



Attach Check Here

Blue Cross Individual Dental PPO Plan Enrollment Application

If you are a Blue Cross of California subscriber, please enter your current Blue Cross group number and certificate number.

GROUP NO. CERTIFICATE NO.

Check Billing Type Selected

- Monthly (by checking account deduction only)
Bimonthly Quarterly

Application Information: Applicant must complete this section.

PLEASE PRINT

Form with fields: LAST NAME, FIRST NAME, MI, SEX, BIRTHDATE, MARITAL STATUS, SOCIAL SECURITY NUMBER, HOME ADDRESS, BILLING ADDRESS, CITY, STATE, ZIP CODE, HOME PHONE NO., BUSINESS PHONE NO.

Spouse To Be Insured (Sign Below)

Form with fields: NAME OF SPOUSE, SEX, BIRTHDATE, SOCIAL SECURITY NUMBER

Children To Be Insured

Form with fields: NAME, SEX, BIRTHDATE for 4 children

Signatures (Required)

Any dispute between you and Blue Cross of California/BC Life & Health must be resolved by binding arbitration...

Statement of Understanding for Areas 1, 2 and 3 (non-network counties only - see page 7.) I understand the difference between a Participating Dentist and a Non-Participating Dentist...

Form with signature lines and dates for Applicant, Spouse, and Dependent

Agent Information

Form with fields: SIGNATURE OF AGENT, AGENT NAME (PRINT), AGENT NUMBER

Form with fields: GROUP NO., CERTIFICATE NUMBER, AGENT NO., EFFECTIVE DATE, PRE-EXIST, AREA, BY, DATE

Optional Monthly Checking Account Deduction

- ① Complete this section.
- ② Attach a blank check marked "VOID" to this form. (DEPOSIT SLIPS or TEMPORARY CHECKS ARE NOT ACCEPTABLE).
- ③ Submit a check for one month's premium payable to Blue Cross of California. If the account listed is a joint account, both account holders' signatures are required.

Checking Account Deduction Authorization

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and made payable to the order of BLUE CROSS OF CALIFORNIA, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn by you and signed personally by me. I authorize Blue Cross of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Cross premiums. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice; I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit is dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor may result in the forfeiture of insurance.

Name of Bank	
Address	
City / State / Zip Code	

NOTE: You will incur a service charge for any withdrawal not honored. Should your withdrawal not be honored by your bank, you automatically will be removed from monthly checking account deduction, and will be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction option.

Subscriber's Name	
Subscriber's Social Security No. / Certificate No.	Group No.
Name on Checking Account (if different than above)	
Checking Account No.	
Authorized Signature (As it appears in the financial institution's records)	
Date	
Authorized Signature (As it appears in the financial institution's records)	
Date	

→ Staple Blank, Voided Check Here ←