



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 <input type="text"/>		First Name <input type="text"/>		MI <input type="text"/>	Social Security No. <input type="text"/>	
Home Phone No. <input type="text"/>		Business Phone No. <input type="text"/>		Age <input type="text"/>	Sex <input type="radio"/> M <input type="radio"/> F	Marital Status <input type="radio"/> Single <input type="radio"/> Married
Date of Birth <input type="text"/>						
Home Address (Must be complete. P.O. Box not acceptable) <input type="text"/>				Billing Address (If different or P.O. Box) <input type="text"/>		
City <input type="text"/>		State <input type="text"/>	Zip Code <input type="text"/>	City <input type="text"/>		State <input type="text"/>
				Zip Code <input type="text"/>		

Spouse to Be Insured - Signature required below.

Last Name of Spouse <input type="text"/>		First Name <input type="text"/>		Sex <input type="radio"/> M <input type="radio"/> F	Date of Birth <input type="text"/>	Social Security No. <input type="text"/>
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Children to Be Insured - Signature required below.

1. Last Name of Child <input type="text"/>	First Name <input type="text"/>	Sex <input type="radio"/> M <input type="radio"/> F	Date of Birth <input type="text"/>	Social Security No. <input type="text"/>
2. Last Name of Child <input type="text"/>	First Name <input type="text"/>	Sex <input type="radio"/> M <input type="radio"/> F	Date of Birth <input type="text"/>	Social Security No. <input type="text"/>
3. Last Name of Child <input type="text"/>	First Name <input type="text"/>	Sex <input type="radio"/> M <input type="radio"/> F	Date of Birth <input type="text"/>	Social Security No. <input type="text"/>
4. Last Name of Child <input type="text"/>	First Name <input type="text"/>	Sex <input type="radio"/> M <input type="radio"/> F	Date of Birth <input type="text"/>	Social Security No. <input type="text"/>

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 biological 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 X	Today's Date	Signature of Applicant's Spouse X	Today's Date
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Agent Information

Name of Agent (Print)	Agent Number	Signature of Agent X	Today's Date
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Rep No.

FOR BCBSGA USE ONLY

Group No. <input type="text"/>	Member ID No. <input type="text"/>	Agent Tax I.D. No. <input type="text"/>	Effective Date <input type="text"/>
Area	By	Date	



SOCIAL SECURITY NO.									

BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS

I hereby authorize **Blue Cross and Blue Shield of Georgia, Inc.** to draw checks, drafts, orders or electronic funds transfer (EFT) upon my account at the:

_____	_____
NAME OF BANK	CHECKING ACCOUNT NUMBER
_____	_____
STREET ADDRESS OF BANK	CITY, STATE, ZIP CODE OF BANK

for the purpose of paying premiums on insurance issued by Blue Cross and Blue Shield of Georgia, Inc.

I understand if any check, draft, order or EFT transmission is returned due to **payment stopped** or **authorization cancelled**, this will be considered as my request to be billed directly.

_____	_____
CONTRACT HOLDER'S NAME	SOCIAL SECURITY NUMBER
_____	_____
CONTRACT HOLDER'S ADDRESS	CITY, STATE, AND ZIP CODE

_____	X	_____	_____
PRINTED SIGNATURE OF ACCOUNT HOLDER		SIGNATURE OF ACCOUNT HOLDER	DATE

NOTE: A VOIDED CHECK MUST BE ATTACHED TO THIS APPLICATION.

First request for bankdraft plan

Complete entire form and attach a voided check.

INSTRUCTIONS FOR COMPLETING THE BANK DRAFT AGREEMENT FOR PREAUTHORIZED PAYMENTS

Automatic Premium Payment Plan

What is it - A special arrangement for payment of premiums automatically each month to relieve you of concern with due dates and the possibilities of having your insurance lapse unintentionally.

Who can use it - Bankdraft is an extra convenience for you. It is available if you maintain a regular checking account at your bank and make arrangements with your bank to honor automatic checks and electronic fund transfers.

How it works - To initiate the bankdraft, you must complete the authorizations above.

INSTRUCTIONS

1. Complete as follows:

- A. Fill in the name of your bank, branch, branch number (*if any*) and the city or state in which the bank or the branch is located.
- B. Print the name of your account exactly as it appears on your bank statement or check.
- C. Include your checking account number. It will usually be found below the signature line of your personal checks.
- D. Sign your name exactly as you do on your personal checks. If there is more than one depositor, all should sign.
- E. Include the date you signed the authorizations.

2. Attach a VOIDED check and this completed form. Please be sure the sample check is drawn on the same account as will be used for the automatic premium payment plan.

3. The coverage provided by this policy may be terminated by you upon thirty (30) days **written** notice.

4. Written notice thirty (30) days in advance as stated above in No. 3 is preferred. However, if any check is returned for **payment stopped** or **authorization cancelled**, this will be considered as your request to be billed directly. No further checks will be presented for payment to your bank. If a check is returned for any other reason, you will be notified by Blue Cross and Blue Shield of Georgia of what is required to pay the premium.

INTERNAL USE ONLY

DCN #: _____
BANK #: _____