

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

For groups with 2 to 50 enrolled employees
Effective February 1, 2008

This form should be used to expedite change requests for your client's renewing group contracts. Once approval and processing is completed, your client's subsequent billing will reflect the corresponding adjustments.

To: **Blue Shield of California** Fax: **(209) 367-6603 Lodi** No. of pages faxed _____

From: Producer Name: _____ Group Name: _____
 Producer Tax ID No.: _____ Group No. (S): _____
 Producer Phone No.: _____ Renewal Date: _____
 Producer Fax No.: _____ Requested Effective Date: _____

Please remember to fax in page 1 and page 2 of this document.

Group Structure required:

- Stand-Alone Plan**
- Dual Option Dental** (select any two dental plans)
- Dual Choice** (Select 1 HMO and 1 other – PPO, PPO Savings, POS, or Active Choice plan [except Access Baja])
- Suite Deal** – This package includes the following seven plans: Shield Spectrum PPO 500 Value*, Shield Spectrum PPO 1000 Value*, Shield Spectrum PPO 1500 Value*, Shield Spectrum PPO Savings 1800/3600*, Shield Spectrum PPO Savings 3000/6000*, Access+ HMO 20 Value and Access+ HMO 30
- PlanSelectSM** – Groups with 2 to 50 enrolled employees, select between 2 and up to 27 plans, not including Access Baja plans.

75% participation in Blue Shield plans is required for all plan combinations except Suite Deal. Suite Deal requires a minimum participation of 65% of eligible employees.

If Blue Shield is offered with another HMO plan, a minimum participation in the combined Blue Shield plans must be equal to the greater of five actively enrolled employees or 50% of the total number of actively enrolled employees. PlanSelect requires the greater of five actively enrolled employees or 75% of the total number of actively enrolled employees. Waivers are required for employees that are enrolling in another carrier's plan

- **Total No. of employees** _____ **Total No. of eligibles** _____ **Total No. of enrolled** _____
- **Select employer defined contribution level, a minimum of:** \$100 or _____ %

Add	Cancel	Shield Spectrum PPO SM Plans
<input type="checkbox"/>	<input type="checkbox"/>	Zero Deductible
<input type="checkbox"/>	<input type="checkbox"/>	250 Premier
<input type="checkbox"/>	<input type="checkbox"/>	250 Standard
<input type="checkbox"/>	<input type="checkbox"/>	500 Premier
<input type="checkbox"/>	<input type="checkbox"/>	500 Standard*
<input type="checkbox"/>	<input type="checkbox"/>	500 Value*
<input type="checkbox"/>	<input type="checkbox"/>	750 Value*
<input type="checkbox"/>	<input type="checkbox"/>	1000 Value*
<input type="checkbox"/>	<input type="checkbox"/>	1500 Value*
<input type="checkbox"/>	<input type="checkbox"/>	1000
<input type="checkbox"/>	<input type="checkbox"/>	3000*
Add	Cancel	Shield Spectrum PPO Savings Plans
<input type="checkbox"/>	<input type="checkbox"/>	1800/3600*
<input type="checkbox"/>	<input type="checkbox"/>	2250/4500
<input type="checkbox"/>	<input type="checkbox"/>	2500*
<input type="checkbox"/>	<input type="checkbox"/>	3000/6000*
<input type="checkbox"/>	<input type="checkbox"/>	4800*
Add	Cancel	Active Choice SM Plans
<input type="checkbox"/>	<input type="checkbox"/>	750 SG*
<input type="checkbox"/>	<input type="checkbox"/>	500 SG*

Add	Cancel	Access+ HMO [®] Plans
<input type="checkbox"/>	<input type="checkbox"/>	5
<input type="checkbox"/>	<input type="checkbox"/>	10
<input type="checkbox"/>	<input type="checkbox"/>	15
<input type="checkbox"/>	<input type="checkbox"/>	20
<input type="checkbox"/>	<input type="checkbox"/>	20 Value
<input type="checkbox"/>	<input type="checkbox"/>	30
<input type="checkbox"/>	<input type="checkbox"/>	25
<input type="checkbox"/>	<input type="checkbox"/>	40
Add	Cancel	Added Advantage POS SM Plan
<input type="checkbox"/>	<input type="checkbox"/>	\$500 Deductible
Add	Cancel	Access Baja [®] HMO Plans
<input type="checkbox"/>	<input type="checkbox"/>	Plan 5
<input type="checkbox"/>	<input type="checkbox"/>	Plan 10
Add	Cancel	
<input type="checkbox"/>	<input type="checkbox"/>	Suite Deal
Add	Cancel	
<input type="checkbox"/>	<input type="checkbox"/>	Other [Specify below]

Note: Access Baja HMO plans can be offered alongside those chosen through the Suite Deal and PlanSelect, but they do not count toward PlanSelect restrictions.

* Underwritten by Blue Shield of California Life & Health Insurance Company.

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Add/Delete Options: Available along with Blue Shield medical plans, Dual Choice, Suite Deal, or PlanSelect.

Add	Delete	Optional Benefits
<input type="checkbox"/>	<input type="checkbox"/>	Infertility
<input type="checkbox"/>	<input type="checkbox"/>	Inpatient substance abuse
<input type="checkbox"/>	<input type="checkbox"/>	Chiropractic (Access+ HMO & POS only)
<input type="checkbox"/>	<input type="checkbox"/>	Acupuncture/chiropractic (Access+ HMO & POS only)
<input type="checkbox"/>	<input type="checkbox"/>	Blue Shield Vision Basic 0/100
<input type="checkbox"/>	<input type="checkbox"/>	Blue Shield Vision Basic 10/75
<input type="checkbox"/>	<input type="checkbox"/>	Blue Shield Vision Basic 0/130
<input type="checkbox"/>	<input type="checkbox"/>	Blue Shield Vision Basic 10/130
<input type="checkbox"/>	<input type="checkbox"/>	Blue Shield Life Vision Basic 0/100*
<input type="checkbox"/>	<input type="checkbox"/>	Blue Shield Life Vision Basic 10/75*
<input type="checkbox"/>	<input type="checkbox"/>	Blue Shield Life Vision Basic 0/130*
<input type="checkbox"/>	<input type="checkbox"/>	Blue Shield Life Vision Basic 10/130*
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile SM Basic Voluntary
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Basic
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Value
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Plus
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Plus Gold
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Deluxe
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Deluxe 2000
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Deluxe Plus 2000
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Deluxe Gold
<input type="checkbox"/>	<input type="checkbox"/>	Dental HMO Basic
<input type="checkbox"/>	<input type="checkbox"/>	Dental HMO Voluntary
<input type="checkbox"/>	<input type="checkbox"/>	Dental HMO Plus
<input type="checkbox"/>	<input type="checkbox"/>	Dental HMO Deluxe
<input type="checkbox"/>	<input type="checkbox"/>	Other [specify] _____

Additional comments or any changes in group name, billing address, or contact person. Please note, if the request is to change employee eligibility hours a current DE-6 must be submitted with the request:

Add/Delete Dental Only Contract: Available to groups without Blue Shield medical plans

Add	Delete	
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Basic Voluntary
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Basic
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Value
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Plus
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Plus Gold
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Deluxe
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Deluxe 2000
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Deluxe Plus 2000
<input type="checkbox"/>	<input type="checkbox"/>	DPPO Smile Deluxe Gold
<input type="checkbox"/>	<input type="checkbox"/>	Dental HMO Basic
<input type="checkbox"/>	<input type="checkbox"/>	Dental HMO Voluntary
<input type="checkbox"/>	<input type="checkbox"/>	Dental HMO Plus
<input type="checkbox"/>	<input type="checkbox"/>	Dental HMO Deluxe
<input type="checkbox"/>	<input type="checkbox"/>	Other [specify] _____

Note: When adding dental please include which (if any) subscribers will be electing dental coverage.

Add/Delete Options: Group Term Life Insurance and AD&D*

Add	Delete	
<input type="checkbox"/>	<input type="checkbox"/>	Group Term Life Insurance and AD&D
Benefit:		
<input type="checkbox"/>		Flat \$ _____ (minimum \$15,000)
<input type="checkbox"/>		_____ times salary to a maximum of \$ _____
<input type="checkbox"/>		Graded \$ _____ Class description _____
		\$ _____ Class description _____
		\$ _____ Class description _____

Employer Contribution:

100% employer paid

employer pays _____% for employees (min 25%), _____% for dependents

Eligibility:

All full-time employees

Only those employees enrolled in Blue Shield medical

Add	Delete	
<input type="checkbox"/>	<input type="checkbox"/>	Add Dependent Life Insurance: \$ _____,000 to plan (between \$1,000 and \$5,000 in \$1,000 increments) Only available with employee Life and AD&D

Employer Signature _____ Date _____

Producer/Agent Signature _____ Date _____

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