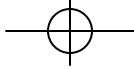


**Please mail completed application
including payment information
and check for the first payment to:**

**EIS Financial & Insurance Services
19641 Parthenia St. Suite 102
Northridge, CA 91324**

**If you have any questions please call:
(818) 700-1494**



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 <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	MARITAL STATUS <input type="checkbox"/> S <input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F	BIRTHDATE (Mo/Day/Year)	SOCIAL SECURITY NUMBER

Children To Be Insured

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

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, 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 and 2 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.

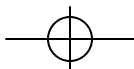
SIGNATURE OF APPLICANT/ PARENT OR LEGAL GUARDIAN X	TODAY'S DATE	SIGNATURE OF APPLICANT'S SPOUSE X	TODAY'S DATE
SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER X	TODAY'S DATE	SIGNATURE OF APPLICANT'S DEPENDENT AGE 18 OR OVER X	TODAY'S DATE

Agent Information

SIGNATURE OF AGENT X	AGENT NAME (PRINT) EIS Financial & Insurance Services	AGENT NUMBER 562346082E
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FOR BLUE CROSS ONLY								
GROUP NO.	CERTIFICATE NUMBER	AGENT NO.	EFFECTIVE DATE	PRE-EXIST	AREA	BY	DATE	
00166A				N				

BC Life & Health Insurance Company is an Independent Licensee of the Blue Cross Association.
 Blue Cross Individual Dental PPO Coverage provided by BC Life & Health Insurance Company.
 Blue Cross and the Blue Cross symbol are Registered Service Marks of the Blue Cross Association.



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. Further, I 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 results in forfeiture of insurance.

Name of Bank	
Address	
City / State / Zip Code	

NOTE: You will incur service charges 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 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** ➔