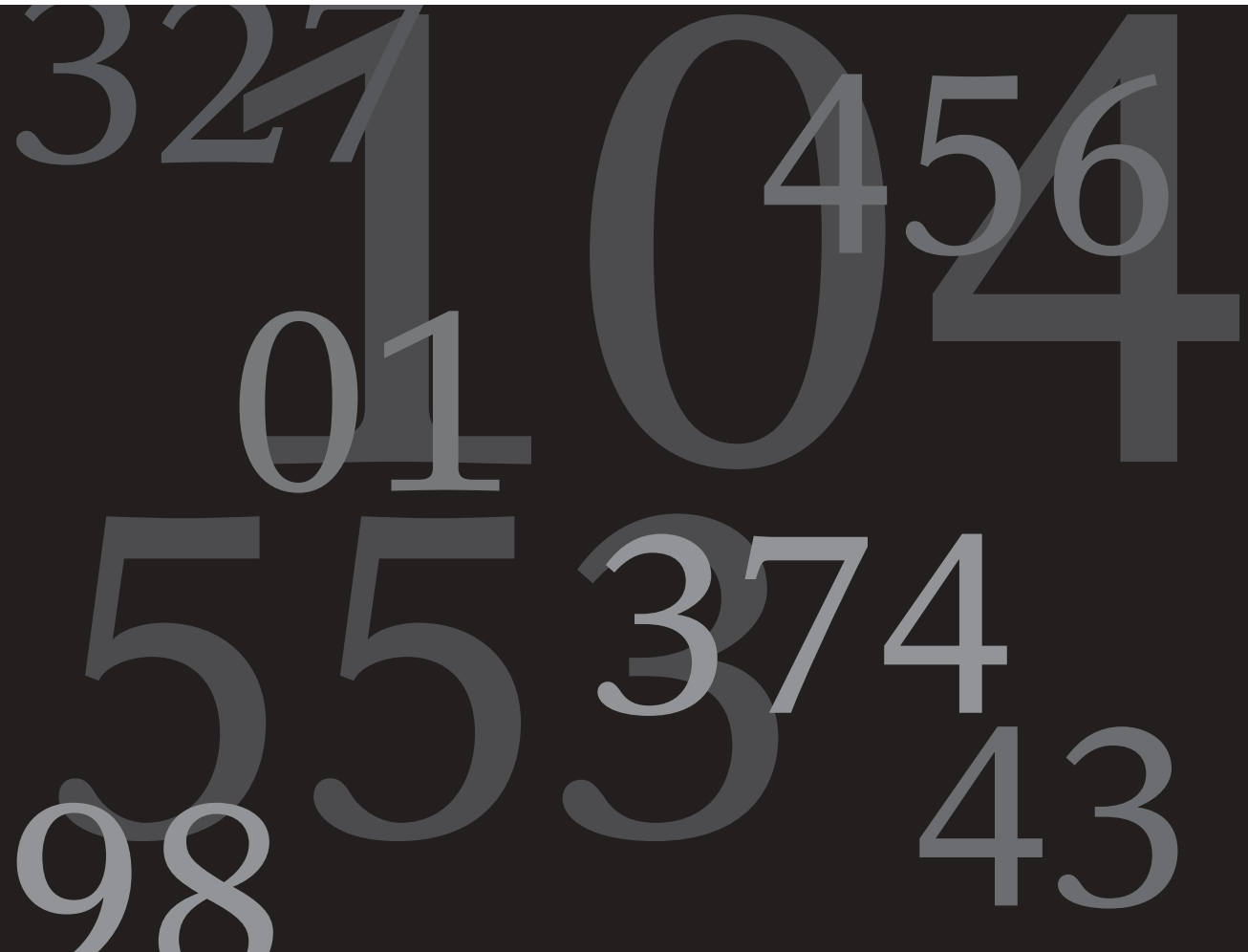


Application is located at the end of this rate guide.



Blue Shield
of California



Monthly Rates for Individuals and Families

Effective January 1, 2004

Visit us at mylifepath.com

Individual and Family Plans

To find the rates that apply to you:

- 1** Decide which plan is best for you and your family. *(Remember, a family deductible is only twice the amount of an individual deductible – no matter how many people are covered by your plan.)*
- 2** Locate your county of residence in one of the Blue Shield Rating Regions, then find the rating chart for your region.
- 3** On the chart you'll see that rates are listed separately for single, party of two, family and YouthCare coverage. Locate the category that applies to you. *(If you have dependent children, you may want to consider covering them separately with YouthCareSM rates. This may cost less per month, especially if you are a single parent.)*
- 4** Under the type of coverage you've selected ("family," for example), find the age range of the person who will be the primary applicant. The rates that apply to you for each Blue Shield plan are in this row. *(If you're married, use the younger spouse as the primary applicant. It may lower your monthly dues!)*

Blue Shield Rating Regions

The rates in this brochure are Blue Shield's "Tier 1" rates, and are offered to individuals and families in good health. Other rates may apply depending on underwriting determination.

Active Choice, Shield Spectrum PPO and PPO Savings Plan Rating Regions

Region 1: Alpine, Butte, Del Norte, Imperial, Inyo, Kern, Plumas, San Luis Obispo, Sonoma, Stanislaus, Trinity, Yolo and the following Santa Barbara zip codes: 93254, 93427, 93429, 93434, 93436-38, 93440-41, 93454-58, 93460, 93463-64

Region 2: Colusa, Kings, Madera, Mendocino, Merced, San Benito, San Joaquin, Siskiyou, Tulare

Region 3: Amador, Calaveras, Glenn, Modoc, Nevada, Placer, Sacramento, Shasta, Sierra, Tuolumne

Region 4: Alameda, Contra Costa, Santa Clara

Region 5: Marin, San Francisco, San Mateo

Region 6: El Dorado, Fresno, Humboldt, Lake, Lassen, Mariposa, Mono, Monterey, Napa, Santa Cruz, Solano, Sutter, Tehama, Yuba

Region 7: San Bernardino, San Diego, Santa Barbara except the zip codes listed in Rating Region 1

Region 8: Orange, Riverside, Ventura and the following Los Angeles zip codes: 91023, 91301, 91310, 91321-22, 91350-51, 91354-55, 91376-77, 91380-87, 91390, 91711, 91750, 91765-69, 91773, 91788-89, 91795, 91797, 91799, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93563, 93584, 93586, 93590-91, 93599

Region 9: Los Angeles except the zip codes listed in Rating Region 8

Access+ HMO Rating Regions

Region 1: Butte, Kern*, Sonoma, San Luis Obispo*, Stanislaus, Yolo and the following Santa Barbara zip codes: 93254, 93427, 93429, 93434, 93436-38, 93440-41, 93454-58, 93460, 93463-64

Region 2: Kings, Madera, Merced, San Joaquin, Tulare

Region 3: Nevada*, Placer*, Sacramento

Region 4: Alameda, Contra Costa, Santa Clara

Region 5: Marin, San Francisco, San Mateo

Region 6: El Dorado*, Fresno, Santa Cruz, Solano

Region 7: San Bernardino*, San Diego*, Santa Barbara* except the zip codes listed in Rating Region 1

Region 8: Orange, Riverside, Ventura and the following Los Angeles zip codes: 91023, 91301, 91310, 91321-22, 91350-51, 91354-55, 91376-77, 91380-87, 91390, 91711, 91750, 91765-69, 91773, 91788-89, 91795, 91797, 91799, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93563, 93584, 93586, 93590-91, 93599

Region 9: Los Angeles except the zip codes listed in Rating Region 8

* Portions of these counties may not be in Blue Shield's approved HMO service area. Contact Blue Shield for more information.

** **Please Note:** The rating regions are subject to change. Call Blue Shield to verify which rating region you are in.

Please Note: To learn about current rates for Guaranteed Issue plans, call **(800) 431-2809**.

REGION 1

Age Range	ACTIVE CHOICE	SHIELD SPECTRUM PPO PLANS					SHIELD SPECTRUM PPO Savings Plan 2400/4800	ACCESS+ HMO PLAN
		PPO Plan 5000	PPO Plan 2000	PPO Plan 1500	PPO Plan 750	PPO Plan 500		
YOUTH CARE – Monthly Dues for Blue Shield							Plan 2400	
Under 1	\$143	\$66	\$121	\$172	\$190	\$276	\$84	\$227
1 to 18	53	23	45	62	70	101	30	130
SINGLE – Monthly Dues for Blue Shield							Plan 2400	
19 to 29	\$80	\$36	\$67	\$97	\$106	\$155	\$46	\$225
30 to 34	109	49	92	130	144	210	62	283
35 to 39	118	54	100	142	158	230	69	302
40 to 44	150	69	126	181	200	292	88	326
45 to 49	183	83	154	218	243	354	106	356
50 to 54	237	109	200	286	317	461	139	390
55 to 59	306	140	258	366	409	592	179	482
60 to 64	396	182	334	476	528	767	233	620
PARTY OF TWO – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$157	\$71	\$132	\$187	\$207	\$302	\$91	\$440
30 to 34	211	96	178	254	281	409	123	551
35 to 39	231	106	195	279	310	449	136	587
40 to 44	294	134	248	353	391	568	172	636
45 to 49	355	162	300	427	473	689	208	695
50 to 54	465	211	392	557	618	898	270	761
55 to 59	598	273	505	717	796	1100	350	940
60 to 64	774	354	653	929	1030	1410	454	1210
FAMILY – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$258	\$118	\$218	\$307	\$342	\$497	\$150	\$683
30 to 34	328	150	277	394	436	634	192	834
35 to 39	361	165	305	432	479	697	211	897
40 to 44	423	193	357	506	563	817	247	946
45 to 49	473	216	399	569	630	915	277	979
50 to 54	559	256	472	671	745	1082	328	992
55 to 59	670	306	566	804	892	1296	392	1118
60 to 64	836	382	706	1003	1114	1596	490	1362

REGION 2

Age Range	ACTIVE CHOICE	SHIELD SPECTRUM PPO PLANS					SHIELD SPECTRUM PPO Savings Plan 2400/4800	ACCESS+ HMO PLAN
		PPO Plan 5000	PPO Plan 2000	PPO Plan 1500	PPO Plan 750	PPO Plan 500		
YOUTH CARE – Monthly Dues for Blue Shield							Plan 2400	
Under 1	\$154	\$69	\$130	\$198	\$206	\$310	\$88	\$254
1 to 18	56	25	47	72	75	114	32	146
SINGLE – Monthly Dues for Blue Shield							Plan 2400	
19 to 29	\$87	\$38	\$74	\$111	\$115	\$174	\$50	\$252
30 to 34	118	53	99	150	158	235	67	318
35 to 39	130	58	110	166	172	259	74	338
40 to 44	163	72	138	209	218	327	93	366
45 to 49	198	87	167	254	263	397	112	400
50 to 54	259	114	218	330	343	518	146	438
55 to 59	334	147	282	425	443	666	189	541
60 to 64	431	190	364	550	574	863	243	695
PARTY OF TWO – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$170	\$75	\$143	\$217	\$226	\$339	\$96	\$494
30 to 34	230	102	194	292	305	459	130	618
35 to 39	253	111	214	321	336	505	142	658
40 to 44	321	141	270	409	425	639	181	713
45 to 49	386	170	326	494	514	774	218	779
50 to 54	506	222	426	643	670	1010	286	854
55 to 59	651	286	550	829	862	1299	367	1054
60 to 64	844	371	712	1072	1118	1683	476	1356
FAMILY – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$280	\$123	\$236	\$357	\$371	\$559	\$158	\$766
30 to 34	358	158	302	454	474	714	202	934
35 to 39	393	173	331	500	520	784	222	1006
40 to 44	461	203	389	585	610	920	260	1061
45 to 49	516	228	435	656	685	1030	292	1098
50 to 54	610	269	514	774	809	1217	345	1112
55 to 59	730	322	616	929	968	1457	413	1252
60 to 64	910	402	768	1159	1209	1818	515	1526

REGION 3

Age Range	ACTIVE CHOICE	SHIELD SPECTRUM PPO PLANS					SHIELD SPECTRUM PPO Savings Plan 2400/4800	ACCESS+ HMO PLAN
		PPO Plan 5000	PPO Plan 2000	PPO Plan 1500	PPO Plan 750	PPO Plan 500		
YOUTH CARE – Monthly Dues for Blue Shield							Plan 2400	
Under 1	\$160	\$72	\$135	\$194	\$203	\$322	\$93	\$274
1 to 18	58	27	50	70	74	118	34	158
SINGLE – Monthly Dues for Blue Shield							Plan 2400	
19 to 29	\$90	\$41	\$76	\$108	\$114	\$180	\$52	\$274
30 to 34	120	55	102	147	153	245	71	342
35 to 39	134	61	113	162	170	268	78	364
40 to 44	168	77	142	204	214	341	98	394
45 to 49	204	93	172	247	260	412	119	432
50 to 54	266	122	225	323	337	536	156	473
55 to 59	342	156	289	414	434	690	200	584
60 to 64	445	202	375	538	562	895	258	750
PARTY OF TWO – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$174	\$79	\$147	\$211	\$221	\$351	\$102	\$532
30 to 34	235	106	198	286	300	477	137	667
35 to 39	260	118	219	314	329	525	152	711
40 to 44	329	149	278	399	418	663	191	770
45 to 49	398	181	335	483	505	802	232	842
50 to 54	518	236	438	630	658	1047	302	922
55 to 59	670	305	565	810	846	1348	390	1139
60 to 64	865	394	730	1049	1096	1745	505	1465
FAMILY – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$287	\$131	\$242	\$347	\$365	\$580	\$168	\$826
30 to 34	368	166	310	444	465	739	214	1010
35 to 39	404	183	341	490	510	814	235	1086
40 to 44	472	215	398	572	598	953	276	1146
45 to 49	530	241	447	642	672	1068	309	1184
50 to 54	625	285	527	759	794	1262	365	1201
55 to 59	750	340	633	908	950	1511	436	1351
60 to 64	934	426	789	1133	1186	1885	546	1646

REGION 4								
Age Range	ACTIVE CHOICE	SHIELD SPECTRUM PPO PLANS					SHIELD SPECTRUM PPO Savings Plan 2400/4800	ACCESS+ HMO PLAN
		PPO Plan 5000	PPO Plan 2000	PPO Plan 1500	PPO Plan 750	PPO Plan 500		
YOUTH CARE – Monthly Dues for Blue Shield							Plan 2400	
Under 1	\$149	\$74	\$126	\$181	\$187	\$277	\$95	\$237
1 to 18	55	28	46	67	69	102	36	136
SINGLE – Monthly Dues for Blue Shield							Plan 2400	
19 to 29	\$82	\$41	\$70	\$101	\$106	\$155	\$53	\$234
30 to 34	113	56	95	137	142	210	72	295
35 to 39	124	62	105	151	155	231	79	314
40 to 44	157	78	132	192	197	293	100	340
45 to 49	190	95	160	231	239	354	122	371
50 to 54	247	123	209	302	311	462	158	408
55 to 59	318	159	269	388	402	594	204	502
60 to 64	412	206	348	502	520	769	263	646
PARTY OF TWO – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$162	\$81	\$137	\$198	\$204	\$302	\$104	\$458
30 to 34	219	110	185	268	277	409	141	574
35 to 39	242	120	204	294	305	450	154	612
40 to 44	306	152	258	373	385	570	195	663
45 to 49	370	183	313	451	466	690	235	725
50 to 54	482	240	407	589	608	899	308	793
55 to 59	622	309	525	757	783	1158	396	981
60 to 64	806	400	680	981	1014	1500	513	1260
FAMILY – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$267	\$133	\$226	\$326	\$336	\$498	\$170	\$712
30 to 34	342	169	289	416	429	636	217	869
35 to 39	375	186	317	457	472	698	238	935
40 to 44	440	218	371	535	553	819	280	986
45 to 49	493	245	416	600	620	918	314	1021
50 to 54	581	289	490	709	734	1085	370	1034
55 to 59	697	346	588	849	878	1299	443	1163
60 to 64	870	433	734	1059	1095	1622	555	1418

REGION 5

Age Range	ACTIVE CHOICE	SHIELD SPECTRUM PPO PLANS					SHIELD SPECTRUM PPO Savings Plan 2400/4800	ACCESS+ HMO PLAN
		PPO Plan 5000	PPO Plan 2000	PPO Plan 1500	PPO Plan 750	PPO Plan 500		
YOUTH CARE – Monthly Dues for Blue Shield							Plan 2400	
Under 1	\$165	\$74	\$139	\$199	\$208	\$300	\$94	\$250
1 to 18	61	27	51	73	75	110	35	143
SINGLE – Monthly Dues for Blue Shield							Plan 2400	
19 to 29	\$92	\$41	\$78	\$111	\$117	\$169	\$53	\$247
30 to 34	126	55	106	151	157	228	71	310
35 to 39	138	62	117	166	173	250	79	330
40 to 44	175	78	148	210	218	318	100	358
45 to 49	211	94	178	254	265	384	120	390
50 to 54	276	123	233	331	346	502	158	427
55 to 59	355	158	300	427	445	644	202	530
60 to 64	460	206	388	552	575	835	263	679
PARTY OF TWO – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$182	\$81	\$154	\$218	\$226	\$329	\$104	\$481
30 to 34	246	110	207	294	306	445	140	604
35 to 39	270	121	228	323	336	489	154	643
40 to 44	340	152	287	409	426	619	195	697
45 to 49	412	185	348	495	516	749	237	761
50 to 54	538	240	454	646	674	978	307	835
55 to 59	694	308	586	831	867	1257	395	1031
60 to 64	897	400	757	1077	1122	1628	513	1326
FAMILY – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$298	\$133	\$251	\$358	\$372	\$541	\$170	\$749
30 to 34	380	169	321	456	476	690	217	913
35 to 39	418	186	353	502	522	759	238	984
40 to 44	490	218	414	587	613	889	280	1038
45 to 49	550	246	464	659	687	996	314	1073
50 to 54	649	290	547	778	811	1177	371	1088
55 to 59	777	346	655	933	971	1410	444	1225
60 to 64	970	433	818	1164	1213	1760	554	1492

REGION 6

Age Range	ACTIVE CHOICE	SHIELD SPECTRUM PPO PLANS					SHIELD SPECTRUM PPO Savings Plan 2400/4800	ACCESS+ HMO PLAN
		PPO Plan 5000	PPO Plan 2000	PPO Plan 1500	PPO Plan 750	PPO Plan 500		
YOUTH CARE – Monthly Dues for Blue Shield							Plan 2400	
Under 1	\$161	\$74	\$136	\$186	\$202	\$298	\$95	\$277
1 to 18	60	27	50	69	74	110	35	158
SINGLE – Monthly Dues for Blue Shield							Plan 2400	
19 to 29	\$89	\$41	\$75	\$105	\$113	\$168	\$53	\$274
30 to 34	122	56	102	142	152	226	72	345
35 to 39	134	63	113	156	167	249	81	368
40 to 44	169	78	142	198	212	314	101	398
45 to 49	205	95	173	239	256	381	122	434
50 to 54	267	124	226	312	334	496	159	476
55 to 59	343	160	290	402	430	638	205	587
60 to 64	445	208	375	520	558	828	266	755
PARTY OF TWO – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$175	\$82	\$148	\$204	\$220	\$326	\$105	\$536
30 to 34	237	110	200	277	297	441	141	671
35 to 39	260	122	219	304	327	484	156	716
40 to 44	329	154	278	386	414	613	198	774
45 to 49	399	186	337	466	501	742	239	846
50 to 54	519	242	438	610	653	968	311	929
55 to 59	668	314	564	782	840	1246	402	1147
60 to 64	866	405	731	1015	1089	1614	519	1474
FAMILY – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$287	\$134	\$242	\$337	\$362	\$535	\$173	\$833
30 to 34	367	172	310	430	462	684	220	1015
35 to 39	403	188	340	472	507	751	241	1094
40 to 44	474	220	400	554	594	880	282	1153
45 to 49	530	248	447	622	666	988	318	1192
50 to 54	626	292	529	734	787	1166	374	1209
55 to 59	751	350	634	878	942	1396	449	1361
60 to 64	936	438	790	1097	1176	1744	561	1659

REGION 7

Age Range	ACTIVE CHOICE	SHIELD SPECTRUM PPO PLANS					SHIELD SPECTRUM PPO Savings Plan 2400/4800	ACCESS+ HMO PLAN
		PPO Plan 5000	PPO Plan 2000	PPO Plan 1500	PPO Plan 750	PPO Plan 500		
YOUTH CARE – Monthly Dues for Blue Shield							Plan 2400	
Under 1	\$158	\$62	\$133	\$190	\$207	\$329	\$79	\$192
1 to 18	58	25	49	70	76	120	32	110
SINGLE – Monthly Dues for Blue Shield							Plan 2400	
19 to 29	\$87	\$39	\$74	\$107	\$116	\$184	\$50	\$191
30 to 34	119	53	101	144	158	249	68	239
35 to 39	131	58	110	158	174	274	74	254
40 to 44	166	74	140	200	219	346	94	276
45 to 49	201	90	170	242	266	419	114	301
50 to 54	262	118	221	317	346	547	150	330
55 to 59	338	150	285	407	445	703	193	408
60 to 64	437	194	369	528	577	911	249	525
PARTY OF TWO – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$171	\$77	\$145	\$206	\$227	\$358	\$98	\$372
30 to 34	232	103	196	280	307	485	133	466
35 to 39	256	114	216	308	337	534	146	498
40 to 44	325	144	274	391	428	675	185	538
45 to 49	391	174	330	474	518	818	224	587
50 to 54	512	228	432	618	676	1066	292	644
55 to 59	658	291	555	794	869	1372	374	796
60 to 64	854	380	720	1029	1125	1777	487	1022
FAMILY – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$282	\$126	\$238	\$341	\$374	\$590	\$162	\$578
30 to 34	361	160	305	435	477	753	206	705
35 to 39	398	176	335	478	523	828	226	759
40 to 44	466	207	393	562	614	970	266	801
45 to 49	521	232	439	630	689	1087	298	827
50 to 54	616	274	520	745	813	1284	351	839
55 to 59	738	329	622	891	974	1539	422	944
60 to 64	922	410	778	1113	1216	1920	526	1151

REGION 8

Age Range	ACTIVE CHOICE	SHIELD SPECTRUM PPO PLANS					SHIELD SPECTRUM PPO Savings Plan 2400/4800	ACCESS+ HMO PLAN
		PPO Plan 5000	PPO Plan 2000	PPO Plan 1500	PPO Plan 750	PPO Plan 500		
YOUTH CARE – Monthly Dues for Blue Shield							Plan 2400	
Under 1	\$166	\$68	\$140	\$197	\$218	\$354	\$87	\$182
1 to 18	61	27	51	72	80	130	34	105
SINGLE – Monthly Dues for Blue Shield							Plan 2400	
19 to 29	\$93	\$41	\$78	\$111	\$122	\$198	\$53	\$181
30 to 34	125	56	106	150	165	267	72	225
35 to 39	138	62	116	165	182	294	79	241
40 to 44	174	78	147	208	230	373	101	261
45 to 49	210	94	178	253	278	453	121	286
50 to 54	277	123	234	329	363	590	158	313
55 to 59	355	158	300	423	467	758	203	385
60 to 64	460	206	388	548	605	983	264	496
PARTY OF TWO – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$181	\$81	\$153	\$216	\$237	\$386	\$103	\$351
30 to 34	245	110	206	291	322	523	140	440
35 to 39	270	121	227	321	354	575	154	470
40 to 44	342	152	288	406	448	728	194	509
45 to 49	412	184	348	491	543	881	236	554
50 to 54	537	241	453	641	708	1150	309	608
55 to 59	692	309	584	825	910	1480	396	751
60 to 64	896	401	756	1069	1180	1917	514	967
FAMILY – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$298	\$133	\$251	\$354	\$392	\$636	\$170	\$545
30 to 34	380	170	321	453	500	812	218	666
35 to 39	418	187	353	498	550	893	240	718
40 to 44	489	218	413	583	644	1046	280	755
45 to 49	549	246	463	654	722	1173	314	782
50 to 54	649	290	547	773	853	1385	371	792
55 to 59	775	347	654	925	1022	1660	445	892
60 to 64	968	433	817	1155	1274	2072	555	1086

REGION 9

Age Range	ACTIVE CHOICE	SHIELD SPECTRUM PPO PLANS					SHIELD SPECTRUM PPO Savings Plan 2400/4800	ACCESS+ HMO PLAN
		PPO Plan 5000	PPO Plan 2000	PPO Plan 1500	PPO Plan 750	PPO Plan 500		
YOUTH CARE – Monthly Dues for Blue Shield							Plan 2400	
Under 1	\$185	\$74	\$156	\$240	\$265	\$374	\$94	\$159
1 to 18	67	30	57	87	97	138	38	91
SINGLE – Monthly Dues for Blue Shield							Plan 2400	
19 to 29	\$103	\$46	\$87	\$134	\$149	\$210	\$58	\$158
30 to 34	139	62	118	182	201	284	79	199
35 to 39	154	69	130	199	221	313	88	212
40 to 44	195	86	165	253	280	394	110	230
45 to 49	236	104	199	306	338	478	134	252
50 to 54	308	135	260	399	442	624	174	276
55 to 59	398	174	336	514	569	804	224	340
60 to 64	514	226	434	665	737	1041	290	437
PARTY OF TWO – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$202	\$90	\$170	\$262	\$290	\$409	\$114	\$310
30 to 34	274	121	231	354	393	553	155	388
35 to 39	302	132	254	389	431	610	170	414
40 to 44	381	168	322	494	546	771	215	449
45 to 49	462	203	390	597	662	934	261	489
50 to 54	601	266	507	778	862	1218	340	537
55 to 59	775	341	654	1001	1110	1566	437	663
60 to 64	1002	441	846	1296	1438	2030	566	852
FAMILY – Monthly Dues for Blue Shield							Plan 4800	
Under 30	\$334	\$146	\$282	\$430	\$477	\$673	\$187	\$482
30 to 34	425	187	358	549	610	860	240	587
35 to 39	467	206	394	605	670	945	263	632
40 to 44	548	242	462	708	786	1109	310	668
45 to 49	614	270	518	794	880	1242	346	689
50 to 54	724	319	611	938	1040	1467	409	698
55 to 59	868	382	733	1122	1246	1758	490	787
60 to 64	1083	477	914	1401	1554	2193	611	959

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at:
Fax:

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: Blue Shield of California

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...



Blue Shield of California



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 HOMEPHONE # () ()	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.

	YES	NO
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.	<input type="checkbox"/>	<input type="checkbox"/>
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. <i>Metabolic system</i> – 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.

- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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.
- 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: _____	TELEPHONE NUMBER: (949) 394-7676	FAX NUMBER: (949) 203-8786
PRODUCER NAME: William S. Lorenz	EMAIL ADDRESS: BillLorenz@earthlink.net	
PRODUCER ADDRESS: 1300 Park Newport #415 Newport Beach, CA 92660		
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