PART 2 — EXTENDED HEALTH CARE: Rates are subject to change

☐ I am applying for Extended Health Benefits

- Monthly Rates effective July 1, 202☐ Single $197.77☐ Couple $361.91☐ Family $439.04

PART 3 — DEPENDENT INFORMATION: Check Extended Health Care box for each dependent if applying for coverage

FIRST NAME	LAST NAME					

☐ Personal

Part 6 — Additional Information on page 2

☐ Credit Card ☐ VISA ☐ MasterCard ☐ A

PART 5 — PAYMENT METHOD (Choose one method below)

☐

PART 7 — APPLICANT SIGNATURE

I agree to the conditions of the contract between my plan sponsor and Pacific Blue Cross (PBC). I confirm that the information I have provided is true and complete.

If I should receive a settlement or a judgement against a liable third party for wage loss or benefits covered under my group plan, I agree to and authorize the third party to reimburse PBC up to the amount advanced to me pending such settlement or judgement.

I understand and consent that some of the personal information provided by me and my dependents under this group plan may be disclosed to agents and representatives of PBC and other providers/insurers and their agents and representatives for the purposes of assessing and providing benefits coverage. I also understand and consent to the disclosure of thbe 52ed to me dvanween mywh beo the quico3(yp[(No tt)4(t a)10(o)10(o)7(

PART 9 — OTHER COVERAGE

Complete this section if you previously waived coverage for yourself and/or any of your dependents and are applying after the 90 day enrollment period

Benefits covered under the other plan ☐ EHC	Is the plan still active? ☐ Yes ☐ No — termination date (mm-dd-yyyy):

PART 10 — ADDITIONAL INFORMATION