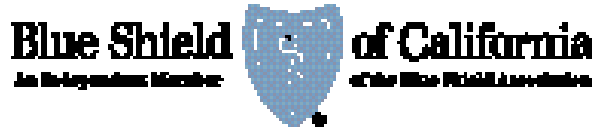


APPLICATION FOR BLUE SHIELD INDIVIDUAL AND FAMILY HEALTH PLANS

BILLING OPTIONS:

- Easy\$Pay (automatic monthly billing)
(complete required form)
- Monthly Billing
- Quarterly Billing



Application must be completed in ink pen or typed. For instructions, turn the page.
 Lose your envelope? Call Andrews Insurance Agency at 1 (877) 433-7868.

PART 1 — Please provide the following: (indicate the younger spouse as the applicant, if applying.)

APPLICANT'S SOCIAL SECURITY NUMBER		APPLICANT'S FIRST NAME		MI	LAST NAME	
INDICATE THE PURPOSE OF THIS APPLICATION (CHECK ONE):						
<input type="checkbox"/> New membership		<input type="checkbox"/> Plan transfer		<input type="checkbox"/> Add family member to existing coverage		
<input type="checkbox"/> Add Term Life Insurance to existing coverage (complete parts 1 and 9 only)						
REQUESTED EFFECTIVE DATE: ____/____/____ (see Part 8, item 2 for instructions)						
DO YOU WANT YOUR EFFECTIVE DATE TO COORDINATE WITH THE TERMINATION DATE OF YOUR CPIC LIFE SHORT TERM HEALTH INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO						
CHOOSE HEALTH PLAN (CHECK ONE BOX ONLY):						
ACCESS+ HMO PLAN		COPAY PLAN		DEDUCTIBLE PLAN		PREFERRED SAVINGS PLAN
<input type="checkbox"/> High Option		<input type="checkbox"/> \$25 Plan		<input type="checkbox"/> \$1,000 Deductible		<input type="checkbox"/> \$1,650 Deductible (Individual)
<input type="checkbox"/> Value Option		<input type="checkbox"/> \$35 Plan		<input type="checkbox"/> \$2,000 Deductible		<input type="checkbox"/> \$2,250 Deductible (Individual)
		<input type="checkbox"/> \$45 Plan				<input type="checkbox"/> \$3,300 Deductible (Two-party/Family)
						<input type="checkbox"/> \$4,500 Deductible (Two-party/Family)
OPTIONAL — CHOOSE DENTAL PLAN (CHECK ONE BOX ONLY):						
<input type="checkbox"/> Dental HMO (DHMO)			<input type="checkbox"/> Dental PPO (DPP0)			
MARRIED YES NO	SPOUSE'S SOCIAL SECURITY NUMBER		APPLICANT'S BUSINESS PHONE NUMBER () ()		APPLICANT'S HOME PHONE NUMBER () ()	
APPLICANT'S FAX NUMBER () ()						
HOME (MAILING) ADDRESS				E-MAIL ADDRESS		
CITY				STATE	ZIP CODE	
BILLING ADDRESS (IF DIFFERENT FROM ABOVE)			CITY	STATE	ZIP CODE	
COUNTY OF RESIDENCE			IF YOU HAVE BEEN A BLUE SHIELD OF CALIFORNIA MEMBER INDICATE:		PRIOR BLUE SHIELD NUMBER	DATE CANCELLED MO. DAY YR.
APPLICANT'S OCCUPATION		EMPLOYER AND EMPLOYER'S ADDRESS (ACCESS+ HMO ONLY)			CITY	ZIP
SPOUSE'S OCCUPATION		EMPLOYER AND EMPLOYER'S ADDRESS (ACCESS+ HMO ONLY)			CITY	ZIP
TO HELP US SERVE YOU BETTER IN THE FUTURE PLEASE INDICATE YOUR LANGUAGE PREFERENCE:						LIST BILL NUMBER (FOR BLUE SHIELD USE ONLY)
<input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> CHINESE <input type="checkbox"/> OTHER: _____						
HAVE YOU BEEN A RESIDENT OF CALIFORNIA FOR THE PAST SIX MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO						

PART 2 — List applicant and all family members you wish to cover. (Dependent children must be under age 19, or under age 23 if full-time students.)

For Access+ HMO: You must select an HMO Personal Physician for yourself and each family member from the Blue Shield HMO Physician and Hospital Network for your service area. You may choose the same or a different Personal Physician for each family member. Be sure to include each Personal Physician's provider number listed in the directory. (If you do not select a Personal Physician, Blue Shield will select one for you. If you have questions regarding your Personal Physician selection, call (800) 424-6521.)

For Dental HMO: You must select a Dental Center from the Dental HMO Dental Center Directory. Be sure to include the Dental Center number listed in the directory. (If you have any questions regarding your Dental Center selection, call (800) 431-2809.)

1	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	YOUR FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH MO. DAY YR.	HEIGHT FT. IN.	WEIGHT LBS.
	ACCESS+ HMO ONLY: PERSONAL PHYSICIAN FIRST NAME			MI	LAST	PROVIDER#	MED. GROUP/IPA #
	DENTAL HMO ONLY: DENTAL CENTER NUMBER			DENTAL HMO ONLY: DENTAL CENTER NAME			
2	<input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH MO. DAY YR.	HEIGHT FT. IN.	WEIGHT LBS.
	ACCESS+ HMO ONLY: PERSONAL PHYSICIAN FIRST NAME			MI	LAST	PROVIDER#	MED. GROUP/IPA #
				<input type="checkbox"/> CHECK IF CURRENT PATIENT			
3	<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH MO. DAY YR.	HEIGHT FT. IN.	WEIGHT LBS.
	ACCESS+ HMO ONLY: PERSONAL PHYSICIAN FIRST NAME			MI	LAST	PROVIDER#	MED. GROUP/IPA #
				<input type="checkbox"/> CHECK IF CURRENT PATIENT			
<input type="checkbox"/> Please consider my child for separate YouthCare rates. CHOOSE PLAN: Copay Plan: <input type="checkbox"/> \$25 Plan <input type="checkbox"/> \$35 Plan <input type="checkbox"/> \$45 Plan Deductible Plan: <input type="checkbox"/> \$1,000 Deductible <input type="checkbox"/> \$2,000 Deductible Access+ HMO: <input type="checkbox"/> High Option <input type="checkbox"/> Value Option Preferred Savings: <input type="checkbox"/> \$1,650 Deductible <input type="checkbox"/> \$2,250 Deductible Child's Social Security Number: _____ Optional — Choose Dental Plan: <input type="checkbox"/> Dental HMO (DHMO) <input type="checkbox"/> Dental PPO (DPP0) Dental Center Name and Number (DHMO Only): _____							
4	<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH MO. DAY YR.	HEIGHT FT. IN.	WEIGHT LBS.
	ACCESS+ HMO ONLY: PERSONAL PHYSICIAN FIRST NAME			MI	LAST	PROVIDER#	MED. GROUP/IPA #
				<input type="checkbox"/> CHECK IF CURRENT PATIENT			
<input type="checkbox"/> Please consider my child for separate YouthCare rates. CHOOSE PLAN: Copay Plan: <input type="checkbox"/> \$25 Plan <input type="checkbox"/> \$35 Plan <input type="checkbox"/> \$45 Plan Deductible Plan: <input type="checkbox"/> \$1,000 Deductible <input type="checkbox"/> \$2,000 Deductible Access+ HMO: <input type="checkbox"/> High Option <input type="checkbox"/> Value Option Preferred Savings: <input type="checkbox"/> \$1,650 Deductible <input type="checkbox"/> \$2,250 Deductible Child's Social Security Number: _____ Optional — Choose Dental Plan: <input type="checkbox"/> Dental HMO (DHMO) <input type="checkbox"/> Dental PPO (DPP0) Dental Center Name and Number (DHMO Only): _____							
5	<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH MO. DAY YR.	HEIGHT FT. IN.	WEIGHT LBS.
	ACCESS+ HMO ONLY: PERSONAL PHYSICIAN FIRST NAME			MI	LAST	PROVIDER#	MED. GROUP/IPA #
				<input type="checkbox"/> CHECK IF CURRENT PATIENT			
<input type="checkbox"/> Please consider my child for separate YouthCare rates. CHOOSE PLAN: Copay Plan: <input type="checkbox"/> \$25 Plan <input type="checkbox"/> \$35 Plan <input type="checkbox"/> \$45 Plan Deductible Plan: <input type="checkbox"/> \$1,000 Deductible <input type="checkbox"/> \$2,000 Deductible Access+ HMO: <input type="checkbox"/> High Option <input type="checkbox"/> Value Option Preferred Savings: <input type="checkbox"/> \$1,650 Deductible <input type="checkbox"/> \$2,250 Deductible Child's Social Security Number: _____ Optional — Choose Dental Plan: <input type="checkbox"/> Dental HMO (DHMO) <input type="checkbox"/> Dental PPO (DPP0) Dental Center Name and Number (DHMO Only): _____							
6	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 one dependent over age 18 who is a full-time student, please attach an additional sheet with the required information and check here. <input type="checkbox"/>						
	NAME	HOURS/WEEK	UNITS	SCHOOL	ADDRESS		

PART 3 — 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." If "Yes," circle the condition(s) applicable and provide the information requested in the appropriate Part: 5, 6, or 7.

		Yes	No			Yes	No
1. Brain or nervous system - such as: dizziness, headaches, seizure disorder, loss of consciousness, epilepsy, paralysis, muscular dystrophy, multiple sclerosis, stroke, cerebral palsy, polio, mental retardation, etc.?				14. Cancer, tumor, cysts, leukemia, Hodgkins, etc.? Type: _____			
					15. Alcoholism, drug dependency or substance abuse? Type: _____		
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.?				16. Presently a member of a support group? How long: _____			
					17. Congenital abnormalities, birth defects - such as: Down's Syndrome, Cerebral Palsy, cleft lip or palate, clubfoot, developmental delay, mental retardation, or other neurological or physical abnormalities?		
3. Circulatory system - such as: varicose veins, peripheral vascular disease, phlebitis, blood clots, stroke, bleeding problems, blood disorder, anemia, or enlarged lymph nodes, etc.?				18. Have you or any applying family member ever received any 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?			
					19. Have you or any applying family member ever been an inpatient or outpatient in a hospital, surgicenter, sanitarium, or other medical facility, including an emergency room, or had any surgery, including angioplasty, cosmetic/reconstructive, bypass, or transplant surgery?		
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, etc.?				20. Have you or any applying family member ever had abnormal laboratory results, blood work, x-rays, EKG, nerve condition, blood flow studies, MRI scan, CT scan, or PET scan?			
					21. Do you or any applying family member have a prosthesis, implant, or retained hardware? Type: _____		
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.? Hepatitis type: _____				22. Have you or any applying family member been advised to undergo further testing, treatment or surgery which has not yet been performed by a physician, dentist, or other provider?			
					23. Do you or any applying family member have any symptoms and/or health problems that have not yet been evaluated by a physician, or have any diagnoses, symptoms or problems not mentioned elsewhere on this application, or have any complications or residuals remaining following any treatment?		
6. Urinary tract - such as: renal colic, gravel or stone, urethra, bladder or kidney problems, infections, stricture, pyelonephritis, etc.?				24. Have you or any applying family member ever smoked cigarettes? Family member: _____ Packs per day: _____ How many years: _____ When did you/they stop? _____			
					25. Do you or any applying family member drink alcoholic beverages? Family member: _____ Drinks per week: _____ Type: _____		
7. Male reproductive system - such as: prostate problems, infertility, impotency, male breast problems, gynecomastia, infections, herpes, syphilis, gonorrhea, or other venereal disease, etc.?				26. Have you or any applying family member ever had any application for health or life insurance declined, postponed or restricted in any way? Family member: _____ Date: _____ Please explain: _____			
					27. Have you or any applying family member ever requested or received a pension, benefits or payment because of any injury, sickness or disability? Family member: _____ Date: _____ Please explain: _____		
8. Female reproductive system - such as: breast problems, breast implants, adhesion, abnormal bleeding, amenorrhea, endometriosis, fibroid tumors, abnormal Pap test, problems of the ovaries, uterus and associated female organs, infertility, in-vitro fertilization, history of caesarean delivery, infections, genital warts, herpes, syphilis, or other venereal disease, etc.? Type of implants: _____ Last menstrual period: _____				28. In the past two years, have you or any applying family member seen a physician or health care provider for an examination that was prompted by symptoms: that the physician wanted to observe; or that resulted in a diagnostic condition, a recommendation for further tests, or treatment; or that resulted in abnormal findings (excluding provider visits for diagnosed flu or cold of less than 14 days duration, and prior completed pregnancies with no complications)?			
					29. Have you or any applying family member seen a physician or health care provider for any reason within the last 60 days?		
9. A. Is either the applicant or spouse, whether or not listed on the application, currently pregnant? B. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on the application? C. Is any female dependent listed on this application currently pregnant? D. If any of the above questions are answered yes, please complete: Expected delivery date: _____ Method of Conception: <input type="checkbox"/> Normal <input type="checkbox"/> In-vitro <input type="checkbox"/> G.I.F.T. <input type="checkbox"/> Other Prior caesarean delivery? <input type="checkbox"/> Yes <input type="checkbox"/> No				30. In the last 12 months, have you or any applying family member taken or been ordered to take prescription medication(s) other than: antibiotics solely for seasonal flu or cold infection OR birth control pills solely for the prevention of conception OR female hormones solely for replacement therapy?			
10. 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, amputation, etc.?							
11. Skin conditions - such as: skin cancer, melanoma, psoriasis, keratosis, herpes, warts, birthmarks, burns, etc.?							
12. Metabolic system - such as: diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders, such as: lupus, Raynauds, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID or Pentamidine therapy, etc.? (CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AS A CONDITION OF OBTAINING COVERAGE.)							
13. 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.?							

PART 4 — Prior Medical Coverage - Please answer each question. If yes, please provide details in the space provided.

1. Did you or any applying family member have other health coverage (insurance) within the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	Family member: _____
Type of coverage: <input type="checkbox"/> Individual/Family <input type="checkbox"/> Group <input type="checkbox"/> HMO <input type="checkbox"/> Disability	Effective date: _____ Cancellation date: _____
<input type="checkbox"/> Short Term or Interim <input type="checkbox"/> Other	Name of company: _____
2. Copay Plan, Deductible Plan, and Preferred Savings Plan applicants: If your previous health plan covered any of the conditions checked "YES" in PART 3, and that plan terminated within 62 days of Blue Shield's receipt of this application, check here <input type="checkbox"/> and attach a Certificate of Creditable Coverage from your previous health plan. We need this to apply prior creditable coverage to your preexisting conditions exclusion waiting period, if applicable. See the Summary of Benefits booklet for more on preexisting conditions, and call (800) 431-2809 for assistance obtaining a certificate.	

PART 5 — Medical Condition Details — If you answered "YES" to any of questions 1-24 in PART 3, give full 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. Check here for attachment.

QUESTION NUMBER	FAMILY MEMBER NAME AND NAME USED ON DOCTOR'S RECORDS	DIAGNOSIS AND PRESENT STATUS	DATES OF TREATMENT, HOSPITALIZATION	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	DIAGNOSIS AND TREATMENT	BEGAN: _____ / _____ MO. YR. DOES THE CONDITION STILL EXIST? <input type="checkbox"/> YES <input type="checkbox"/> NO ENDED: _____ / _____ MO. YR.	NAME ADDRESS STE#
	MEDICAL RECORD NO.	PRESENT STATUS	HOSPITALIZED? DATES: <input type="checkbox"/> YES <input type="checkbox"/> NO	CITY STATE ZIP
	NAME	DIAGNOSIS AND TREATMENT	BEGAN: _____ / _____ MO. YR. DOES THE CONDITION STILL EXIST? <input type="checkbox"/> YES <input type="checkbox"/> NO ENDED: _____ / _____ MO. YR.	NAME ADDRESS STE#
	MEDICAL RECORD NO.	PRESENT STATUS	HOSPITALIZED? DATES: <input type="checkbox"/> YES <input type="checkbox"/> NO	CITY STATE ZIP
	NAME	DIAGNOSIS AND TREATMENT	BEGAN: _____ / _____ MO. YR. DOES THE CONDITION STILL EXIST? <input type="checkbox"/> YES <input type="checkbox"/> NO ENDED: _____ / _____ MO. YR.	NAME ADDRESS STE#
	MEDICAL RECORD NO.	PRESENT STATUS	HOSPITALIZED? DATES: <input type="checkbox"/> YES <input type="checkbox"/> NO	CITY STATE ZIP
	NAME	DIAGNOSIS AND TREATMENT	BEGAN: _____ / _____ MO. YR. DOES THE CONDITION STILL EXIST? <input type="checkbox"/> YES <input type="checkbox"/> NO ENDED: _____ / _____ MO. YR.	NAME ADDRESS STE#
	MEDICAL RECORD NO.	PRESENT STATUS	HOSPITALIZED? DATES: <input type="checkbox"/> YES <input type="checkbox"/> NO	CITY STATE ZIP
	NAME	DIAGNOSIS AND TREATMENT	BEGAN: _____ / _____ MO. YR. DOES THE CONDITION STILL EXIST? <input type="checkbox"/> YES <input type="checkbox"/> NO ENDED: _____ / _____ MO. YR.	NAME ADDRESS STE#
	MEDICAL RECORD NO.	PRESENT STATUS	HOSPITALIZED? DATES: <input type="checkbox"/> YES <input type="checkbox"/> NO	CITY STATE ZIP

PART 6 — Physician Visit Details — List your last physician visit.

If you answered "YES" to question 28 or 29 in PART 3, please provide the details of the physician visits. **A COMPLETE PHYSICAL EXAMINATION IS REQUIRED FOR ANY FAMILY MEMBER AGE 55 YEARS OR OLDER. THIS EXAMINATION SHOULD BE WITHIN THE LAST TWO YEARS.**

NAME OF FAMILY MEMBER	DATE OF VISIT	REASON FOR EXAMINATION/CHECK-UP	FINDINGS AND PRESENT STATUS	FULL NAME, SPECIALTY AND MEDICAL GROUP OF PHYSICIAN	COMPLETE ADDRESS, SUITE NO., CITY AND ZIP CODE OF PHYSICIAN
				NAME	ADDRESS
				SPECIALTY MEDICAL GROUP	CITY STATE ZIP
				NAME	ADDRESS
				SPECIALTY MEDICAL GROUP	CITY STATE ZIP
				NAME	ADDRESS
				SPECIALTY MEDICAL GROUP	CITY STATE ZIP
				NAME	ADDRESS
				SPECIALTY MEDICAL GROUP	CITY STATE ZIP
				NAME	ADDRESS
				SPECIALTY MEDICAL GROUP	CITY STATE ZIP

PART 7 — Prescription Medication Details — Current or recent prescription medications.

If you answered "YES" to question 30 in PART 3, please provide the details of the current and previous medications.

NAME OF FAMILY MEMBER	NAME OF MEDICATION AND CONDITION FOR WHICH MEDICATION WAS PRESCRIBED	DATES FROM TO	FULL NAME, SPECIALTY AND MEDICAL GROUP OF PHYSICIAN	COMPLETE ADDRESS, SUITE NO., CITY AND ZIP CODE OF PHYSICIAN
	MEDICATION		NAME	ADDRESS
	CONDITION		SPECIALTY MED. GROUP	CITY STATE ZIP
	MEDICATION		NAME	ADDRESS
	CONDITION		SPECIALTY MED. GROUP	CITY STATE ZIP
	MEDICATION		NAME	ADDRESS
	CONDITION		SPECIALTY MED. GROUP	CITY STATE ZIP
	MEDICATION		NAME	ADDRESS
	CONDITION		SPECIALTY MED. GROUP	CITY STATE ZIP

PART 8 — Disclosure Statements — Please read these conditions of membership and authorization and date and sign below.

- Attached is my personal check or money order in an amount equal to one month's dues. It will be refunded if my application is not approved. (If you are also applying for CPIC Life short term health insurance, full CPIC Life short term health insurance payment is required INSTEAD of one month's dues. Cashing of your check by Blue Shield does not constitute approval.)
- To specify an effective date for **Preferred Savings Plan, Copay Plan, or Deductible Plan** coverage, indicate a date that is between 30 and 90 days from your signature date and either the 1st or the 15th of the month. If you do not specify an effective date in Part One of this application, Blue Shield will assign one. **Access+ HMO** effective dates are always on the first of the month. (If you are requesting Dental HMO coverage, you must request a health plan effective date on the first of the month. If you are also applying for CPIC Life short term health insurance, specify a health plan effective date that coincides with the last day of your CPIC Life short term health insurance. Attach a copy of your CPIC Life short term health insurance application.) **Charges incurred before your effective date of coverage are never covered.**
- To find Blue Shield providers by name, location, specialty, and language, go to our Web site: www.blueshieldca.com. You can use the Web site to print out a listing of Blue Shield providers in your area.
- If my application is approved, Blue Shield will inform me of my effective date of coverage. Then, after Blue Shield receives my full dues, I will be covered as of that effective date. This application, including the Statement(s) of Health, will become part of my agreement with Blue Shield. My agent cannot approve my application or change any terms or conditions of my coverage. I understand Blue Shield has the right to decline my application.
- The Copay Plan, Deductible Plan, and Preferred Savings Plan pay substantially lower benefits when non-Preferred Providers are used. In most cases, the Access+ HMO Plan pays benefits only for services received through the Personal Physician. Refer to the Summary of Benefits brochure for a full explanation.
- If you are not approved for the plan you have applied for, Blue Shield will automatically consider you for other options within the same plan, or other Blue Shield plans — which may have higher deductibles, copayments or dues rates. If this occurs and you are approved for another plan, we will send you information about that plan and you will have 10 days to examine the information before you become responsible for payment.**
- Legal Guardian** (if the applicant is a minor): I will assume all responsibility for dues payments and for managing the provision of benefits under the plan applied for by my child. **(Court documents must be attached authorizing guardianship if the responsible adult is not the parent.)**
- Authorization for Disclosure of Personal Information**
I authorize any "provider of care," insurer, or health plan to disclose to Blue Shield of California and CPIC Life Insurance Company (if applicable), or their representatives, all "medical information" (as these terms are defined in the California Civil Code) regarding me or any applying family member, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for evaluating this application, determining eligibility for benefits, and/or for quality assurance and peer review. This authorization will remain valid for the term of coverage of the Blue Shield health service contract/CPIC Life policy. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization.

THIS SECTION MUST BE COMPLETED:

I HAVE READ THE SUMMARY OF BENEFITS AND THE ABOVE CONDITIONS. I UNDERSTAND AND AGREE TO THEM. I ALONE AM RESPONSIBLE FOR THE ACCURACY AND COMPLETENESS OF THIS APPLICATION FOR BLUE SHIELD HEALTH COVERAGE, DENTAL COVERAGE (IF APPLICABLE), AND CPIC LIFE TERM LIFE INSURANCE (IF APPLICABLE). I understand that neither I nor my family will be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

Applicant's Social Security Number _____

Other name under which applicant or family member has received care _____

TODAY'S DATE (REQUIRED) SIGNATURE OF APPLICANT (OR LEGAL GUARDIAN)

TODAY'S DATE (REQUIRED) SIGNATURE OF APPLICANT'S SPOUSE (IF APPLYING)

TODAY'S DATE (REQUIRED) SIGNATURE OF FAMILY MEMBER AGE 18 AND OVER (IF APPLYING)

PRINT NAME (AND RELATIONSHIP IF APPLICANT IS A MINOR)

PRINT NAME

PRINT NAME

PART 9 — CPIC LIFE INSURANCE — If you want CPIC Life Term Life Insurance please complete the following.

If you, the primary applicant, are approved for Blue Shield health coverage, you **may qualify** for CPIC Life Term Life Insurance at an additional charge. Applicants under the age of one year are not eligible for life insurance.

- Indicate the Term Life Insurance amount desired: \$10,000 \$25,000 \$50,000 (not available to applicants under age 19)
- Approval or declination of Term Life Insurance coverage will be based on the information you provide on this application.
- Designate your beneficiary below.

BENEFICIARY	RELATIONSHIP (AND AGE, IF A MINOR)	CITY/STATE	ZIP
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If you want life insurance coverage for your spouse, enter this person as the primary applicant. (NOTE: This may impact your Blue Shield health plan dues rate.) If a beneficiary is not indicated, and the policy is issued, death benefits will be paid in accordance with the Succession of Interest of Beneficiaries provision on page 4 of the policy.

TODAY'S DATE (REQUIRED) SIGNATURE OF APPLICANT OR LEGAL GUARDIAN PRINT NAME

PART 10 — AGENT INFORMATION — to be completed by Agent.

AGENT NUMBER	TELEPHONE NUMBER ()	FAX NUMBER ()	AGENT'S CERTIFICATION 1. Are you aware of any information not disclosed in this application of health, which may have a bearing on this risk? <input type="checkbox"/> Yes, attach explanation <input checked="" type="checkbox"/> No 2a. Did you see the applicant? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 2b. Did you ask each question in this application exactly as set forth? <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Are the answers recorded exactly as given to you? <input type="checkbox"/> Yes <input type="checkbox"/> No, attach explanation 4. Who completed this application? <input type="checkbox"/> Agent <input type="checkbox"/> Applicant 5. Did you offer CPIC Life short term health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Did you offer CPIC Life Term Life? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Do you want the Service Agreement sent directly to the subscriber? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
AGENT NAME	EMAIL ADDRESS		
AGENT ADDRESS			
SUPER PRODUCER NAME	SUPER PRODUCER NUMBER		
AGENT SIGNATURE	DATE		

PAGE 4 OF 4 OF THE BLUE SHIELD APPLICATION



Information Practices

In accordance with California law, Blue Shield may collect personal information about you to evaluate your application or to properly administer your benefits. This is generally limited to information relating to the condition of your health, what services were provided, and at what cost.

Under California law, this information may be given to others under certain circumstances. For example, Blue Shield may provide information to a hospital to verify benefits. Upon your request, Blue Shield will provide details to you of the nature of personal information that may be collected, the circumstances under which it may be disclosed without your authorization, and your right to access and, if you believe it to be inaccurate, correct this information. Blue Shield may furnish this medical information directly to you or to a medical professional designated by you.

Applying for Children's Coverage

When applying for coverage of children under age 19, you may include them as dependents on your family plan or apply for separate YouthCareSM plans for each child. YouthCare's special rates may cost you less overall. Call your Blue Shield Agent for help determining which option is best for you.

To apply for YouthCare rates, include each child's Social Security Number and mark the plan you've chosen for him or her in Part 2 of the application.

Eligibility

If you are a California resident under age 65, and are not eligible for Medicare, you may apply for any Blue Shield plan. 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 the first or 15th of the month following Blue Shield's approval date for any 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 you apply for the Access+ HMO Plan, you must live or work in the Access+ HMO Plan Service Area (the geographic area served by the plan). You, and each family member covered by this plan, need to select a Personal Physician. The Personal Physician must be located sufficiently close to your home or work address to ensure reasonable access to care as determined by Blue Shield.

Preferred Savings Plan Applicants Only:

Medical Savings Account (MSA) Eligibility

Eligibility for the Preferred Savings Plan *does not* automatically qualify you for a Medical Savings Account (MSA). To qualify for an MSA, you must have a high-deductible health plan such as the Preferred Savings Plan, and also be self-employed. You must then open your account with a financial institution offering MSAs. Other eligibility restrictions for MSAs may apply, as determined by federal and state government agencies. Please consult a financial advisor or institution if you would like to open an MSA.

Covering Children with an MSA

A child who is a dependent for tax purposes is not eligible to set up a Medical Savings Account (MSA). If you are interested in opening an MSA to contribute to your children's medical expenses, do not cover them using Preferred Savings YouthCare plans. Instead, consider Preferred Savings family coverage. Consult a financial advisor and read Blue Shield's *Beginner's Guide to Medical Savings Accounts* to learn more about family use of MSAs.

Statement of Guaranteed Issue Eligibility

If you meet every condition below, you are eligible for guaranteed issue in accordance with the federal Health Insurance Portability and Accountability Act (HIPAA), and Blue Shield is obligated to automatically accept your application for the \$1,000 or \$2,000 Deductible Plan, without underwriting.

If you are applying for coverage of any dependents who are not eligible for guarantee issue, their coverage will be subject to medical underwriting, except for children born or adopted under your prior creditable coverage within 30 days of the birth or placement for adoption. **Dependents applying for guaranteed issue must complete a separate Statement of Guaranteed Issue Eligibility and provide proof of prior creditable coverage.** (Please contact your Blue Shield agent, or Blue Shield for additional applications.)

No pre-existing conditions exclusion may be applied to members enrolled under guaranteed issue. For current guaranteed issue rates, please contact your Blue Shield agent at 1 (877) 433-7868.

Guaranteed Issue Eligibility Checklist.

Please mark the box next to each true statement. If you meet every condition listed, you are eligible for guaranteed issue.

- 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 62-day break (excluding any employer-imposed waiting periods) in coverage.*
- My most recent coverage was through a group health plan (COBRA and Cal-COBRA are considered group coverage).*
- I am **not** currently eligible for coverage under any group health plan, Medicare or Medicaid.*
- My most recent coverage was **not** terminated because of nonpayment of dues or fraud.*
- I accepted COBRA or Cal-COBRA coverage and exhausted all of its benefits, or was not eligible for COBRA or Cal-COBRA.*

X _____

Signature of Applicant or Legal Guardian

Date

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.

How to Apply for Guaranteed Issue

1. Complete the application for Blue Shield Individual and Family Health Plans:

- In part one of the application, choose the \$1,000 or \$2,000 Deductible Plan
- Complete only parts 1, 2 and 8 of the application if:
 - You are applying for coverage for yourself only, or yourself and dependents who also meet the eligibility requirements; **and**
 - You are **NOT** applying for CPIC *Life Term Life Insurance*.

Please note: If you complete the entire application we will examine your application to see if you or any applying dependents are eligible for rates which are lower than the guarantee issue rates, and will notify you of the rates for which you qualify. (Completing the entire application will not affect your eligibility for guarantee issue.)

- Complete the entire application if you wish to be considered for non-guaranteed issue coverage. You must qualify for non-guaranteed issue coverage in order to be considered for any of the following:
 - Dependent coverage of a spouse or child who does not meet the requirements stated in the guaranteed issue eligibility checklist, above; or
 - CPIC Life Term Life Insurance; or
 - Lower rates than the guaranteed issue rates.

2. Obtain the following as proof of prior health coverage:

- A copy of the Certificate(s) of Creditable Coverage issued by your prior health plan(s) indicating your 18 months or more of coverage. The 18 months include the number of months you were covered under COBRA. (Contact your prior health plan(s) for copies of these documents. If necessary, call Blue Shield at (800) 431-2809 regarding other acceptable proof of coverage.)
- A letter from the employer through whom you had your most recent group health coverage that states:
 - The date on which you exhausted or will exhaust your COBRA or Cal-COBRA coverage; or
 - Your ineligibility for COBRA or Cal-COBRA.

3. Submit to your Agent or Blue Shield:

- Your completed and signed Blue Shield Individual and Family Health Plan application;
- This Statement of Guaranteed Issue Eligibility, completed and signed;
- Your certificate(s) of creditable coverage; and
- The COBRA/Cal-COBRA letter from your employer.

Tear here to detach the application from the rest of this form.

Blue Shield Flexible Billing Options

Dues must be paid in advance. Blue Shield offers three payment methods. Please select a billing method in the box at the top of the application.

1. Monthly billing

2. Quarterly billing

With options 1 and 2, your bill will tell you the date your payment is due. Payments should be sent to:

Blue Shield of California
P.O. Box 7021
Anaheim, CA 92850-7021

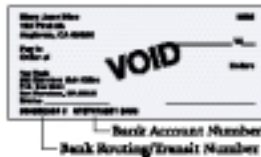
3. Easy\$Pay Monthly Billing —

a convenient, automatic way to pay your dues.

When you sign up for Easy\$Pay, your monthly payments to Blue Shield are handled automatically via electronic transfer from your checking or savings account.

To sign up for Easy\$Pay:

Simply complete the Easy\$Pay Authorization Form on this page and return it with your application to Blue Shield. Staple a deposit slip or a blank check marked "VOID" to your Easy\$Pay Authorization Form (not your dues check). This will be used as a record of your account number, your bank's code, and other information we need to set up Easy\$Pay. If you do not attach a voided check or deposit slip, you must provide the routing/transit number of your financial institution (see illustration).



Staple voided check here.

(not your dues check)

Easy\$PaySM Authorization Form

Type of account: Checking Savings
Debit date: 1st of month 15th of month
(HMO applicants must use 1st of month)

Name of Applicant

Applicant's Daytime Telephone Number

Mailing Address

City State Zip Code

Applicant's Social Security Number

Name of Financial Institution

Name(s) on Bank Account

Branch Address

City State Zip Code

Branch Telephone Number

Bank Routing/Transfer Number

Bank Account Number

I authorize Blue Shield of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Shield of California dues.

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 financial institution indicated, at least 10 days before my account is to be debited.

I understand that, if there are insufficient funds in my account when it is automatically debited, Blue Shield of California will debit for all dues owed in the next debit. I also understand that, if there are insufficient funds in my account two consecutive times, Blue Shield of California will convert my account to one that is billed to me monthly.

Authorized Signature(s) — as it/they appear in the financial institution's records. If the account listed is a joint account, both account holders must sign.

X _____
Date

X _____
Date

Applying Is Easy!

You can use this application to apply for any Blue Shield health plan for individuals and families: Access+ HMO, Copay Plan, Deductible Plan, or Preferred Savings. Follow the six steps below and your application will be processed more quickly!

- ✓ **Before you start** – Separate your application from the rest of this form. Read all instructions on the application carefully. Make sure you do not skip any questions. Print clearly in blue or black ink. Do not use pencil.
- ✓ Calculate your Blue Shield monthly rates, using the rates included with your booklet.
- ✓ Staple a personal check or money order to your application in an amount equal to one month's dues, payable to Blue Shield of California. Please note: cashing this check does not constitute approval. The amount will be refunded in full if your application is not approved.
- ✓ **Important** – Sign and date page four of the application. Signatures are required for all applicants, including your spouse, and dependents age 18 and older.
- ✓ To cover dependents age 19 through 22, be sure to complete Part 2, Number 6 on the application.
- ✓ Return the application in the envelope provided within 30 days of your date of signature. Blue Shield will notify you in writing if your application is approved.

Application Tips

- ✓ Provide an answer to every question, even if you are not sure it applies to you. This will speed the processing of your application.
- ✓ Indicate your billing choice at the top of the application. (If you choose Easy\$Pay, complete the Easy\$Pay form next to the application.)
- ✓ If married: list the younger spouse as the applicant. It may lower your monthly dues.
- ✓ If applying for Access+ HMO: be sure to select a Personal Physician. Our online provider directories make it quick and easy, at www.blueshieldca.com.
- ✓ Be sure to include your check or money order.*
- ✓ Remember — each applying family member age 18 or older must sign on page four of the application.

Have questions?

For help filling out your Blue Shield application, call your Blue Shield Agent. He or she will help you complete it correctly so it is processed as quickly as possible!

Before You Start:

Simply tear on the dotted line next to the Guaranteed Issue form inside to separate and complete your application.