



WAIVER OF PREMIUM CLAIM FORM FOR BLUE SHIELD OF CALIFORNIA LIFE & HEALTH INSURANCE COMPANY (BLUE SHIELD LIFE)

NOTE: Please complete the entire claim form. This form cannot be processed if information is incomplete.

IMPORTANT: PLEASE PRINT ALL SECTIONS IN BLACK INK.

STATEMENT OF APPLICANT					
FULL NAME				TELEPHONE NO. ()	
ADDRESS (NUMBER, STREET, APARTMENT)			CITY	STATE	ZIP
BIRTHDATE (mo/day/yr)	SOCIAL SECURITY NO.	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	DATE HIRED	LAST DAY AT WORK	
Date you became unable to work at your occupation as a result of illness or injury:			Did disability result from employment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you been CONTINUOUSLY disabled since you became unable to work? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If YES, when CAN you resume your duties at work?			If NO, when DID you become able to work?		
Is your disability due to an <input type="checkbox"/> ACCIDENT <input type="checkbox"/> ILLNESS? If an accident, describe the incident (including date and place). If an illness, identify when the symptoms first appeared: (Attach explanation if more space needed)					
<hr/> <hr/>					

AUTHORIZATION TO OBTAIN AND RELEASE MEDICAL INFORMATION
I hereby authorize any hospital or physician who has attended to me to disclose when requested to do so by the Blue Shield of California Life and Health Insurance Company any and all information with respect to any illness or injury, medical history or treatment and to furnish copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.
Signed: X _____ DATED _____, 20_____
IMPORTANT NOTICE: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.

STATEMENT OF GROUP POLICYHOLDER (Employer)					
EMPLOYER'S NAME					
GROUP POLICY NO.		EFFECTIVE DATE OF POLICY	TELEPHONE NO. ()		
DATE OF HIRE	JOB TITLE				
Was employee actively at work the day before disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	LAST DATE PREMIUM PAID	LAST DAY OF WORK BEFORE DISABILITY COMMENCED	NUMBER OF HOURS WORKED PER WEEK		
WORKER'S COMPENSATION CARRIER NAME AND ADDRESS					
AMOUNTS OF ALL INSURANCE WITH BLUE SHIELD LIFE			CLASS		
EMPLOYER;S NAME			REPRESENTATIVE AND TITLE		
STREET ADDRESS		CITY	STATE	ZIP	TELEPHONE NO. ()

ATTACHMENTS
Important Information Please Attach:
1. Original Enrollment 2. Copy of Job Description 3. Copy of Employment Application or Resumé

ATTENDING PHYSICIAN'S STATEMENT *Please print*

NAME OF CLAIMANT		DATE OF BIRTH	
PRIMARY SICKNESS OR INJURY CAUSING INABILITY TO WORK (describe complications, if any): _____			
WHEN DID SYMPTOMS FIRST APPEAR/ACCIDENT HAPPEN?		WHEN DID PATIENT CEASE WORK BECAUSE OF DISABILITY?	
HAS PATIENT EVER HAD THE SAME OR SIMILAR CONDITION? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please explain: _____			
DATE OF FIRST VISIT		DATE OF LAST VISIT	
FREQUENCY OF VISITS: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually <input type="checkbox"/> Other (specify): _____			
WHAT PROGRESS IS THE PATIENT MAKING IN REGARD TO THIS CONDITION? (Check One) <input type="checkbox"/> Recovered <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Retrogressed			
PLANNED COURSE OF TREATMENT (include expected duration, surgeries, etc.) _____ _____			
IF PATIENT WAS HOSPITALIZED, NAME OF HOSPITAL			
ADDRESS		CITY	STATE ZIP
Admitted: ____/____/____/ Discharged: ____/____/____/ (Please attach operative reports and discharge summary)			
MEDICAL PROGNOSIS (Please include any changes in physical and mental limitations and work activity restrictions) _____ _____			
WHEN DO YOU THINK PATIENT CAN RETURN TO WORK? Anticipated date: ____/____/____/ or <input type="checkbox"/> Unable to determine, follow-up in _____ months. Remarks: _____			
IN YOUR OPINION, IS THE PATIENT A CANDIDATE FOR REHABILITATION? <input type="checkbox"/> YES <input type="checkbox"/> NO Remarks: _____			
ATTENDING PHYSICIAN (please print) NAME		TELEPHONE NO. ()	
ADDRESS		CITY	STATE ZIP
SPECIALTY/DEGREE		DATE	
SIGNATURE		TAXPAYER ID NO.	