Disability addendum

Note: This must be submitted with your new group application

Prior carrier information	Name and address of group's previous carrier	Group / section number — previous carrier

Please advise of special contract provisions such as:

1. Self-funded plan: ☐ Yes ☐ No
2. Transferred from an underwritten Blue Shield contract to self-funded Blue Shield plan: ☐ Yes ☐ No
3. Please indicate below if the subscriber/dependent was actually covered on the prior carrier's contract.
4. OED with prior carrier: Month / day / year ________________________

Subscriber name	Subscriber Blue Shield identification number	Name of person disabled / hospitalized	Age	Sex		Check one	
				F	M	Disabled / hospitalized	
Name and address of attending physician							
Brief description of illness / injury* and date of onset							

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Name and address of attending physician							
Brief description of illness / injury* and date of onset							

For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

* If work related, please advise.