blue california

Dental PPO Plans Enrollment Form for Blue Shield Medicare Supplement Plan Members

Subscriber name (first, last): _____

Blue Shield subscriber ID number: _____

Address: _____

City: _____ State: _____ ZIP: _____

Enrollment plan type: ☐ Individual ☐ Household Savings (see Section 2 below)

1. **Dental plan option:**

   ☐ Dental PPO 1000 ☐ Dental PPO 1500

2. **Household Savings Program*:** This section must be completed if you are enrolled in the Household Savings Program. You and your other household member need to both select and enroll in the same dental PPO plan to continue to receive household savings.

   You will no longer be enrolled in the Household Savings Program if you select a different dental plan option below or only one household member wants to enroll in a dental PPO plan. As a result, your Medicare Supplement medical plans dues will change on your next bill because you will each receive an individual bill and the bills will not include the household savings.

   *Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber.

   Other household member name (first, last): _____

   Other household member dental plan option:

   ☐ Dental PPO 1000 ☐ Dental PPO 1500

3. **Terms and conditions acknowledgment**

   Before submitting this enrollment form, please read the following acknowledgments and confirm your agreement with your signature and date below:

   a. I confirm that I am, or will be, at the time of enrollment in this dental PPO plan, a Blue Shield Medicare supplement plan member.

   b. I understand that if my dental plan coverage is cancelled for any reason (by me or by Blue Shield), I will have to wait six months to reapply for coverage.

   c. I understand that if my Blue Shield Medicare Supplement plan coverage is cancelled for any reason (by me or by Blue Shield), this dental plan coverage will also be automatically terminated.

   d. I understand that Blue Shield will notify me of my effective date of coverage. I understand that any charges for services received prior to my effective date or after termination of coverage are not covered.

   e. I understand that Blue Shield may cancel this agreement upon thirty (30) days written notice if I move out of California.

I have read the summary of benefits and each of the terms and conditions of coverage set forth above. I understand and agree to each of them. To the best of my knowle dge and belief, information and confirmations provided on this form are correct and true.

Subscriber's signature _____ Date _____

Other household member's signature _____ Date _____

Please fax, mail, or email the completed and signed application to:

Installation & Billing
Blue Shield of California
P.O. Box 3008
Lodi, CA 95241-9969

Fax: **(844) 266-1850**

Email: **msinstall@blueshieldca.com**

FMO/Agency Name: _____
FMO/Agency ID No.: _____
Producer Name: _____
Producer phone number: _____
Producer ID No.: _____
Producer NPN No.: _____