



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

SELECT YOUR PLAN: OPTION 1 OPTION 2

WHO DO YOU WANT TO ENROLL? *Check one box*

- ADULT, SPOUSE AND ONE CHILD
(dependent child must be under age 26)
- ADULT (over age 19)
- ADULT AND SPOUSE
(dependent children must be under age 26)
- CHILD ONLY *(under age 19)*
- ADULT, SPOUSE AND TWO OR MORE CHILDREN
(dependent children must be under age 26)
- ADULT AND ONE CHILD
(dependent children must be under age 26)
- ADULT AND TWO OR MORE CHILDREN
(dependent children must be under age 26)

TELL US ABOUT YOURSELF *Please print or type*

LAST NAME OF APPLICANT	FIRST	MIDDLE	RESIDENCE PHONE ()		
MAILING ADDRESS (STREET OR P.O. BOX, CITY, STATE, ZIP+4)					
SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARITAL STATUS <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED	BUSINESS PHONE ()	
EMPLOYED BY	EMPLOYER ADDRESS (STREET OR P.O. BOX, CITY, STATE, ZIP+4)				
DO YOU NOW HAVE BLUE CROSS/BLUE SHIELD OR BLUEINCS HMO? <input type="checkbox"/> YES <input type="checkbox"/> 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 *(if applicable)*

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

SELECT YOUR PAYMENT OPTION

DO NOT SEND MONEY NOW

- *Membership premium is to be deducted from my checking/savings account (check one): ***COMPLETE FINANCIAL INSTITUTION INFORMATION**
- Monthly Quarterly Semi-Annually Annually
- 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.
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.

FINANCIAL INSTITUTION INFORMATION

IMPORTANT: If you select the ACH payment option, payments will be deducted from your 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 <input type="checkbox"/> CHECKING <input type="checkbox"/> 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.		

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 understand that an act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact, with the intent to deceive the Plan, on this application may result in rescission of coverage. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. I will be provided with at least 30 days' advance written notice before my or my dependent's coverage may be rescinded, retroactive to the effective date of coverage.
- Eligible dependents are defined as: 1) my spouse, or 2) a child, over age one and under age 26, for whom I am legally responsible, I understand that the limiting age for a dependent child is the child's 26 birth 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).
- **Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.**

Please read and review the terms of this application before signing.

[APPLICANT'S 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. 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.

AGENT INFORMATION (IF APPLICABLE) This section to be completed by the producer, if any, who represents the applicant.

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