

# Blue Shield Medicare Supplement plan rates

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Blue Shield of California rates effective:  
July 1, 2025

## Region 1

Los Angeles County (except for ZIP codes 91711, 91759, 91765, 91766, 91767, 93535, 93544, 93563, and 93591)

### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.<sup>1</sup>

#### Single-party rates

Age range	A	F Extra <sup>3</sup>	G	G Extra	N
65	\$134	\$251	\$192	\$211	\$181
66	\$138	\$260	\$200	\$220	\$191
67	\$142	\$270	\$213	\$230	\$195
68	\$149	\$281	\$226	\$244	\$203
69	\$155	\$292	\$238	\$257	\$212
70	\$165	\$298	\$251	\$267	\$223
71	\$177	\$312	\$266	\$284	\$237
72	\$183	\$328	\$280	\$299	\$251
73	\$193	\$351	\$299	\$317	\$272
74	\$206	\$362	\$310	\$327	\$277
75	\$220	\$376	\$322	\$340	\$286
76	\$227	\$406	\$346	\$364	\$303
77	\$237	\$438	\$373	\$392	\$323
78	\$246	\$471	\$397	\$416	\$332
79	\$244	\$493	\$410	\$428	\$331
80	\$256	\$527	\$438	\$456	\$346
81	\$266	\$560	\$463	\$481	\$361
82	\$272	\$574	\$481	\$502	\$370
83	\$279	\$590	\$503	\$521	\$382
84	\$284	\$607	\$520	\$540	\$395
85 and over	\$292	\$637	\$545	\$563	\$414
Under 65 <sup>2</sup>	\$576	\$1,250	\$1,071	\$1,107	\$812

## Region 2

### Orange County

#### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.<sup>1</sup>

#### Single-party rates

Age range	A	F Extra <sup>3</sup>	G	G Extra	N
65	\$135	\$262	\$198	\$218	\$186
66	\$139	\$268	\$208	\$227	\$193
67	\$143	\$280	\$219	\$239	\$196
68	\$150	\$291	\$232	\$251	\$205
69	\$156	\$301	\$246	\$265	\$213
70	\$166	\$310	\$259	\$277	\$225
71	\$179	\$322	\$274	\$293	\$239
72	\$185	\$339	\$291	\$309	\$253
73	\$194	\$361	\$309	\$328	\$274
74	\$210	\$375	\$319	\$337	\$286
75	\$228	\$391	\$333	\$350	\$299
76	\$235	\$420	\$359	\$376	\$315
77	\$245	\$451	\$387	\$405	\$334
78	\$254	\$487	\$410	\$428	\$343
79	\$254	\$511	\$423	\$442	\$343
80	\$264	\$545	\$450	\$470	\$361
81	\$274	\$576	\$478	\$497	\$377
82	\$281	\$594	\$498	\$517	\$386
83	\$287	\$608	\$520	\$539	\$394
84	\$293	\$628	\$537	\$555	\$409
85 and over	\$302	\$660	\$563	\$582	\$427
Under 65 <sup>2</sup>	\$596	\$1,296	\$1,104	\$1,144	\$839

## Region 3

San Diego, Sonoma, San Bernardino and Kern counties, and Los Angeles  
ZIP codes 91711, 91759, 91765, 91766, 91767, 93535, 93544, 93563, and 93591

### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.<sup>1</sup>

### Single-party rates

Age range	A	F Extra <sup>3</sup>	G	G Extra	N
65	\$131	\$242	\$183	\$203	\$171
66	\$135	\$250	\$193	\$212	\$183
67	\$139	\$258	\$204	\$223	\$194
68	\$148	\$268	\$216	\$235	\$204
69	\$156	\$277	\$229	\$247	\$211
70	\$166	\$287	\$241	\$260	\$221
71	\$178	\$299	\$256	\$274	\$236
72	\$184	\$315	\$269	\$288	\$253
73	\$194	\$335	\$285	\$306	\$272
74	\$208	\$345	\$295	\$313	\$279
75	\$223	\$360	\$308	\$326	\$290
76	\$228	\$387	\$332	\$349	\$305
77	\$238	\$417	\$358	\$376	\$321
78	\$247	\$452	\$380	\$398	\$331
79	\$247	\$472	\$391	\$410	\$331
80	\$258	\$504	\$417	\$437	\$348
81	\$268	\$536	\$442	\$461	\$362
82	\$275	\$549	\$461	\$480	\$371
83	\$282	\$562	\$480	\$500	\$382
84	\$287	\$582	\$497	\$517	\$394
85 and over	\$295	\$609	\$520	\$541	\$412
Under 65 <sup>2</sup>	\$581	\$1,195	\$1,022	\$1,062	\$810

## Region 4

### Riverside and Ventura counties

#### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.<sup>1</sup>

#### Single-party rates

Age range	A	F Extra <sup>3</sup>	G	G Extra	N
65	\$141	\$268	\$203	\$223	\$192
66	\$145	\$276	\$214	\$232	\$203
67	\$150	\$287	\$224	\$245	\$212
68	\$162	\$298	\$240	\$259	\$220
69	\$171	\$311	\$255	\$273	\$227
70	\$182	\$317	\$265	\$285	\$242
71	\$195	\$329	\$283	\$301	\$258
72	\$201	\$348	\$298	\$318	\$276
73	\$210	\$372	\$317	\$336	\$295
74	\$226	\$382	\$327	\$345	\$303
75	\$243	\$398	\$342	\$359	\$314
76	\$249	\$430	\$367	\$386	\$330
77	\$258	\$465	\$396	\$415	\$349
78	\$270	\$501	\$421	\$438	\$359
79	\$268	\$524	\$433	\$453	\$359
80	\$281	\$560	\$464	\$480	\$376
81	\$291	\$594	\$490	\$510	\$392
82	\$297	\$608	\$512	\$532	\$402
83	\$304	\$625	\$534	\$552	\$414
84	\$310	\$645	\$551	\$570	\$428
85 and over	\$320	\$676	\$578	\$597	\$450
Under 65 <sup>2</sup>	\$630	\$1,327	\$1,133	\$1,173	\$884

## Region 5

### Santa Barbara, San Joaquin, and Stanislaus counties

#### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.<sup>1</sup>

#### Single-party rates

Age range	A	F Extra <sup>3</sup>	G	G Extra	N
65	\$121	\$221	\$168	\$186	\$157
66	\$124	\$227	\$174	\$195	\$163
67	\$128	\$236	\$184	\$203	\$171
68	\$133	\$244	\$195	\$214	\$182
69	\$138	\$254	\$207	\$227	\$188
70	\$147	\$260	\$220	\$238	\$197
71	\$158	\$271	\$232	\$251	\$211
72	\$165	\$288	\$244	\$263	\$224
73	\$174	\$305	\$262	\$279	\$241
74	\$185	\$315	\$269	\$287	\$248
75	\$197	\$328	\$280	\$299	\$256
76	\$202	\$354	\$302	\$321	\$271
77	\$211	\$380	\$325	\$344	\$288
78	\$220	\$410	\$345	\$363	\$295
79	\$220	\$430	\$357	\$376	\$295
80	\$230	\$458	\$380	\$400	\$309
81	\$238	\$485	\$404	\$422	\$323
82	\$244	\$498	\$420	\$439	\$332
83	\$249	\$511	\$438	\$456	\$339
84	\$253	\$529	\$451	\$471	\$352
85 and over	\$261	\$553	\$473	\$493	\$366
Under 65 <sup>2</sup>	\$514	\$1,087	\$930	\$967	\$720

## Region 6

### Lake, Lassen, Inyo, and Kings counties

#### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.<sup>1</sup>

#### Single-party rates

Age range	A	F Extra <sup>3</sup>	G	G Extra	N
65	\$117	\$223	\$170	\$190	\$161
66	\$119	\$230	\$178	\$197	\$166
67	\$122	\$240	\$187	\$205	\$170
68	\$129	\$248	\$199	\$217	\$176
69	\$135	\$258	\$211	\$230	\$182
70	\$143	\$265	\$222	\$239	\$192
71	\$153	\$276	\$236	\$255	\$203
72	\$158	\$291	\$247	\$266	\$217
73	\$167	\$309	\$264	\$282	\$228
74	\$179	\$319	\$272	\$291	\$239
75	\$191	\$332	\$284	\$301	\$250
76	\$197	\$357	\$305	\$324	\$264
77	\$205	\$386	\$329	\$349	\$280
78	\$213	\$416	\$350	\$369	\$286
79	\$212	\$436	\$361	\$380	\$286
80	\$222	\$465	\$386	\$404	\$300
81	\$230	\$494	\$408	\$427	\$313
82	\$237	\$505	\$426	\$445	\$322
83	\$242	\$518	\$445	\$464	\$331
84	\$247	\$537	\$459	\$478	\$342
85 and over	\$255	\$561	\$480	\$500	\$359
Under 65 <sup>2</sup>	\$502	\$1,104	\$942	\$981	\$705

## Region 7

Napa, Alameda, Contra Costa, Siskiyou, and Yolo counties

### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.<sup>1</sup>

### Single-party rates

Age range	A	F Extra <sup>3</sup>	G	G Extra	N
65	\$124	\$234	\$177	\$195	\$168
66	\$128	\$240	\$186	\$205	\$173
67	\$131	\$251	\$195	\$215	\$177
68	\$146	\$258	\$209	\$226	\$192
69	\$162	\$269	\$221	\$238	\$207
70	\$171	\$276	\$231	\$250	\$219
71	\$184	\$287	\$247	\$263	\$235
72	\$190	\$303	\$259	\$277	\$246
73	\$201	\$323	\$276	\$294	\$263
74	\$215	\$333	\$285	\$303	\$269
75	\$231	\$346	\$297	\$314	\$283
76	\$237	\$373	\$320	\$336	\$302
77	\$246	\$403	\$345	\$361	\$319
78	\$256	\$436	\$367	\$384	\$328
79	\$254	\$457	\$378	\$396	\$325
80	\$266	\$486	\$403	\$420	\$343
81	\$276	\$516	\$427	\$447	\$358
82	\$283	\$528	\$446	\$463	\$369
83	\$289	\$544	\$464	\$483	\$377
84	\$295	\$560	\$479	\$498	\$388
85 and over	\$304	\$589	\$502	\$520	\$408
Under 65 <sup>2</sup>	\$599	\$1,156	\$986	\$1,022	\$801

## Region 8

Alpine, Butte, Del Norte, Fresno, Glenn, Humboldt, Imperial, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, San Francisco, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Solano, Sutter, Trinity, Tulare, Tuolumne, and Yuba counties

### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.<sup>1</sup>

### Single-party rates

Age range	A	F Extra <sup>3</sup>	G	G Extra	N
65	\$120	\$221	\$168	\$186	\$157
66	\$124	\$227	\$174	\$195	\$166
67	\$130	\$236	\$184	\$203	\$176
68	\$133	\$244	\$195	\$214	\$181
69	\$137	\$254	\$207	\$227	\$188
70	\$149	\$260	\$220	\$238	\$199
71	\$163	\$271	\$232	\$251	\$217
72	\$169	\$288	\$244	\$263	\$231
73	\$179	\$305	\$262	\$279	\$246
74	\$190	\$316	\$269	\$287	\$254
75	\$202	\$329	\$280	\$299	\$262
76	\$209	\$355	\$302	\$321	\$277
77	\$219	\$383	\$325	\$344	\$295
78	\$227	\$411	\$345	\$363	\$302
79	\$224	\$433	\$357	\$376	\$301
80	\$235	\$460	\$380	\$400	\$317
81	\$245	\$489	\$404	\$422	\$332
82	\$251	\$500	\$420	\$439	\$340
83	\$257	\$513	\$438	\$456	\$350
84	\$262	\$530	\$451	\$471	\$361
85 and over	\$269	\$555	\$473	\$493	\$378
Under 65 <sup>2</sup>	\$531	\$1,089	\$930	\$967	\$743

## Region 9

Sacramento, Amador, Calaveras, Colusa, El Dorado, Tehama,  
and Marin counties

### Monthly plan dues – billed and to be paid in advance

The amounts listed are **before** any applicable program savings are applied.

If you are enrolled in the Household Savings Program, your dues will be 7% less than what is listed.<sup>1</sup>

### Single-party rates

Age range	A	F Extra <sup>3</sup>	G	G Extra	N
65	\$117	\$219	\$167	\$186	\$157
66	\$118	\$226	\$173	\$192	\$165
67	\$120	\$236	\$184	\$201	\$168
68	\$127	\$246	\$196	\$213	\$172
69	\$134	\$253	\$208	\$226	\$173
70	\$142	\$260	\$219	\$236	\$184
71	\$152	\$272	\$232	\$250	\$196
72	\$157	\$285	\$245	\$262	\$209
73	\$165	\$303	\$262	\$280	\$220
74	\$178	\$314	\$269	\$286	\$231
75	\$190	\$327	\$281	\$297	\$240
76	\$196	\$352	\$301	\$319	\$250
77	\$204	\$380	\$326	\$343	\$264
78	\$211	\$411	\$344	\$364	\$272
79	\$210	\$431	\$357	\$374	\$275
80	\$220	\$458	\$380	\$398	\$286
81	\$228	\$487	\$402	\$421	\$296
82	\$233	\$498	\$420	\$438	\$307
83	\$239	\$513	\$438	\$459	\$315
84	\$244	\$529	\$453	\$471	\$327
85 and over	\$252	\$554	\$473	\$493	\$343
Under 65 <sup>2</sup>	\$497	\$1,089	\$929	\$967	\$674

# Rates for Blue Shield Dental PPO plans

## Blue Shield dental rates no dental savings

	Dental PPO 1000	Dental PPO 1500
Individual	\$39.20	\$58.80

Please note: Monthly premiums for the dental plans are in addition to the premium for medical benefits covered by the Blue Shield health plan. However, your client will receive one bill that combines their health and dental premiums.



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Medicare Beneficiary Identification (MBI) number:

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I'm entitled to:

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

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Please check the plan type you are applying for:

A       F Extra \*    G  
 G Extra    N

Requested effective date:

The 1<sup>st</sup> day of (MM/YYYY)

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Current Blue Shield of California members please provide member ID number:

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### Household Savings Program<sup>1</sup>

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If you and the other member of your household are age 65 or 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 addresses?  Yes  No

If Yes, please provide the other household member

Name:

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Medicare Beneficiary Identification (MBI) number:

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

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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 below:

Signature of individual listed above:

Date (MM/DD/YYYY):

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**Each individual must complete their own application if not already a current member.** If both members are either new enrollees or 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

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**Dental plans for Medicare Supplement plan members.**

Please see the page on [blueshieldca.com/MedSuppDental2025](https://blueshieldca.com/MedSuppDental2025) for more information.

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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

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You can save \$3 each month for the first six months on your dental plan rates if you enroll in a dental plan **at the same time** you enroll in any Blue Shield Medicare Supplement plan.<sup>1</sup>

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

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

**Current insurance coverage information (required for all submissions)**

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance contract, or that you had certain rights to buy such a contract, you may be eligible for guaranteed acceptance in one or more of our Medicare Supplement plans. The Blue Shield Guaranteed Acceptance Guide describes the different situations in which you may be eligible for guaranteed issue of a Medicare Supplement plan. It is important to note that the time period of eligibility for guaranteed issuance may vary by situation, and you must apply within this time period to be eligible for guaranteed acceptance.

If you think you qualify for guaranteed acceptance, please write the number of the qualifying situation, as described in the Blue Shield Guaranteed Acceptance Guide included in the enrollment kit or visit [blueshieldca.com/medicareoptions](http://blueshieldca.com/medicareoptions), in the space below. Then attach proof of prior coverage as a separate sheet, and sign and date the sheet.

**I believe I qualify for guaranteed acceptance based on situation number \_\_\_\_\_.**

If applying for guaranteed acceptance under situation No. 2 on the Blue Shield Guaranteed Acceptance Guide, please complete the Notice of Replacement of Coverage form on the next page and submit with your completed enrollment application.

**Please include a copy of the front and back of your current carrier ID card. Please also include a copy of the notice from your prior insurer with your application.**

**Please answer all questions to the best of your knowledge.**

(Please check Yes or No below)

<b>1</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Did you turn 65 years of age in the last six months?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Did you enroll in Medicare Part B in the last six months?
		c. If Yes, what is the effective date? (MM/DD/YYYY) _____
<b>2</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you covered for medical assistance through California's Medi-Cal program? NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program and have not met your share of cost, please answer NO to this question.
	<b>If Yes,</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	a. Will Medi-Cal pay your premiums for this Medicare Supplement plan contract?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?
<b>3</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Have you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO)? If yes, fill in your start and end dates below. If you are still covered under this plan, leave the "END" blank. Start (MM/DD/YYYY) _____ Carrier name: _____ End (MM/DD/YYYY) _____ Plan type: _____ Reason for coverage ending:
	<b>If Yes,</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan contract?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Was this your first time in this type of Medicare plan?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	d. Did you drop a Medicare Supplement plan contract to enroll in the Medicare plan?

4	<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Do you have another Medicare Supplement plan policy, certificate, contract in force? b. If so, with what company? _____ What plan do you have? _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	c. If so, do you intend to replace your current Medicare Supplement plan policy or certificate with this contract? If you answered yes, please complete the Notice to applicant regarding replacement of Medicare Supplement or Medicare Advantage coverage on the next page.
5	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? a. If so, what companies and what kind of policy? Carrier name: _____ Carrier phone no.: _____ Plan type: _____ Current ID no.: _____ b. What are your dates of coverage under the other policy? (If you are still covered under this plan, leave the "END" blank.) Start (MM/DD/YYYY) _____ End (MM/DD/YYYY) _____
6	<input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you under age 65?  a. Do you have end-stage renal disease?

**You may contact the California Health Insurance Counseling and 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 is a service provided free of charge by the state of California.**

**A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Managed Health Care's consumer toll-free telephone number (888) 466-2219, by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (800) 434-0222, or by accessing the Department of Managed Health Care's website ([www.dmhc.ca.gov](http://www.dmhc.ca.gov)).**

**Notice to applicant regarding replacement of Medicare Supplement or Medicare Advantage coverage**

According to question four on the previous page, you intend to lapse or otherwise terminate an existing Medicare Supplement policy or contract or Medicare Advantage plan and replace it with a contract to be issued by Blue Shield. Your contract to be issued by Blue Shield will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or plan contract only if, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

**Statement to applicant by plan, solicitor, solicitor firm, or other representative**

1	I have reviewed your current medical or health coverage. To the best of my knowledge, the replacement of coverage involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement contract is being purchased for the following reason (check one): <input type="checkbox"/> Additional benefits <input type="checkbox"/> No change in benefits, but lower premiums or charges <input type="checkbox"/> Fewer benefits and lower premiums or charges <input type="checkbox"/> Plan has outpatient prescription drug coverage, and applicant is enrolled in Medicare Part D <input type="checkbox"/> Disenrollment from a Medicare Advantage plan. Reasons for disenrollment: _____ <input type="checkbox"/> Other (please specify): _____
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2	If the issuer of the Medicare supplement contract being applied for does not impose or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.
3	State law provides that your replacement Medicare Supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.
4	If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.
5	<b>Do not cancel your present Medicare Supplement coverage until you have received your new contract and are sure you want to keep it.</b>

### Terms, conditions, and authorizations

**Information regarding Medicare Supplement plan coverage:** Before you apply, it's important that you read the following information, then sign and date at the end of this application.

1	You do not need more than one Medicare Supplement plan policy or contract.
2	If you purchase this contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.
3	You may be eligible for benefits under Medi-Cal or Medicaid, and may not need a Medicare Supplement plan contract.
4	If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstated if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5	If you are eligible for, and have enrolled in, a Medicare Supplement plan contract by reason of disability, and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement plan contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

- 6** Counseling services are available in California to provide advice concerning your purchase of Medicare Supplement plan coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). You may obtain information regarding counseling services from the State Department of Aging.
- 7** Receiving materials and communications electronically versus print: You 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 your consent to electronic delivery. You also have the right to obtain printed, mailed materials at any time and at no expense to you. To receive printed materials in the mail and to opt out of email communications, please call **(800) 248-2341 (TTY: 711)**, 8 a.m. – 8 p.m., seven days a week.

**Conditions of membership**

- 1** I understand this application and the Statement of Health, if applicable, together with the *Evidence of Coverage and Health Service Agreement* and any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.
- 2** I will not receive coverage from Blue Shield 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 application. With my signature below, I represent that the information provided in this 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.

<b>Applicant's signature:</b>	<b>Date (MM/DD/YYYY):</b>

**Producer/writing agent information**

\* Indicates required field

A producer who assists an applicant or applicants in submitting an application to a health plan or insurer has a duty to assist the applicant(s) in providing answers to health questions accurately and completely.

This attestation must be completed by the producer and submitted with each Blue Shield Medicare Supplement plan application. This form is available for use with Medicare Supplement plan applications not containing a producer attestation with these questions and shall become part of the original application.

**Review and select one of the following:**

- I did not assist the applicant/applicants in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me.
- I assisted the applicant/applicants in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant(s) that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant(s) indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to \$10,000.

**Notice:** Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information.

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 NPN: (please print producer/writing agent's individual NPN)
Producer/writing agent's email address:	Producer/writing agent's fax number:	Producer/writing agent's phone number:
<b>Producer/writing agent's signature (required):</b>	<b>Print name:</b>	<b>Today's date (required) (MM/DD/YYYY):</b>

**Applicant's statement of health**

**Blue Shield does not collect or use genetic information in Underwriting. No genetic information, including family medical history, and no information related to HIV testing should be provided. If you qualify for guaranteed acceptance, do not complete this section.** (See the Guaranteed Acceptance Guide for qualifying information.) Otherwise, please answer Yes or No to each of the following questions:

<b>1</b>	Have you, within the past five years, received treatment or been hospitalized for any of the conditions listed below? If Yes, please explain the condition and indicate the date of treatment at the end of this section.
<input type="checkbox"/> Yes <input type="checkbox"/> No	a. Brain or nervous system disorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, dementia, Alzheimer's, paralysis, stroke, etc.
<input type="checkbox"/> Yes <input type="checkbox"/> No	b. Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.
<input type="checkbox"/> Yes <input type="checkbox"/> No	c. Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.
<input type="checkbox"/> Yes <input type="checkbox"/> No	d. Gastrointestinal disorders such as liver cirrhosis, hepatitis, ulcerative colitis, etc.
<input type="checkbox"/> Yes <input type="checkbox"/> No	e. Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.
<input type="checkbox"/> Yes <input type="checkbox"/> No	f. Metabolic disorders such as diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID, or pentamidine therapy.*
<input type="checkbox"/> Yes <input type="checkbox"/> No	g. Cancer or malignant tumors.
<input type="checkbox"/> Yes <input type="checkbox"/> No	h. Have you received treatment or been hospitalized for any other condition than those listed above?

<b>2</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have a pacemaker or artificial heart valve, or have you had transplant surgery or heart surgery such as angioplasty or bypass? If Yes, please explain the condition and indicate the date of treatment at the end of this section.
<b>3</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you been bedridden or confined to a hospital, nursing home, convalescent hospital, or other institution within the past three years? If Yes, please explain the confinement and indicate the date of confinement at the end of this section.
<b>4</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you currently taking medication? If Yes, please list at the end of this section all medications you are currently taking and the condition for which the medication is prescribed.
<b>5</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you used any tobacco-related products in the last 24 months?

If you answered Yes to any of the above questions, please provide additional information and dates associated with the condition, as well as current status of the condition. If additional space is required, please use additional sheets as necessary, and sign and date each sheet.

Condition	Date (MM/DD/YYYY)	Explanation/current status
		Medication(s) for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Name(s) and dosage:
		Medication(s) for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No Name(s) and dosage:

\* California law prohibits an HIV test from being required or used by healthcare service plans as a condition of obtaining coverage.

I alone am responsible for the accuracy and completeness of the information provided in this application. I have personally reviewed all information provided on this application. To the best of my knowledge and belief, all information on this application, including all information provided in the Statement of Health section, is accurate, true, and complete. I understand that coverage may be canceled or rescinded if Blue Shield determines that information on this application is materially inaccurate, not true, or incomplete. I further understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.

<b>Signature<sup>†</sup>:</b>	<b>Date (MM/DD/YYYY):</b>
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<sup>†</sup>Your signature is required in this section only if completing the Statement of Health.

## Authorization for release of medical information

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By signing below, you are authorizing the release of your healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent, to Blue Shield of California for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing below you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or valuating any claim for benefits.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your eligibility for coverage and enrollment determinations if you choose not to sign the authorization below unless you qualify for enrollment on the basis of guaranteed acceptance.

You are entitled to a copy of this authorization after you sign it.

**Expiration:** This authorization will remain valid until 1) for 30 months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

**Right to revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

**If you qualify for guaranteed acceptance, do not sign this release.** (See the Guaranteed Acceptance Guide for qualifying information.)

Signature:	Date (MM/DD/YYYY):
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## Payment information

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To determine the monthly dues amount, refer to Blue Shield's rate tables included in the enrollment kit or visit [blueshieldca.com/MedSupp2025](https://www.blueshieldca.com/MedSupp2025). If you are not approved, Blue Shield will refund your payment amount. If your application is approved, you will receive a monthly bill indicating the amount and the date your next payment is due. Blue Shield will also send you an approval letter, an *Evidence of Coverage and Health Service Agreement*, and a member identification card as proof of approval.

Save \$3 a month by paying dues through automatic monthly debit from your checking or savings account using our AutoPay program<sup>1</sup>. **To enroll, after receiving and paying for your first bill, register for and log into your Blue Shield account at [blueshieldca.com](https://www.blueshieldca.com) and access the Billing and Payment tab.** You may also call Customer Service at **(800) 248-2341 (TTY: 711)**, 8 a.m. – 8 p.m., seven days a week, year-round. 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.

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