



Request for Summary Billing for Individual Health Plans

Forms and Reference Guide

Designed for convenience in combining the billing of either multiple subscribers and/or multiple Individual plans

A summary bill is a convenient way to pay if you have more than two medical, dental or life coverages. However, if more than one person is on the summary bill, then each insured person has coverage under his or her own Individual plan/policy.

A Summary Bill **is not** a suitable substitute for group coverage or any type of employer-sponsored group insurance benefit program.

Please refer to the applicable plan's Evidence of Coverage or Certificate booklet for more information on benefits, conditions, limitations, and exclusions. Blue Cross Dental SelectHMO and all medical plans, except the Basic PPO 1000, PPO Saver, BC Life Share 1000 and BC Life Share 500, are offered by Blue Cross of California. The Basic PPO 1000, PPO Saver, BC Life Share 1000, BC Life Share 500, PPO Dental and Term Life products are offered by BC Life & Health Insurance Company. Blue Cross of California provides certain administrative services to BC Life & Health. To identify which company provides your coverage, see your ID card. Blue Cross of California and BC Life & Health Insurance Company are Independent Licensees of the Blue Cross Association (BCA). Blue Card and the Blue Cross name and symbol are registered service marks of the BCA.

Setting Up a Summary Bill

Checklist

A minimum of two (2) policies (medical, dental or life) and/or with multiple subscribers must be approved and paid to the same date in order to establish and maintain a Summary Bill.

Completed Applications/Effective Dates

- Application(s) must be completed by applicant(s) only. Blue Cross approved applications will be given an effective date on the first of the month following underwriting approval.

Request For Summary Bill Cover Sheet

- Make a copy of the Applicant Summary Bill Agreement for **each** summary bill applicant. Have each applicant sign and date the Agreement. Attach these to the group of applications.

Attach a legible copy of the completed and signed Request for Summary Bill Cover Sheet to the group of applications and agreements. Note: please print in blue or black ink and keep the original for your files.

Premium Payment With Each New Individual Application

- Attach a separate check for premium payment to each application. For bi-monthly billing, submit a check for two month's premium. For quarterly billing, submit a check for three month's premium.

For Inquiries Regarding Claims and Billing

Please contact your agent or Blue Cross of California

Service Center Address:

Blue Cross of California
P.O. Box 9051
Oxnard, CA 93031-9051

Telephone:

1-800-333-0912

FAX:

1-800-327-9255



Request For Summary Bill Cover Sheet

Summary billing does not constitute a Small Group policy, a Small Group Certificate of Coverage or any type of employer sponsored group insurance benefit program.

- New Summary Bill – List all applicants on this form, then attach a copy of the form and a copy of the Agreement (reverse side) for **each** applicant. Attach a separate premium check to each application.
- New applicant(s) – Write the summary bill number on this form (current date and signature required). Attach a separate premium check to each application.

Summary Bill Recipient			Summary Bill Number <i>(if applicable)</i>
Contact Name	Phone ()	Fax ()	
Common Billing Address			Suite #
City	State	ZIP Code	E-Mail Address

Underwriting acceptance is not guaranteed. In order to establish a Summary Bill, effective dates will be on the first of the month upon underwriting completion for applications submitted.

Indicate billing type: Bimonthly Bill Quarterly Bill
 If a billing cycle is not selected, we will assign a bimonthly billing cycle.

Name of Applicant(s)	Social Security or ID No.	Medical	Life	Dental	Total Premium Received
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					

Signature of Employer <i>(if applicable)</i>	Date	Name of Employer <i>(if applicable – please print)</i>
X		
Signature of Agent	Date	Name of Agent <i>(please print)</i>
X		

Please make copies for your files.

Blue Cross Dental SelectHMO and all medical plans, except the Basic PPO 1000, PPO Saver, BC Life Share 1000 and BC Life Share 500, are offered by Blue Cross of California. The Basic PPO 1000, PPO Saver, BC Life Share 1000, BC Life Share 500, PPO Dental and Term Life products are offered by BC Life & Health Insurance Company. Blue Cross of California and BC Life & Health Insurance Company are Independent Licensees of the Blue Cross Association (BCA). The Blue Cross name and symbol are registered service marks of the BCA.



IMPORTANT NOTICE

Please make a copy of this form for EACH summary bill applicant before obtaining signatures.

I, the undersigned, understand that the attached applications are for Individual insurance plans/policies which **do not** conform to Employee Retirement Income Security Act (ERISA) legal requirements applicable to employer sponsored benefit plans and **do not** constitute any type of employer-sponsored group insurance benefits program. I agree that if Blue Cross of California or BC Life & Health Insurance Company received or receives information that the individuals included on the summary bill should be considered a Small Group, group or employer sponsored group insurance benefit program, Blue Cross of California or BC Life & Health Insurance Company will discontinue the summary bill and each individual will be billed separately. I have read the complete Summary Billing for Individual Health Plans Forms and Reference Guide. The employer is not paying any part of the premium either directly or through reimbursement and since the employer does not sponsor the health plan, the employer is not deducting any part of the premiums from gross income under Section 106 or 162 of the Internal Revenue Code, if applicable.

I understand that my enrollment in Blue Cross of California or BC Life & Health Insurance Company's Health Plan includes combined bimonthly or quarterly billing with other plan subscribers/insureds. I agree to submit my dues/premiums to Blue Cross of California or BC Life & Health Insurance Company through my employer acting on my behalf. I remain fully responsible for the timely submission of my dues/premiums to Blue Cross of California or BC Life & Health Insurance Company.

I understand that either Blue Cross of California or BC Life & Health Insurance Company or I may terminate the summary billing agreement at any time. Applicable bimonthly/quarterly premiums will then be billed directly to me starting at the due date. I understand that it is my obligation to inform Blue Cross of California or BC Life & Health Insurance Company in writing, of any change of address, employment or status of dependents at least 31 days prior to the next billing due date.

I have read and understand this notice and the terms and conditions of my payment options of my plan(s) as amended, to include combined billing procedures.

X

Subscriber's Signature

Date

X

Subscriber's Printed Name

X

Subscriber's Social Security or ID No.

X

Summary Bill Number (if applicable)

Please have each applicant on summary bill sign and date this form.

Please sign and return this agreement with your completed application.