



Senior Dental Plan Enrollment Application

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

GROUP NO.

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. Phone No. Business Phone No.

Sex Male Female Marital Status Single Married Age Date of Birth

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

City City

State Zip Code State Zip Code

Signature (Required)

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 my 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 Today's Date

Agent Information

Name of Agent (Print) Agent Tax I.D. Number Check One
 EIN
 SS# Signature of Agent Today's Date

Rep No.

FOR BCBSGA USE ONLY

Group No. Member ID No. Agent Tax I.D. No.

Effective Date

Area By Date