

# 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** – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months). Please submit first payment by check with application.

## Step 3

**PLEASE SEND THE COMPLETED APPLICATION AND CHECK TO:**

**Please make your check payable to: Blue Cross of California**

**We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.**

**If you have questions please contact our office at:**

Thank you for choosing...



**Blue Cross of California**



**Blue Cross  
Senior Dental PPO Plan  
Enrollment Application**

If you are a Blue Cross of California or BC Life & Health subscriber, please enter your current group number and certificate number.

GROUP NO.	CERTIFICATE NO.

**Check Billing Type Selected**

**(Attach Check Here)**

Monthly (By checking account deduction only.)
  Bi-monthly
  Quarterly

**Applicant Information:** Applicant must complete this section.

**PLEASE PRINT**

Last Name		First Name		MI	Social Security Number		
Home Phone (    )		Business Phone (    )		Sex	Marital Status	Age	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 (Sign Below)**

Name of Spouse	Sex	Date of Birth**	Social Security Number

**Signatures (Required)**

If you are applying for coverage, please note that Blue Cross requires binding arbitration to settle all disputes, including claims of medical malpractice. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 required specified disclosures in this regard, including the following notice: 'it is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.' Both parties also agree to give up any right to pursue on a class basis any claim or controversy against the other.

Signature of Applicant	Today's Date	Signature of Applicant's Spouse	Today's Date

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

**Statement of Understanding for Area 1 and 2 Non-Network Counties\*** only. I understand the difference between a Participating Dentist and a non-Participating Dentist and would like to apply. I know that I will probably will not be able to use a Participating Dentist and that I will probably pay more for dental care. When I use non-Participating Dentists, I will pay the difference between the limited benefit that the plan pays and the actual charge by the non-Participating Dentist. This means that I may be responsible for a larger portion of my dental bills.

Signature of Applicant	Today's Date	Signature of Applicant's Spouse	Today's Date

**Agent Information**

Name of Agent (Print) William S. Lorenz	Signature of Agent	Agent Tax I.D. Number MNJKMHRNRZ
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**OFFICE USE ONLY**

Group No.	Certificate No.	Agent Tax I.D. No.	Effective Date	Area	By	Date

\* Non-network counties include: Alpine, Mono, Sierra, Mariposa. Some counties may have limited network access, please contact your BC Life & Health representative.  
\*\* All applicants must be age 65 or older.

# Monthly Bank Draft Authorization

## 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 payable to the order of Blue Cross of California (administrator for BC Life & Health Insurance Company) 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 on you and signed personally by me. I authorize Blue Cross of California (administrator for BC Life & Health Insurance Company) to initiate debits (and/or corrections to previous debits) from my account with financial institution indicated for payment of my Senior Dental PPO Plan dues. 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 be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

**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 be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction options.

### Instructions:

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 (1) month's premium made out to Blue Cross of California. If the account listed below is a joint account, both account holders' signatures are required.

All funds are drawn on the first of each month. Premiums may be pro-rated in order to adjust the initial paid to date or in the event of membership changes.

Name of Bank

Bank Address

City/State/ZIP

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)

**X**

Date

Authorized Signature (spouse)  
(As it appears in the financial institution's records)

**X**

Date

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