

Enrolling is Simple. 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. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at:
Fax:

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:

Please make your check payable to: Blue Cross of California

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.

If you have questions please contact our office at:

Thank you for choosing...



**ATTACH BLANK, VOIDED CHECK FOR BANK DRAFT AUTHORIZATION,
IF APPLICABLE, HERE. DO NOT TAPE.**

Applicant's Social Security or ID No.

Payment Method Premium payment required. First payment will be credited to approved applicants only. By sending your check to us, you authorize Blue Cross of California to convert your check into an electronic fund transfer. If you are approved for coverage, your bank account will be debited for the amount indicated on the check. If you do not qualify for coverage, your check will not be submitted for a funds transfer. Please be aware that your check will not be returned to you.

Credit Card

FAX to: (800) 327-9255

Initial premium (For new member's Medical and Dental fees only) **Monthly premiums**

Monthly Credit Card Authorization - As a convenience to me, I request and authorize you to charge my card for monthly recurring premiums on each due date. I understand that the amount may vary as a result of changes I make, such as, but not limited to, adding and deleting dependents, or moving to a new location. The amount may also change as outlined in my policy. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such card payments. I further agree that if any such card payment be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, including any fees imposed by my bank, should my card be rejected even though such dishonor results in forfeiture of coverage. Credit Card: VISA MasterCard Discover

Card No.: _____ Exp.: _____ Cardholder's Zip Code _____ - _____

Cardholder's Name (As it appears on the credit card) PRINT	Authorized Signature (As it appears on the credit card)	Date
X	X	

Checking Account Automatic Premium Payment

Monthly checking account deduction premium payments

Name of Bank or Financial Institution: _____

Account No.: _____ Bank Routing No.: _____

Submit a blank check marked "VOID" above where indicated (DEPOSIT SLIPS NOT ACCEPTABLE). If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account. Premiums may be prorated in order to adjust the initial paid to date or in the event of membership changes.

Monthly Checking Account Automatic Premium Payment - As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and 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 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 of California premiums. This authority is to remain in effect until revoked by me by providing you a 30-day written notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. **NOTE:** Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Automatic Premium Payment and be billed bimonthly. **You may incur a \$25 service charge for any withdrawal not honored.**

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

Billing

Bimonthly (Submit 2 months premium) **Quarterly** (Submit 3 months premium)

FOR BLUE CROSS USE ONLY			
Group No.	Certificate No.	Agent I.D. No.	Effective Date
Pre-Exist	Area	By	Date