DIRECT BILL

BlueCross BlueShield of Oklahoma

A Division of Health Care Service Corporation, A Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.
® Registered Marks Blue Cross and Blue Shield Association.

www.bcbsok.com

BlueSelect Dental and BlueSelect Children's Dental

OFFICE USE ONLY	MEMBER IDENTIFICATION NUMBER	GROUP NUMBER	EFFECTIVE DATE	APPROVED BY	
	DATE PROCESSED		BROKER NUMBER	TM NUMBER	AE NUMBER

1. SELECT YOUR PLAN: ☐ Option 1 ☐ Option 2

2. TELL US WHO YOU WANT TO ENROLL (Check one box below):

☐ CHILD ONLY
COMPLETE ITEMS 1 THROUGH 7, AND 9 & 10 (CHILD IS APPLICANT)*

☐ ADULT (AGE 19 AND OVER)
COMPLETE ITEMS 1 THROUGH 7 AND 9 & 10

☐ ADULT AND SPOUSE
COMPLETE ITEMS 1 THROUGH 10

☐ ADULT, SPOUSE AND ONE CHILD*
COMPLETE ITEMS 1 THROUGH 10

☐ ADULT, SPOUSE AND TWO OR MORE CHILDREN*
COMPLETE ITEMS 1 THROUGH 10

☐ ADULT AND ONE CHILD*
COMPLETE ITEMS 1 THROUGH 10

☐ ADULT AND TWO OR MORE CHILDREN*
COMPLETE ITEMS 1 THROUGH 10

***CHILD MUST BE UNDER AGE 19**

TELL US ABOUT YOURSELF (Please print or type):

3. NAME OF APPLICANT (LAST, FIRST, MIDDLE) | RESIDENCE TELEPHONE A/C

4. (STREET OR BOX NO.) (CITY) (STATE) (9-DIGIT ZIP CODE) ☐☐☐☐☐ – ☐☐☐☐

5. SOCIAL SECURITY NUMBER ☐☐☐ ☐☐ ☐☐☐☐ | DATE OF BIRTH MO. DAY YR. | SEX M ☐ F ☐ | MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SINGLE ☐ SEPARATED | BUSINESS PHONE A/C

6. I AM EMPLOYED BY (NAME OF COMPANY) | ADDRESS (STREET OR BOX NO., CITY, STATE, ZIP)

7. DO YOU NOW HAVE BLUE CROSS/BLUE SHIELD OR BLUELINCS HMO? ☐ YES ☐ NO | ID NUMBER | YOUR CURRENT GROUP NO. | LOCATION OF BLUE CROSS BLUE SHIELD PLAN (CITY & STATE)

TELL US ABOUT OTHER FAMILY MEMBERS APPLYING FOR COVERAGE:

8.

NAME	RELATIONSHIP TO APPLICANT	DATE OF BIRTH (MO. DAY YR.)	SOCIAL SECURITY NUMBER
NAME OF SPOUSE (FIRST, MIDDLE, LAST)			
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)			
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)			
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)			
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)			
DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST)			

9. SELECT YOUR PAYMENT OPTION: DO NOT SEND MONEY NOW

A. *Membership premium is to be deducted from my checking/savings account (check one):
☐ Monthly ☐ Quarterly
☐ Semi-Annually ☐ Annually
*COMPLETE ITEM 10

***IMPORTANT** See reverse side

B. Membership premium is to be individually billed to my home (check one):
☐ Quarterly
☐ Semi-Annually ☐ Annually

SELECT MEMBER EFFECTIVE DATE: ☐ 1ST ☐ 15TH ☐ Earliest possible effective date (as determined by the Plan)

***NOTE: PLEASE COMPLETE REVERSE SIDE**

FOR OFFICE USE ONLY

GROUP NUMBER	F/C AGREEMENT NUMBER	F/C CODE	WVR CODE	WVR CODE EXP DATE	DIV CODE	CROSS REFERENCE AGREEMENT NO.	BRK IND	BRK NO.
			00	00-00-0000				

COB CODE	INVOICE NUMBER	MSC CODE	EFFECTIVE DATE	CHAR. CODE DATE	SUB CHAR	DEP. CHAR.	MINOR CHAR.	SUB DENT. CHAR.	DEP. DENT. CHAR.

LOB	EFF. DATE	DUES AMT.	LOB	EFF. DATE	DUES AMT.	LOB	EFF. DATE	DUES AMT.	LOB	EFF. DATE	DUES AMT.

2.403 (02/06)

10. FINANCIAL INSTITUTION INFORMATION:

IMPORTANT: If you select the ACH payment option, payments will be deducted from you personal checking or savings account. Complete this authorization and attach a voided check in the space below.

AUTHORIZATION TO HONOR DEBIT ENTRIES ORDERED BY BLUE CROSS AND BLUE SHIELD OF OKLAHOMA

As a convenience to me, I hereby authorize BLUE CROSS AND BLUE SHIELD OF OKLAHOMA to initiate debit entries from my account when the payment is due.

FINANCIAL INSTITUTION NAME		FINANCIAL INSTITUTION PHONE NUMBER
CITY	STATE	ZIP CODE
TRANSIT ROUTING NUMBER (from lower left corner of check or deposit slip)	ACCOUNT NUMBER	TYPE OF ACCOUNT ☐ CHECKING ☐ SAVINGS

Attach a voided personal check here. This voided check gives the necessary information for your financial institution to deduct your premium from your account.

11. DENTAL APPLICATION AGREEMENT:

I and any other persons whose names appear on this application hereby apply for coverage from Blue Cross and Blue Shield of Oklahoma as indicated in this application. I understand and agree to the items listed below:

- This is an application only, and I should not cancel any existing dental coverage unless and until I am notified in writing by Blue Cross and Blue Shield of Oklahoma of my acceptance.
- I must be a resident of Oklahoma to apply.
- I have read all the statements on this application and represent that they are true and complete. I understand that any false or incomplete information can result in retroactive cancellation of coverage for all persons under the membership, and I will repay promptly any benefit payment to which persons covered under this membership were not entitled.
- Eligible dependents are defined as: 1) my spouse, or 2) a child for whom I am legally responsible. I understand that the limiting age for a dependent child is January 1st following the year during which the child attains age 19, provided the child has not reached age 19 prior to his or her effective date.
- Any insurance agent, dentist, or other person who knowingly and willfully makes a false or fraudulent statement or representation relative to any application for insurance, or who makes any such statement to obtain a fee, commission, money or benefit shall be guilty of a misdemeanor (TITLE 36, SECTION 1204 of the Oklahoma State Statutes).

Please read and review the terms of this application before signing

APPLICANTS SIGNATURE (IF AGE 15 OR OVER)	TODAY'S DATE
PARENT OR LEGAL GUARDIAN SIGNATURE (MUST SIGN IF APPLICANT IS UNDER 18)	TODAY'S DATE
SPOUSE'S SIGNATURE (IF APPLYING FOR COVERAGE)	TODAY'S DATE

PROXY STATEMENT: The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

Primary Applicant's Signature

X _____

Print Your Name as You Signed It: _____ Date Signed ____/____/____
Month Day Year

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

PRODUCER INFORMATION (IF APPLICABLE)

This section to be completed by the producer, if any, who represents the applicant.

PRODUCER NAME		
ADDRESS (STREET, CITY, STATE, ZIP)		TELEPHONE
PRODUCER SIGNATURE	BLUE CROSS AND BLUE SHIELD PRODUCER NUMBER	STATE LICENSE NUMBER