blue california

2024 Blue Shield of California

Optional Supplemental Dental HMO or PPO Enrollment Request Form

Please contact Blue Shield of California if you need information in another language at **(800) 776-4466 (TTY 711)**, 8 a.m. to 8 p.m., seven days a week.

Please fax, mail, or email your completed enrollment form to:
Email: WHMembership@blueshieldca.com
Mail: Blue Shield of California, PO Box 948, Woodland Hills, CA 91365-9856
Fax: (877) 251-3660

Blue Shield Member ID No.

Last Name:	**First Name:**	**Middle Initial:**
Birth Date (MM/DD/YYYY):	**Sex:** ☐ Male ☐ Female	
Phone Number:	**Phone Type:** ☐ Landline ☐ Mobile	

Permanent Residence street address (Don't enter a P.O. Box):

Street Address

City State ZIP code

Mailing address, if different from your permanent address

Street Address

City State ZIP code

If you are already a Blue Shield of California Medicare Advantage Prescription Drug Plan member, and would like to enroll in the Optional Supplemental Dental HMO or PPO plan, please provide the following information:

Please check which plan you want to enroll in.

☐ **Optional Supplemental Dental HMO Plan,** ($15.00 per month)
(not available in all plans/service areas; refer to the plan summary of benefits for additional information.)

Name of dentist

Provider ID#

If you do not select a dentist, you will be assigned a dentist at the time of enrollment.

☐ **Optional Supplemental Dental PPO Plan,** ($45.00 per month)
No dentist selection necessary for the PPO plan.

(not available in all plans/service areas; refer to the plan summary of benefits for additional information.)

All fields in this section are optional

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Mobile phone number: _____

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 (for example: Explanation of Benefits or the Annual Notice of Changes) 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.

Paying your plan premiums:

You can pay your monthly plan premium (including any late enrollment penalty you currently have or may owe) by mail each month. If your plan has a premium due, you will receive a monthly bill including the amount and the date of when your next payment is due, or you may choose to pay your premium by having it automatically taken out of your Social Security or Railroad Retirement Board (RRB) benefit each month.

To learn more about your payment options, visit us at **blueshieldca.com/medicarewaystopay** or call Customer Service at **(800) 776-4466 TTY: 711**

☐ Automatic deduction from your monthly Social Security or Railroad Retirement Board (RRB) benefit check.

I get monthly benefits from: ☐ Social Security ☐ RRB

(The Social Security/Railroad Retirement Board deduction may take two or more months to begin. In most cases, if Social Security/Railroad Retirement Board accepts your request for automatic deduction, the first deduction from your Social Security/Railroad Retirement Board benefit check will include all premiums due from your enrollment effective date up to the point withholding begins. If Social Security/Railroad Retirement Board does not approve your request for automatic deduction, we will send you a paper bill for your monthly premiums.)

If you have to pay a Part D-Income Related Monthly Adjustment Amount (Part D-IRMAA), you must pay this extra amount in addition to your plan premium. The amount is usually taken out of your Social Security benefit, or you may get a bill from Medicare (or the RRB). DON'T pay Blue Shield of California the Part D-IRMAA.

Please note: If your Blue Shield of California Medicare Advantage Prescription Drug Plan has a monthly premium, or if you currently pay a late enrollment penalty, whatever plan premium option you select now will be applicable to ALL components of your plan premium.

If you do not make your premium payment according to the payment option you selected, you will receive a written notice and will be given 3 months from the payment due date to pay all amounts due to Blue Shield of California. If you do not pay all amounts due within that time, Blue Shield of California will disenroll you from the Optional Supplemental Dental HMO or PPO plan.

Once you have enrolled in the Optional Supplemental Dental HMO or PPO plan, your membership will continue as long as you pay your premiums as specified by the plan and remain enrolled as a Blue Shield of California Medicare Advantage Prescription Drug Plan member.

You must be a member of a Blue Shield of California Medicare Advantage Prescription Drug plan in order to be eligible to enroll in the Optional Supplemental Dental HMO or PPO plan. If you disenroll from our Blue Shield of California Medicare Advantage Prescription Drug plan, you will also be disenrolled from the Optional Supplemental Dental HMO or PPO plan. If you disenroll from the Optional Supplemental Dental HMO or PPO plan only and wish to re-enroll at a later date, you must wait 6 months from the disenrollment date and pay any premium amount owed before you will be allowed to re-enroll in the Optional Supplemental Dental HMO or PPO plan.

I understand that my signature (or the signature of the person legally authorized to act on my behalf) on this application means that I have read and understand the contents of this application. If signed by an authorized representative (as described above), this signature certifies that:
1) This person is authorized under State law to complete this enrollment, and
2) Documentation of this authority is available upon request by Medicare.

Your Signature*:	**Today's Date (MM/DD/YYYY):**

If you're the authorized representative, sign above and fill out these fields.

Name:

Street Address:

City: State: ZIP code:

Phone Number:

Relationship to Enrollee:

Producer information: Producer name and ID or NPN **is required**.

Agency name: _____
(please print appointed agency name)

Agency ID #: _____
(please print agency tax ID)

Producer (writing agent) name (required): _____
(please print writing agent name)

Producer ID #: _____(please print agent tax ID number)

Producer (writing agent) NPN or TIN (one required): _____
(please print NPN or TIN number)

Producer phone number: _____

Producer email address: _____

Date application received by producer (MM/DD/YYYY): _____

Producer signature: _____

With my signature, I hereby certify that I have read and understand the CMS Medicare Communications and Marketing Guidelines and Enrollment rules and confirm that the enrollee has received a complete enrollment kit. I agree that this enrollment of a Medicare beneficiary, on behalf of Blue Shield of California, has complied with these rules.

Blue Shield of California is an HMO and a PPO plan with a Medicare contract. Enrollment in Blue Shield of California depends on contract renewal.