



Blue Cross Blue Shield of Georgia
3350 Peachtree Road, NE
Mail Code: G00302 Individual
Atlanta, GA 30326

Please print legibly and use black ink.
 SmileNet is not an insurance plan — it is a dental discount program.

SmileNetSM Discount Dental Program Enrollment Application

Individual Family

Product Selection: Basic Ortho Cosmetic Basic, Ortho & Cosmetic
 Basic & Ortho Basic & Cosmetic Ortho & Cosmetic

Applicant information – all fields must be completed

APPLICANT'S NAME (LAST, FIRST, MIDDLE) _____

SEX BIRTH DATE (MM/DD/YY) / / APPLICANT SOCIAL SECURITY NUMBER - -

BILLING ADDRESS _____ CITY _____ STATE _____ ZIP _____

COUNTY _____ DAY TELEPHONE (()) - _____ EVENING TELEPHONE (()) - _____

SPOUSE'S NAME (IF TO BE COVERED) _____ SEX BIRTH DATE (MM/DD/YY) / /

CHILDREN, FULL NAME (IF TO BE COVERED)	SEX <input type="checkbox"/>	BIRTH DATE (MM/DD/YY) / /	CHILDREN, FULL NAME (IF TO BE COVERED)	SEX <input type="checkbox"/>	BIRTH DATE (MM/DD/YY) / /
1. _____			3. _____		
2. _____			4. _____		

Total Amount Due: (Refer to page 5 in brochure for the rate of your selected plan)

Annual Membership Fee \$ _____ + \$19.95 (one-time admin. fee) = \$ _____ **total amount due BCBSGa.**

Payment Options:

CHECK (Please make your check payable to Blue Cross Blue Shield of Georgia)
 CREDIT CARD MC VISA Discover Credit Card # _____ Exp. Date _____
 Name as it appears on Credit Card _____ month/year
 Signature of Card Holder _____

I have read and understand the Terms and Conditions of the SmileNet program.

Signature (Required)

Signature of Applicant/Parent or Legal Guardian X	Today's Date
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FOR INTERNAL USE		DCN		ACN	
REP NO.	CITY CODE	AREA	DEDUCTIBLE	AMT RECEIVED	AGENT SIGNATURE
				PRINT NAME:	E-MAIL ADDRESS:
					FAX NO.:



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