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

Subscriber name (first, last): _____

Blue Shield subscriber ID number: _____

Address: _____

City: _____ State: _____ ZIP: _____

Medicare supplement plan contract type: ☐ Individual ☐ Two-party (see Section 2 below)

1. **Dental plan option:**

   ☐ Dental PPO 1000 ☐ Dental PPO 1500 ☐ Specialty Duo dental + vision package*

2. **Two-party enrollment:** Must be completed if you have a two-party agreement. If you have a two-party Medicare Supplement plan contract with Blue Shield, you and your spouse or domestic partner need to both select and enroll in the same dental PPO plan or dental + vision package.

   Important: If only one of you wants to enroll in a dental PPO plan or dental + vision package, or if you each want different dental PPO plans or dental + vision package (as indicated by selecting a different plan option in this Section 2), your two-party contract for the Medicare Supplement plan will be affected. If no dental plan is selected, or if a different dental plan option is selected for the spouse/domestic partner below, you are requesting Blue Shield to change your two-party contract and rate to individual contracts and single party rates.

   Spouse/domestic partner name (first, last): _____

   Spouse/domestic partner dental plan option:

   ☐ Dental PPO 1000 ☐ Dental PPO 1500 ☐ Specialty Duo dental + vision package* ☐ None

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 or dental + vision package, a Blue Shield Medicare supplement plan member.

   b. I understand that if my dental plan or dental + vision 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 terminated, this dental plan or dental + vision coverage will also terminate.

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

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 knowledge and belief, information and confirmations provided on this form are correct and true.

Subscriber's signature _____ Date _____

Spouse/domestic partner's signature _____ Date _____

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). This plan is pending regulatory approval. Specialty Duo package includes both Specialty Duo Dental Plan and Specialty Duo Vision Plan for Medicare Supplement plan members.

Please fax or mail the completed and signed application to:

Installation & Membership, Blue Shield of California
P.O. Box 3008
Lodi, CA 95241-1912

Fax: (209) 367-6490

For internal use only
DSA name: _____
DSA number: _____
Producer number: _____

A43738 (1/12)