Blue Shield of California
Medicare Supplement Plan Transfer Application

Current Blue Shield of California Medicare Supplement plan members may use this application to:

1. Transfer to a Medicare Supplement plan of equal or lesser value during an Open Enrollment Period – Guaranteed Acceptance.
2. Enroll in the Household Savings Program.[1] (Both participants must be current Blue Shield of California Medicare Supplement plan members).
3. Enroll in a dental plan.

If you are interested in transferring to a Medicare Supplement plan of equal or lesser value outside your enrollment period or to a richer benefit plan at any time, you must complete the Medicare Supplement Plan Enrollment Application (Form C12687).

Transferring is easy

1 Provide ALL requested information and print clearly in all capital letters in black ink. Sign and date at the end.

2 Submit your application within 30 days of your signature date by:
- Fax to **(844) 266-1850**
- Email: **msinstall@blueshieldca.com**
- Mail: Medicare Supplement Installation, P.O. Box 3008 Lodi, CA 95241-1912

Please note: It is required that a signed copy of this contract is made for your records. Be sure to print and save the member copy pages of this application with all other important Blue Shield of California documents.

If you have questions about how to enroll, please contact your broker or call us at **(888) 713-0000 (TTY: 711)**.

You may also contact the California Health Insurance Counseling & Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at (800) 434-0222 for a referral to your local HICAP office. HICAP services are provided free of charge by the state of California.

Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first become eligible for Medicare benefits due to disability before January 1, 2020.

Personal information

Last name:	First name:	Middle initial:
Date of birth (MM/DD/YYYY):	Sex: ☐ Male ☐ Female	
Phone number:	Phone Type: ☐ Landline ☐ Mobile	
Home address:		
City:	State:	ZIP code:

Language preference:
☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Email address:

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Mailing address (if different from above):

Mailing city:	Mailing state:	Mailing ZIP code:

Billing address (if different from above):

Billing city:	Billing state:	Billing ZIP code:

Please check the plan type you are applying for: ☐ A ☐ F Extra* ☐ G ☐ G Extra ☐ N Or are you choosing to stay in your current plan? ☐ Yes ☐ No	Requested effective date: The first day of (MM/YYYY)

* Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first become eligible for Medicare benefits due to disability before January 1, 2020.

Medicare Beneficiary Identification (MBI) number:

Blue Shield subscriber number:

Medicare hospital (Part A) effective date: (MM/DD/YYYY)	Medicare (Part B) effective date: (MM/DD/YYYY)

Household Savings Program[1]

If you and the other household member are age 65 and older and both members have, or are applying for, the same plan (including any dental plans), you may be eligible for a 7% monthly savings on your combined medical plan dues when **both members are enrolled in the same eligible plan. Both members must share the same home and mailing addresses**. Tobacco users are not eligible for the Household Savings Program.

Is the other member of your household enrolled in, or applying for, the **same** Blue Shield Medicare Supplement plan that you are applying for and share both address types? ☐ Yes ☐ No

If "Yes," please provide the following information for the other household member:

Name:

Medicare Beneficiary Identification (MBI) number:

Blue Shield Medicare Supplement plan member ID (if available):

Please provide other household member's authorization to cancel their separate Blue Shield contract and enroll under the primary subscriber's agreement for the Household Savings Program by having the other household member sign at the end of the application.

Each individual must complete their own new member application. If both members are existing enrollees, the subscriber is determined based on which application is enrolled first. Otherwise, the existing member already enrolled in the requested plan type will be designated as the subscriber.

The subscriber is responsible for payment of dues/premiums to Blue Shield, and only the subscriber can make changes to the contract/policy. When enrolled under the Household Savings Program, Blue Shield will also accept payment of dues/premiums from the other household member enrolled in the plan. Billing information and amounts due can/will be shared with both parties enrolled in the plan when calling Customer Service.

Dental PPO plans

Dental plans for Medicare Supplement plan members.
Please see the page on **blueshieldca.com/MedSuppDental2027** for more information.

To sign up for Blue Shield dental coverage, select a plan below:
Dental plan options (check one):
☐ Dental PPO 1000 ☐ Dental PPO 1500 ☐ No dental plan

Conditions of coverage

- Dental benefits aren't subject to health plan deductible requirements.
- If your dental coverage is canceled for any reason (by you or by Blue Shield), you may apply for reenrollment, but you will have to wait six months to reapply.

Payment information

To determine the monthly dues amount, refer to Blue Shield's rate table included in the enrollment kit or visit **blueshieldca.com/MedSupp2027**. Unless you currently participate in AutoPay, you will receive a monthly bill indicating the amount and the date your next payment is due.

Save $3 a month by paying dues through automatic monthly debit from your checking or savings account using our AutoPay program.[1] To enroll, after receiving and paying for your first bill, register for and log into your Blue Shield account at **blueshieldca.com** and access the Billing and Payment tab. You may also call Customer Service at **(800) 248-2341 (TTY: 711)**, 8 a.m. to 8 p.m. PT, seven days a week. Requests to enroll in the AutoPay program may take up to two billing cycles for completion. Members should pay all paper bills received until an email confirming registration in the AutoPay program is received.

Conditions of membership

1 This transfer application will become part of the *Evidence of Coverage* (EOC) for which I am applying, and together with any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.

2 If I choose to enroll in a plan that goes up in value, I will not be covered by a Blue Shield Medicare Supplement plan unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.

3 Only Blue Shield can approve this application. I understand that any insurance agent, broker, or sales representative cannot grant approval, change terms, or waive requirements.

4 I acknowledge receipt of the:

- **Summary of Benefits**
- **Rate table**
- **The Guide to Health Insurance for People with Medicare**
- **A copy of this transfer application**

With my signature below, I represent that the information provided in this transfer application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage, the Household Savings Program, and the authorizations I have provided.

I have read the Summary of Benefits and the terms, conditions, and authorizations set forth above. I certify that I meet the eligibility requirements set forth in the Summary of Benefits. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

5 I understand I may receive materials and communications electronically versus print: I may receive required benefit plan and coverage-related materials and communications via email and/or the Blue Shield website **blueshieldca.com**, as applicable. Obtaining a document electronically will confirm my consent to electronic delivery. I also have the right to obtain printed, mailed materials at any time and at no expense to me. To receive printed materials in the mail, to opt out of email communications, I can call **(800) 248-2341 (TTY: 711)**, 8 a.m. to 8 p.m. PT, seven days a week, year-round.

Applicant's signature:	**Date (MM/DD/YYYY):**
Household member's signature (if applicable):	**Date (MM/DD/YYYY):**

Producer/writing agent information

* Indicates required field

Appointed agency name: _____
(please print appointed agency name)

Appointed agency's Tax ID*: _____
(please print appointed agency's tax ID)

Producer/writing agent's name*: _____
(please print producer/writing agent's name)

Producer/writing agent's individual NPN*: _____

Producer/writing agent's email address: _____

Producer/writing agent's fax number: _____

Producer/writing agent's phone number: _____

Today's date (required) (MM/DD/YYYY):

Producer/writing agent's signature (required):

Print name:

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

Blue Shield of California
Medicare Supplement Plan Transfer Application

Current Blue Shield of California Medicare Supplement plan members may use this application to:

1. Transfer to a Medicare Supplement plan of equal or lesser value during an Open Enrollment Period – Guaranteed Acceptance.
2. Enroll in the Household Savings Program.[1] (Both participants must be current Blue Shield of California Medicare Supplement plan members).
3. Enroll in a dental plan.

If you are interested in transferring to a Medicare Supplement plan of equal or lesser value outside your enrollment period or to a richer benefit plan at any time, you must complete the Medicare Supplement Plan Enrollment Application (Form C12687).

Transferring is easy!

1 Provide ALL requested information and print clearly in all capital letters in black ink. Sign and date at the end.

2 Submit your application within 30 days of your signature date by:
- Fax to **(844) 266-1850**
- Email: **msinstall@blueshieldca.com**
- Mail: Medicare Supplement Installation, P.O. Box 3008 Lodi, CA 95241-1912

Please note: It is required that a signed copy of this contract is made for your records. Be sure to print and save the member copy pages of this application with all other important Blue Shield of California documents.

If you have questions about how to enroll, please contact your broker or call us at **(888) 713-0000 (TTY: 711)**.

You may also contact the California Health Insurance Counseling & Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at (800) 434-0222 for a referral to your local HICAP office. HICAP services are provided free of charge by the state of California.

Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first become eligible for Medicare benefits due to disability before January 1, 2020.

Personal information

Last name:	First name:	Middle initial:
Date of birth (MM/DD/YYYY):	Sex: ☐ Male ☐ Female	
Phone number:	Phone Type: ☐ Landline ☐ Mobile	
Home address:		
City:	State:	ZIP code:

Language preference:
☐ English ☐ Spanish ☐ Chinese ☐ Korean ☐ Vietnamese

Select one if you want us to send you information in an accessible format.
☐ Braille ☐ Large print ☐ Audio CD ☐ Data CD

Email address:

Providing your email address above automatically enrolls you in paperless delivery for some of your plan communications.

You will get many of your required plan communications delivered electronically. We will send you an email when new communications are available online. You can access these communications through any device such as a computer, tablet, or mobile phone.

☐ Instead of paperless delivery, we will mail you hard copies of required materials. Please note that some communications are very large and may not fit in all mailboxes. You can change your preference for delivery at any time.

Mailing address (if different from above):

Mailing city:	Mailing state:	Mailing ZIP code:

Billing address (if different from above):

Billing city:	Billing state:	Billing ZIP code:

Please check the plan type you are applying for: ☐ A ☐ F Extra* ☐ G ☐ G Extra ☐ N Or are you choosing to stay in your current plan? ☐ Yes ☐ No	Requested effective date: The first day of (MM/YYYY)

* Plan F Extra is only available to applicants who attained age 65 before January 1, 2020, or first become eligible for Medicare benefits due to disability before January 1, 2020.

Medicare Beneficiary Identification (MBI) number:

Blue Shield subscriber number:

Medicare hospital (Part A) effective date: (MM/DD/YYYY)	Medicare (Part B) effective date: (MM/DD/YYYY)

Household Savings Program[1]

If you and the other household member are age 65 and older and both members have, or are applying for, the same plan (including any dental plans), you may be eligible for a 7% monthly savings on your combined medical plan dues when **both members are enrolled in the same eligible plan. Both members must share the same home and mailing addresses**. Tobacco users are not eligible for the Household Savings Program.

Is the other member of your household enrolled in, or applying for, the **same** Blue Shield Medicare Supplement plan that you are applying for and share both address types? ☐ Yes ☐ No

If "Yes," please provide the following information for the other household member:

Name:

Medicare Beneficiary Identification (MBI) number:

Blue Shield Medicare Supplement plan member ID (if available):

Please provide other household member's authorization to cancel their separate Blue Shield contract and enroll under the primary subscriber's agreement for the Household Savings Program by having the other household member sign at the end of the application.

Each individual must complete their own new member application if not already a current member. If both members are existing enrollees, the subscriber is determined based on which application is enrolled first. Otherwise, the existing member already enrolled in the requested plan type will be designated as the subscriber.

The subscriber is responsible for payment of dues/premiums to Blue Shield, and only the subscriber can make changes to the contract/policy. When enrolled under the Household Savings Program, Blue Shield will also accept payment of dues/premiums from the other household member enrolled in the plan. Billing information and amounts due can/will be shared with both parties enrolled in the plan when calling Customer Service.

Dental PPO plans

Dental plans for Medicare Supplement plan members.
Please see the page on **blueshieldca.com/MedSuppDental2027** for more information.

To sign up for Blue Shield dental coverage, select a plan below:
Dental plan options (check one):
☐ Dental PPO 1000 ☐ Dental PPO 1500 ☐ No dental plan

Conditions of coverage

- Dental benefits aren't subject to health plan deductible requirements.
- If your dental coverage is canceled for any reason (by you or by Blue Shield), you may apply for reenrollment, but you will have to wait six months to reapply.

Payment information

To determine the monthly dues amount, refer to Blue Shield's rate table included in the enrollment kit or visit **blueshieldca.com/MedSupp2027**. Unless you currently participate in AutoPay, you will receive a monthly bill indicating the amount and the date your next payment is due.

Save $3 a month by paying dues through automatic monthly debit from your checking or savings account using our AutoPay program.[1] To enroll, after receiving and paying for your first bill, register for and log into your Blue Shield account at **blueshieldca.com** and access the Billing and Payment tab. You may also call Customer Service at **(800) 248-2341 (TTY: 711)**, 8 a.m. to 8 p.m. PT, seven days a week. Requests to enroll in the AutoPay program may take up to two billing cycles for completion. Members should pay all paper bills received until an email confirming registration in the AutoPay program is received.

Conditions of membership

1 This transfer application will become part of the *Evidence of Coverage* (EOC) for which I am applying, and together with any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.

2 If I choose to enroll in a plan that goes up in value, I will not be covered by a Blue Shield Medicare Supplement plan unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.

3 Only Blue Shield can approve this application. I understand that any insurance agent, broker, or sales representative cannot grant approval, change terms, or waive requirements.

4 **I acknowledge receipt of the:**

- **Summary of Benefits**
- **Rate table**
- **The Guide to Health Insurance for People with Medicare**
- **A copy of this transfer application**

With my signature below, I represent that the information provided in this transfer application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage, the Household Savings Program, and the authorizations I have provided.

I have read the Summary of Benefits and the terms, conditions, and authorizations set forth above. I certify that I meet the eligibility requirements set forth in the Summary of Benefits. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

5 I understand I may receive materials and communications electronically versus print: I may receive required benefit plan and coverage-related materials and communications via email and/or the Blue Shield website **blueshieldca.com**, as applicable. Obtaining a document electronically will confirm my consent to electronic delivery. I also have the right to obtain printed, mailed materials at any time and at no expense to me. To receive printed materials in the mail, to opt out of email communications, I can call **(800) 248-2341 (TTY: 711)**, 8 a.m. to 8 p.m. PT, seven days a week, year-round.

Applicant's signature:	**Date (MM/DD/YYYY):**
Household member's signature (if applicable):	**Date (MM/DD/YYYY):**

Producer/writing agent information

* Indicates required field

Appointed agency name: _____
(please print appointed agency name)

Appointed agency's Tax ID*: _____
(please print appointed agency's tax ID)

Producer/writing agent's name*: _____
(please print producer/writing agent's name)

Producer/writing agent's individual NPN*: _____

Producer/writing agent's email address: _____

Producer/writing agent's fax number: _____

Producer/writing agent's phone number: _____

Today's date (required) (MM/DD/YYYY):

Producer/writing agent's signature (required):

Print name:

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