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...

Dental SelectHMO Enrollment Application

ATTACH CHECK HERE

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

GROUP NO.	CERTIFICATE NO.	PROPOSED EFFECTIVE DATE
		/ /

Plan Choice

☐ Saver SelectHMO (40) ☐ SelectHMO (41) ☐ Premier SelectHMO (42) **Dental Office No:**

Check Billing Type

☐ Monthly *(By checking account deduction only.* ***Complete Authorization form on reverse side.)*** ☐ Bimonthly ☐ Quarterly

Applicant Information – Applicant must complete this section.

Please print

Last Name	First Name	MI	Social Security Number

Home Phone No.	Business Phone No.	Sex	Marital Status	Age	Date of Birth
( )	( )	☐ M ☐ F	☐ Single ☐ Married		

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

Spouse to be Included – Signature required below.

Last Name of Spouse	First Name	Sex	Date of Birth (Mo/Day/Yr)	Social Security Number
		☐ M ☐ F		

Signatures (Required)

Authorization to Obtain or Release Medical Information: I authorize any physician or other health care professional, hospital, or other health care facility, counselor, therapist, or any other medical or medically related facility or professional to give Blue Cross of California or affiliate ("Blue Cross") its agents, employees, designees, or representatives, including my Blue Cross agent or broker, any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related Complex) of me or any of my dependents applying for or having Blue Cross coverage. I understand that this information may be collected in connection with the review investigation or evaluation of any application for coverage, of any claim for benefits, or of any inquiry or grievance. I understand that California law prohibits an HIV test from being required or used as a condition of obtaining medical coverage. If the applicant is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. (Court documents establishing guardianship must be submitted if the responsible adult is not the parent.)

I have personally read and completed this application. If I am accepted, this application will become part of the contract between Blue Cross and me. I and any enrolled family members agree to abide by the terms of that contract, including the arbitration provision as follows:

Even if I pay money with this application, that money is only a deposit against future premium if this application is accepted. Cashing my check does not mean my application is approved. If this application is declined, neither Blue Cross nor any affiliated company shall have any liability to me or anyone else listed on it, except for the obligation to return the money submitted with this application. If this application is not accepted, neither I nor anyone listed on it will be entitled to benefits or coverage from Blue Cross.

Any dispute between you and Blue Cross of California must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of Small Claims Court, 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.

I also understand that only the services I receive from my Blue Cross Dental SelectHMO participating provider are covered by the plan or are subject to a discount if not covered.

Signature of Applicant	Today's Date	Signature of Applicant's Spouse	Today's Date
X		X	

Name of Agent (Print) Oleg Skurskiy	Agent No.	Signature of Agent	Today's Date
	– BCLNGNPVMZ	X	

Monthly Checking Account Deduction Authorization

INSTRUCTIONS:

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 (1) month’s premium made out to BLUE CROSS OF CALIFORNIA. If the account listed below is a joint account, both account holders’ signatures are required.

OPTIONAL MONTHLY 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 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 on 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 of California dues. 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 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 automatically will be removed from Monthly Checking Account Deduction and be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction options.

Subscriber Name

Subscriber’s Social Security No.

Group No.

Name on Checking Account (if different than above)

Checking Account No.

Name of Bank

Bank Address

City/State/ZIP

Joint Account Holders Authorized Signature (As it appears in the financial institution’s records)

X

Date

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

X

Date

FOR BLUE CROSS USE ONLY

roup No.	Certificate No.		Agent I.D. No.	Effective Date
re-Exist		Area	By	Date

How to Enroll

- Complete and sign the attached application. *Note: The Participating Dental Office that you choose must appear on your application*
- Determine your premium from the chart below
- Choose your payment plan (page 9)
- Write a check payable to **Blue Cross of California**

Please mail your application and payment to:

Oleg Skurskiy

18375 Ventura Blvd. # 226

Tarzana , CA 91356

MONTHLY	Blue Cross Dental SelectHMO		RATES
	Blue Cross Saver SelectHMO	**Blue Cross SelectHMO**	**Blue Cross Premier SelectHMO**
Single	$10	$14.5	$18
Two Party *(Subscriber & spouse)*	$20	$29	$35.5