

**Blue Shield of California and
Blue Shield of California Life & Health Insurance Company
Dental Plan Application**



This form is to be used by applicants applying for dental plans who are not currently covered under a Blue Shield individual or family medical plan.

Part 1 – Coverage, plan, and applicant information

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

Dental plan: (please check one below)

SmileSM PPO*† Value SmileSM PPO*† Other _____

To find a Blue Shield dental provider by name location and specialty, go to our Web site: blueshieldca.com.

Applicant Information

Applicant Social Security number		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mo/day/yr)
First name	MI	Last name	
Do you currently have dental coverage through Blue Shield? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please indicate plan		Dental subscriber number (if applicable)	
Requested effective date		Married: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Applicant business phone number	Applicant home phone number	Applicant fax number	
Applicant mailing address			
City		State	ZIP code
Billing address (if different from above)			
City		State	ZIP code
E-mail address		Language preference: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other _____	
Payment options: <input type="checkbox"/> Easy\$Pay SM (must complete and sign Easy\$Pay Enrollment Form) <input type="checkbox"/> Monthly direct billing <input type="checkbox"/> Quarterly direct billing			

Part 2 – Dependent information

List all dependent family members you wish to cover (dependent children must be age 22 or under)

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)	

4. Son Daughter

First name	MI	Last name (if different from above)	
Social Security number:		Date of birth (mo/day/yr)	

* Underwritten by Blue Shield of California Life & Health Insurance Company.

† Pending regulatory approval.

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 rescission/cancellation of coverage.

2. First payment of dues/premium: Attached is my personal check or money order in an amount equal to one month's dues/premium made payable to Blue Shield of California. 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 dues/premium will be refunded to me.

3. Dues/premium payments: This Blue Shield dental plan is a prepaid dues/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 dues/premium in a timely manner as set forth in the Health Services Agreement/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 Evidence of Coverage and Health Service Agreement/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 dues/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 your dependent spouse/domestic partner is enrolling for dental plan coverage, please specify if you authorize your spouse/domestic partner changes to the contract on your behalf. Yes No
 You 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 health care 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 READ THE SUMMARY OF BENEFITS AND THE TERMS AND CONDITIONS OF COVERAGE ABOVE. I UNDERSTAND AND AGREE TO EACH OF THEM. I ALONE AM RESPONSIBLE FOR THE ACCURACY AND COMPLETENESS OF THIS APPLICATION. ALL INFORMATION PROVIDED ON THIS APPLICATION IS ACCURATE, TRUE AND COMPLETE. I UNDERSTAND THAT NEITHER I, NOR ANY DEPENDENTS, WILL BE ELIGIBLE FOR COVERAGE IF ANY INFORMATION IS FALSE OR INCOMPLETE. I ALSO UNDERSTAND THAT IF COVERAGE IS ISSUED, COVERAGE MAY BE RESCINDED IF BLUE SHIELD DETERMINES THAT INFORMATION ON THIS APPLICATION IS MATERIALLY INACCURATE, NOT TRUE, OR INCOMPLETE. I ALSO UNDERSTAND THAT COVERAGE MAY BE CANCELLED IF I/WE LOSE ELIGIBILITY.

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	

Producer signature	Today's date	Print name
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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: **(415) 651-8696**