

Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department
at: _____ fax: _____

Step 2

SELECT THE TYPE OF BILLING YOU WANT – annual.

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to:BC Life & Health Insurance Company

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...





Choose One: Enroll Change

Application Information: All fields must be completed

PLEASE PRINT

LAST NAME	FIRST NAME	MI	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> M	SOCIAL SECURITY NUMBER
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	
HOME PHONE NO. ()			BUSINESS PHONE NO. ()			

Spouse To Be Enrolled

NAME OF SPOUSE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	SOCIAL SECURITY NUMBER
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Children To Be Enrolled

NAME (First and Last) 1.	SEX	BIRTHDATE (Mo/Day/Year)	NAME (First and Last) 3.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)
NAME (First and Last) 2.	SEX	BIRTHDATE (Mo/Day/Year)	NAME (First and Last) 4.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)

SmileNet Program Fees

Annual Fee: Single \$80 Family \$120	Administrative Fee: \$20 (one time fee for new members)
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Payment Options

Electronic check

NAME ON BANK ACCOUNT	ROUTING NUMBER	ACCOUNT NUMBER	AMOUNT	CHECK NUMBER
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Use the enclosed check as payment. *Please make check payable to BC Life & Health Insurance Company.*

By choosing the electronic check option, I authorize Blue Cross of California to convert my check into an electronic funds transfer. I understand that my bank account will be debited for the amount indicated on the check. I am aware that my check will not be returned. If I pay by electronic or paper check, I understand that I will be sent an invoice prior to my renewal date. No refunds, cancellations or changes (such as adding or deleting a family member) will be allowed in the first 12 months, except in the case of death. I have read and understand the Terms and Conditions of the SmileNetSM program.

Signatures (Required)

SIGNATURE OF APPLICANT/PARENT OR LEGAL GUARDIAN X	TODAY'S DATE	SIGNATURE OF APPLICANT'S SPOUSE X	TODAY'S DATE
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Agent Information

SIGNATURE OF AGENT X	AGENT NAME (PRINT)	AGENT NUMBER
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