHIELD SPECTRUM PPO SAVINGS PLANS <input type="checkbox"/> PPO SAVINGS PLAN 2400 (INDIVIDUAL) <input type="checkbox"/> PPO SAVINGS PLAN 4800 (FAMILY)	BLUE SHIELD HMO PLAN <input type="checkbox"/> ACCESS+ HMO PLAN
ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME: _____ PROVIDER #: _____ MED.GROUP/IPA #: _____ <input type="checkbox"/> 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.				
<input type="checkbox"/> PPO PLAN 1500 (GUARANTEED ISSUE) <input type="checkbox"/> PPO PLAN 2000 (GUARANTEED ISSUE) <input type="checkbox"/> PPO PLAN 1500 (BSL) (GUARANTEED ISSUE)* <input type="checkbox"/> PPO PLAN 2000 (BSL) (GUARANTEED ISSUE)* <input type="checkbox"/> 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): <input type="checkbox"/> DENTAL HMO (DHMO) <input type="checkbox"/> DENTAL PPO (DPPO) <input type="checkbox"/> 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.				
<input type="checkbox"/> \$10,000 (APPLICANTS AGES 1-64) <input type="checkbox"/> \$30,000 (APPLICANTS AGES 1-64) <input type="checkbox"/> \$60,000 (APPLICANTS AGES 19-64) <input type="checkbox"/> \$90,000 (APPLICANTS AGES 19-49) <input type="checkbox"/> 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: THESE PLANS SHALL BE PROVIDED THROUGH AND UNDERWRITTEN BY BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY (AS APPLICABLE).				
BILLING OPTIONS: <input type="checkbox"/> EASY\$ PAY (AUTOMATIC MONTHLY BILLING – COMPLETE REQUIRED FORM) <input type="checkbox"/> MONTHLY BILLING <input type="checkbox"/> 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
<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE				_____ - _____ - _____	____/____/____			<input type="checkbox"/> HMO <input type="checkbox"/> PPO
ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME:			PROVIDER #:	MED.GROUP/IPA #:			<input type="checkbox"/> 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
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				_____ - _____ - _____	____/____/____			<input type="checkbox"/> HMO <input type="checkbox"/> PPO
ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME:				PROVIDER #:	MED.GROUP/IPA #:	<input type="checkbox"/> CHECK IF CURRENT PATIENT		
DENTAL HMO ONLY: DENTAL CENTER #:				DENTAL CENTER NAME:				
CONSIDER MY CHILD FOR SEPARATE YOUTHCARE RATES <input type="checkbox"/>								
CHOOSE PLAN (CHECK 1 BOX ONLY): <input type="checkbox"/> ACTIVE CHOICE 600 PLAN <input type="checkbox"/> PPO PLAN 500 <input type="checkbox"/> PPO PLAN 750 <input type="checkbox"/> PPO PLAN 1500 <input type="checkbox"/> PPO PLAN 2000 <input type="checkbox"/> PPO PLAN 5000 <input type="checkbox"/> PPO SAVINGS PLAN 2400 <input type="checkbox"/> ACCESS+ HMO PLAN								
OPTIONAL LIFE INSURANCE FOR YOUTHCARE APPLICANTS: <input type="checkbox"/> \$10,000 LIFE INSURANCE <input type="checkbox"/> \$30,000 LIFE INSURANCE								
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				_____ - _____ - _____	____/____/____			<input type="checkbox"/> HMO <input type="checkbox"/> PPO
ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME:				PROVIDER #:	MED.GROUP/IPA #:	<input type="checkbox"/> CHECK IF CURRENT PATIENT		
DENTAL HMO ONLY: DENTAL CENTER #:				DENTAL CENTER NAME:				
CONSIDER MY CHILD FOR SEPARATE YOUTHCARE RATES <input type="checkbox"/>								
CHOOSE PLAN (CHECK 1 BOX ONLY): <input type="checkbox"/> ACTIVE CHOICE 600 PLAN <input type="checkbox"/> PPO PLAN 500 <input type="checkbox"/> PPO PLAN 750 <input type="checkbox"/> PPO PLAN 1500 <input type="checkbox"/> PPO PLAN 2000 <input type="checkbox"/> PPO PLAN 5000 <input type="checkbox"/> PPO SAVINGS PLAN 2400 <input type="checkbox"/> ACCESS+ HMO PLAN								
OPTIONAL LIFE INSURANCE FOR YOUTHCARE APPLICANTS: <input type="checkbox"/> \$10,000 LIFE INSURANCE <input type="checkbox"/> \$30,000 LIFE INSURANCE								
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER				_____ - _____ - _____	____/____/____			<input type="checkbox"/> PPO
ACCESS+ HMO ONLY: PERSONAL PHYSICIAN NAME:				PROVIDER #:	MED.GROUP/IPA #:	<input type="checkbox"/> CHECK IF CURRENT PATIENT		
DENTAL HMO ONLY: DENTAL CENTER #:				DENTAL CENTER NAME:				
CONSIDER MY CHILD FOR SEPARATE YOUTHCARE RATES <input type="checkbox"/>								
CHOOSE PLAN (CHECK 1 BOX ONLY): <input type="checkbox"/> ACTIVE CHOICE 600 PLAN <input type="checkbox"/> PPO PLAN 500 <input type="checkbox"/> PPO PLAN 750 <input type="checkbox"/> PPO PLAN 1500 <input type="checkbox"/> PPO PLAN 2000 <input type="checkbox"/> PPO PLAN 5000 <input type="checkbox"/> PPO SAVINGS PLAN 2400 <input type="checkbox"/> ACCESS+ HMO PLAN								
OPTIONAL LIFE INSURANCE FOR YOUTHCARE APPLICANTS: <input type="checkbox"/> \$10,000 LIFE INSURANCE <input type="checkbox"/> \$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: <input type="checkbox"/>								
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 EVER received any professional advice or treatment for 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, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
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, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
3. Circulatory system – such as: varicose veins, peripheral vascular disease, phlebitis, blood clots, stroke, bleeding problems, blood disorder (except HIV infection), anemia, or enlarged lymph nodes, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
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, etc.? IF ASTHMA OR ALLERGIES CIRCLE FREQUENCY: DAILY, WEEKLY, MONTHLY, SEASONAL SEVERITY (CIRCLE ONE): MILD, MODERATE, SEVERE, OTHER	<input type="checkbox"/>	<input type="checkbox"/>
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, etc.? IF HEPATITIS, TYPE (S): A, B, C, OTHER	<input type="checkbox"/>	<input type="checkbox"/>
6. Urinary tract – such as: renal colic, gravel or stone, urethra, bladder, ureter or kidney problems, infections, stricture, pyelonephritis, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
7. Male reproductive system – such as: prostate problems, impotency, male breast problems, gynecomastia, infections, herpes, syphilis, gonorrhea, or other venereal disease, etc. or is either the applicant or spouse, whether or not listed on the application, currently being treated for infertility?	<input type="checkbox"/>	<input type="checkbox"/>
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, etc. 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	<input type="checkbox"/>	<input type="checkbox"/>
B. Does any female applicant between the ages of 12-60 menstruate? IF YES, LIST THE NAMES OF FAMILY MEMBER(S) AND DATES OF LAST MENSTRUAL PERIOD: _____/_____/_____; _____/_____/_____; _____/_____/_____ IF NO, LIST THE NAMES OF FAMILY MEMBER(S) AND REASON: _____/_____/_____; _____/_____/_____; _____/_____/_____	<input type="checkbox"/>	<input type="checkbox"/>
9. Is either the applicant, spouse, or dependent, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
10. Males only: are you expecting a child with anyone, even if the birth mother is not listed on the application?	<input type="checkbox"/>	<input type="checkbox"/>
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, etc.? IF CHIROPRACTIC TREATMENT, PLEASE EXPLAIN REASON FOR TREATMENT: _____ NUMBER OF CHIROPRACTIC TREATMENTS WITHIN THE PAST 6 MONTHS: _____	<input type="checkbox"/>	<input type="checkbox"/>
12. Skin conditions – such as: skin cancer, melanoma, psoriasis, keratosis, herpes, warts, birthmarks, burns, etc.?	<input type="checkbox"/>	<input type="checkbox"/>

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, etc., or immune system disorders (except HIV infection), such as: lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID or Pentamidine therapy, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
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, etc.?	<input type="checkbox"/>	<input type="checkbox"/>
15. Cancer (malignancy) – Such as: leukemia, Hodgkin's, tumor/cyst, lymphoma, etc? Type _____ IF YES, CIRCLE TREATMENT TYPE: CHEMOTHERAPY, RADIATION THERAPY, OTHER?	<input type="checkbox"/>	<input type="checkbox"/>
16. Alcoholism, drug dependency or substance abuse? TYPE: _____	<input type="checkbox"/>	<input type="checkbox"/>
17. Presently a member of a support group? TYPE: _____ HOW LONG: _____	<input type="checkbox"/>	<input type="checkbox"/>
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, etc?	<input type="checkbox"/>	<input type="checkbox"/>
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 _____	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
21. Abnormal laboratory results, blood work, x-rays, EKG, nerve condition, blood flow studies, MRI, CT, PET or other scan(s) (except HIV antibody detection tests)?	<input type="checkbox"/>	<input type="checkbox"/>
22. Prosthesis, implant, or retained hardware? TYPE: _____	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
24. Requested or received a pension, benefits or payment because of any injury, sickness, disability or workers compensation?	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>
26. Smoked cigarettes? FAMILY MEMBER: _____ NUMBER OF PACKS PER DAY _____ FOR HOW MANY YEARS: _____ WHEN DID YOU/THEY STOP? _____	<input type="checkbox"/>	<input type="checkbox"/>
27. Drink alcoholic beverages? FAMILY MEMBER: _____ NUMBER OF DRINKS PER WEEK _____ FOR HOW MANY YEARS: _____ WHEN DID YOU/THEY STOP? _____	<input type="checkbox"/>	<input type="checkbox"/>
28. Had any application for health or life insurance revoked, declined, deferred, postponed, or restricted in any way? FAMILY MEMBER: _____ DATE: ____/____/____ PLEASE EXPLAIN: _____	<input type="checkbox"/>	<input type="checkbox"/>

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? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRESENT STATUS:		
	MEDICAL ID CARD #. (IF AVAILABLE)	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ER VISITS? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRESENT STATUS:		
	MEDICAL ID CARD #. (IF AVAILABLE)	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ER VISITS? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	PRESENT STATUS:		
	MEDICAL ID CARD #. (IF AVAILABLE)	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ER VISITS? <input type="checkbox"/> YES <input type="checkbox"/> 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 5 – MEDICAL CONDITION DETAILS (continued)

LIST QUESTION NUMBER	NAME	DIAGNOSIS AND TREATMENT	BEGAN: ____/____/____ (MO/YR)		
			ENDED: ____/____/____ (MO/YR)		
	DOES THE CONDITION STILL EXIST? <input type="checkbox"/> YES <input type="checkbox"/> NO		PRESENT STATUS:		
	MEDICAL ID CARD #. (IF AVAILABLE)	HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> NO	ER VISITS? <input type="checkbox"/> YES <input type="checkbox"/> 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.

- Did you or any applying family member have other health coverage (insurance) within the last 63 days? YES NO
- IF YES, COMPLETE THE FOLLOWING:

	TYPE OF COVERAGE	EFFECTIVE DATE	CANCEL DATE:	HEALTH PLAN CARRIER OR COBRA ADMINISTRATOR
APPLICANT _____	<input type="checkbox"/> GROUP <input type="checkbox"/> COBRA <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> OTHER	____/____/____	____/____/____	_____
SPOUSE/DEPENDENT _____	<input type="checkbox"/> GROUP <input type="checkbox"/> COBRA <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> OTHER	____/____/____	____/____/____	_____
- 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 64 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.

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

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

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 IN COVERAGE (EXCLUDING ANY 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 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: _____

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

4. I AM CURRENTLY ELIGIBLE FOR COVERAGE UNDER A GROUP HEALTH PLAN, MEDICARE OR MEDICAID. YES NO
5. MY MOST RECENT COVERAGE WAS TERMINATED BECAUSE OF NONPAYMENT OF DUES OR FRAUD. YES NO

IF YOU ANSWERED "NO" TO STATEMENTS 4 AND 5 AND "YES" TO STATEMENTS 1 THROUGH 3, 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: 105529858	TELEPHONE NUMBER: (888) 992-2244	FAX NUMBER: (415) 520-5554
PRODUCER NAME: Bradley Vaccaro	EMAIL ADDRESS: mybroker@allpointe-is.com	
PRODUCER ADDRESS: 290 Missouri Street, San Francisco, CA 94107		
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.

If you are married, your spouse (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) 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 or a third party to access to 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 deposit slip or a 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.

Mary Jane Blue 123 First St. Anytown, CA 99999	3025
Pay to Order of	_____ 20 _____ Dollars
Any Bank San Francisco Main Office P.O. Box 8944 San Francisco, CA 94126 Memo _____	
032056884 9 8707228001 0233	
	_____ Bank Account Number
	_____ Bank Routing/Transit Number

VOID

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.)

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

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