3 Easy Steps… Enrolling…
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.
1. Print all pages of the application including instructions.
2. Complete all questions.
If you have any questions, or you are not sure how to answer a question, simply contact us : Tel. **(818)987-5000 fax: (818)776-9865**

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy
18375 Ventura Blvd. # 226
Tarzana , CA 91356

Please make your check payable to: Blue Cross

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact us :

Oleg Skurskiy
Authorized Independent Agent
Tel.: 1-818-987-5000
Fax: 1-818-776-9865
oleg@askoleg.com

Thank you for choosing...

BC Life & Health Insurance Company

Attach Check Here

Blue Cross Individual Dental PPO Plan Enrollment Application

If you are a Blue Cross of California subscriber, please enter your current Blue Cross group number and certificate number.

GROUP NO.	CERTIFICATE NO.

Check Billing Type Selected

☐ Monthly (by checking account deduction only)
☐ Bimonthly ☐ Quarterly

Application Information: Applicant must complete this section.

PLEASE PRINT

LAST NAME	FIRST NAME	MI	SEX ☐ M ☐ F	BIRTHDATE (Mo/Day/Year)	MARITAL STATUS ☐ S ☐ M	SOCIAL SECURITY NUMBER

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
HOME PHONE NO. ( )			BUSINESS PHONE NO. ( )		

Spouse To Be Insured (Sign Below)

NAME OF SPOUSE	SEX ☐ M ☐ F	BIRTHDATE (Mo/Day/Year)	SOCIAL SECURITY NUMBER

Children To Be Insured

NAME (First and Last)	SEX	BIRTHDATE (Mo/Day/Year)	NAME (First and Last)	SEX ☐ M ☐ F	BIRTHDATE (Mo/Day/Year)
1.			3.		
NAME (First and Last)	SEX	BIRTHDATE (Mo/Day/Year)	NAME (First and Last)	SEX ☐ M ☐ F	BIRTHDATE (Mo/Day/Year)
2.			4.		

Signatures (Required)

Any dispute between you and Blue Cross of California/BC Life & Health must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of Small Claims Court, and not by lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. Under this coverage, both you and Blue Cross of California and its affiliates are giving up the right to have any dispute decided in a court of law before a jury.

Statement of Understanding for Areas 1, 2 and 3 (non-network counties only - see page 7.) ***I understand the difference between a Participating Dentist and a Non-Participating Dentist, and would like to apply. I know that I 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/PARENT OR LEGAL GUARDIAN	TODAY'S DATE	SIGNATURE OF APPLICANT'S SPOUSE	TODAY'S DATE
X		X	
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER	TODAY'S DATE	SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER	TODAY'S DATE
X		X	

Agent Information

SIGNATURE OF AGENT	AGENT NAME (PRINT)	AGENT NUMBER
X	Oleg Skurskiy	BCLNGNPVMZ

FOR BLUE CROSS ONLY								
GROUP NO.	CERTIFICATE NUMBER	AGENT NO.	EFFECTIVE DATE	PRE-EXIST		AREA	BY	DATE

Optional Monthly Checking Account Deduction

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 month's premium payable to Blue Cross of California. If the account listed is a joint account, both account holders' signatures are required.

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 made payable to the order of BLUE CROSS OF CALIFORNIA, 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 by you and signed personally by me. I authorize Blue Cross of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Cross premiums. 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 is dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor may result in the forfeiture of insurance.

Name of Bank
Address
City / State / Zip Code

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

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

→ ***Staple Blank, Voided Check Here*** ←