Blue Shield of California
An Independent Member of the Blue Shield Association

SHADED BOX – FOR BSC ONLY

GROUP NUMBER _____

PLAN TYPE _____

EFFECTIVE DATE _____

Dental Only
EMPLOYEE APPLICATION
(No Medical)

DO NOT WRITE IN SHADED AREAS

PLEASE PROVIDE THE FOLLOWING:

☐ NEW APPLICATION ☐ RE-HIRE ☐ ADD FAMILY MEMBER TO EXISTING COVERAGE	APPLICANT'S SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___	FIRST NAME	MI	LAST NAME
	DATE OF HIRE	GROUP NAME		BIRTHDATE

REQUESTED EFFECTIVE DATE _____/_____/_____

CHOOSE DENTAL PLAN (CHECK ONE BOX ONLY):

☐ DENTAL PPO ☐ DENTAL HMO

IF YOU ARE APPLYING FOR THE DENTAL HMO, YOU MUST CHOOSE A DENTAL CENTER FROM THE BLUE SHIELD DENTAL CENTER DIRECTORY (ALSO AVAILABLE ONLINE AT WWW.MYLIFEPATH.COM). THE DENTAL CENTER YOU CHOOSE WILL PROVIDE AND ARRANGE DENTAL CARE FOR YOU AND ALL COVERED DEPENDENTS.

MARRIED ☐ Y ☐ N	E-MAIL ADDRESS	APPLICANT'S BUSINESS PHONE NUMBER ( )	APPLICANT'S HOME PHONE NUMBER ( )	
RESIDENCE OF APPLICANT		CITY	STATE	ZIP CODE
MAILING ADDRESS (IF DIFFERENT FROM ABOVE)		CITY	STATE	ZIP CODE

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 DENTAL HMO: YOU MUST SELECT A DENTAL CENTER FROM THE DENTAL HMO DENTAL CENTER DIRECTORY. (ALSO AVAILABLE ONLINE AT WWW.MYLIFEPATH.COM).
BE SURE TO INCLUDE THE DENTAL CENTER NUMBER LISTED. (IF YOU HAVE ANY QUESTIONS REGARDING YOUR DENTAL CENTER SELECTION, CALL (800) 585-8111).

1	☐ MALE ☐ FEMALE	YOUR FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)		
	DENTAL HMO ONLY: DENTAL CENTER NUMBER			DENTAL HMO ONLY: DENTAL CENTER NAME		
2	☐ HUSBAND ☐ WIFE	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH (MO/DAY/YR) _____/_____/_____	SPOUSE'S SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___
	DENTAL HMO ONLY: DENTAL CENTER NUMBER			DENTAL HMO ONLY: DENTAL CENTER NAME		
3	☐ SON ☐ DAUGHTER	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH (MO/DAY/YR) _____/_____/_____	DEPENDENT SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___
	DENTAL HMO ONLY: DENTAL CENTER NUMBER			DENTAL HMO ONLY: DENTAL CENTER NAME		
4	☐ SON ☐ DAUGHTER	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH (MO/DAY/YR) _____/_____/_____	DEPENDENT SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___
	DENTAL HMO ONLY: DENTAL CENTER NUMBER			DENTAL HMO ONLY: DENTAL CENTER NAME		
5	☐ SON ☐ DAUGHTER	FIRST NAME	MI	LAST (IF DIFFERENT FROM ABOVE)	DATE OF BIRTH (MO/DAY/YR) _____/_____/_____	DEPENDENT SOCIAL SECURITY NUMBER ___ ___ ___ - ___ ___ - ___ ___ ___ ___
	DENTAL HMO ONLY: DENTAL CENTER NUMBER			DENTAL HMO ONLY: DENTAL CENTER NAME		

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. ☐

NAME	HOURS/WEEK	UNITS	SCHOOL	ADDRESS

DISCLOSURE STATEMENTS – Please read these conditions of membership and authorization and sign below.

1. To find Blue Shield dental provider by name, location and specialty, go to our Web site: **www.mylifepath.com**. You can use the Web site to print out a listing of Blue Shield providers in your area. This directory is for information purposes only and is not to be considered a total representation of Blue Shield's Dental Provider Network.
2. **Parent or 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. Individuals authorized to make changes to my minor child's contract include

   A. Parent or Legal Guardian only or,

   B. my designee _____ (include relationship) or,

   C. Qualified Medical Child Support Order designee _____ (include relationship).

   I further request that all changes to this contract be made only upon Blue Shield's receipt of such written request.

   Please indicate only one: ☐ A ☐ B or ☐ C. (Court documents must be attached authorizing guardianship if the responsible adult is not the parent.)

DISCLOSURE STATEMENTS – Please read these conditions of membership and authorization and sign below. (CONTINUED)

3. **Applicants with a Spouse:** If you are applying for coverage and your coverage is approved, please specify whether or not you authorize your spouse, if also covered, to make inquiries or changes on your behalf to your contract. □ **Yes** □ **No.** This authorization may be discontinued at any time upon Blue Shield's receipt of such written request.

AUTHORIZATION: THE FOLLOWING AUTHORIZATION SECTION IS TO BE SIGNED BY ALL EMPLOYEES APPLYING FOR COVERAGE

I agree: All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have misrepresented or omitted any material fact that my coverage may be cancelled or my employer's contract rescinded. I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California Life and Health Insurance Company.

Authorization for Disclosure of Personal Information – I authorize any "provider of care", insurer or health plan to disclose to Blue Shield of California, or their representatives, all "medical information" (as those terms are defined in the California Civil Code), including any medical information regarding substance abuse, or mental or emotional conditions, regarding me, my spouse or my children. This medical information is collected for the purpose of evaluating my employer's application, determining claims for benefits, or for quality assurance and peer review. This authorization will remain valid for the term of the coverage of the Blue Shield health service contract. 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.

I, the applicant, acknowledge that I have read and understood this Application in its entirety.

Signature of Employee X _____ **Date X** _____