Individual/Family Dental Plan Enrollment Application

If you are a BCBSGA subscriber, please enter your current BCBSGA group number and/or member ID number.

MEMBER ID NO.

FOR BCBSGA USE ONLY:

DCN #

Billing Type

◯ Monthly (***By checking account deduction only.*** **Please complete the enclosed Bank Draft Authorization form.**)

Applicant Information - Applicant must complete this section.

Last Name | First Name | MI | Social Security No.

Home Phone No. | Business Phone No. | Age | Sex ◯ M ◯ F | Marital Status ◯ Single ◯ Married | Date of Birth

Home Address (*Must be complete. P.O. Box not acceptable)* | Billing Address (*If different or P.O. Box)*

City | State | Zip Code | City | State | Zip Code

Spouse to Be Insured - Signature required below.

Last Name of Spouse | First Name | Sex ◯ M ◯ F | Date of Birth | Social Security No.

Children to Be Insured - Signature required below.

1. Last Name of Child | First Name | Sex ◯ M ◯ F | Date of Birth | Social Security No.
2. Last Name of Child | First Name | Sex ◯ M ◯ F | Date of Birth | Social Security No.
3. Last Name of Child | First Name | Sex ◯ M ◯ F | Date of Birth | Social Security No.
4. Last Name of Child | First Name | Sex ◯ M ◯ F | Date of Birth | Social Security No.

Signatures (Required)

If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. If the responsible adult is not the natural parent, please submit court papers authorizing guardianship. I understand that coverage is subject to all conditions and provisions specified in the Policy. By submitting an application for coverage, I have authorized every provider furnishing care to disclose all facts pertaining to our care, treatment, and physical conditions, upon your request. I agree to assist in obtaining this information if needed. I understand that receipt of money with this application does not create BCBSGA coverage. Coverage will come into effect only on approval by BCBSGA.

Signature of Applicant /Parent or Legal Guardian	Today's Date	Signature of Applicant's Spouse	Today's Date
X		**X**	

Agent Information

Name of Agent (Print)	Agent Number	Signature of Agent	Today's Date
		X	

Rep No.

FOR BCBSGA USE ONLY

Group No. | Member ID No. | Agent Tax I.D. No. | Effective Date

Area	By	Date

An Independent Licensee of the Blue Cross Blue Shield Association
Print Date 07/02