



**SmileNetSM Dental Discount Program
Individual & Family Enrollment Application**

Choose One: Enroll Change

Application Information: All fields must be completed

PLEASE PRINT

| | | | | | | |
|--|------------|----------|--|--|---|------------------------|
| LAST NAME | FIRST NAME | M: | 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 Enrolled

| | | | |
|----------------|--|-------------------------|------------------------|
| NAME OF SPOUSE | SEX <input type="checkbox"/> M <input type="checkbox"/> F | BIRTHDATE (Mo/Day/Year) | SOCIAL SECURITY NUMBER |
|----------------|--|-------------------------|------------------------|

Children To Be Enrolled

| | | | | | |
|-----------------------------|--|-------------------------|-----------------------------|--|-------------------------|
| NAME (First and Last) 1. | SEX <input type="checkbox"/> M <input type="checkbox"/> F | BIRTHDATE (Mo/Day/Year) | NAME (First and Last) 3. | SEX <input type="checkbox"/> M <input type="checkbox"/> F | BIRTHDATE (Mo/Day/Year) |
| NAME (First and Last) 2. | SEX <input type="checkbox"/> M <input type="checkbox"/> F | BIRTHDATE (Mo/Day/Year) | NAME (First and Last) 4. | SEX <input type="checkbox"/> M <input type="checkbox"/> F | BIRTHDATE (Mo/Day/Year) |

SmileNet Program Fees

| | |
|--------------------------------------|---|
| Annual Fee: Single \$80 Family \$120 | Administrative Fee: \$20 (one-time fee for new members) |
|--------------------------------------|---|

Payment Options

Electronic check

| | | | | |
|----------------------|----------------|----------------|--------|--------------|
| NAME ON BANK ACCOUNT | ROUTING NUMBER | ACCOUNT NUMBER | AMOUNT | CHECK NUMBER |
|----------------------|----------------|----------------|--------|--------------|

Use the enclosed check as payment. *Please make check payable to Anthem Blue Cross Life and Health Insurance Company.*

By choosing the electronic check option, I authorize Anthem Blue Cross to convert my check into an electronic funds transfer. I understand that my bank account will be debited for the amount indicated on the check. I am aware that my check will not be returned. If I pay by electronic or paper check, I understand that I will be sent an invoice prior to my renewal date. No refunds, cancellations or changes (such as adding or deleting a family member) will be allowed in the first 12 months, except in the case of death. I have read and understand the Terms and Conditions of the SmileNetSM program.

Signatures (Required)

| | | | |
|---|--------------|---|--------------|
| SIGNATURE OF APPLICANT/PARENT OR LEGAL GUARDIAN X | TODAY'S DATE | SIGNATURE OF APPLICANT'S SPOUSE X | TODAY'S DATE |
|---|--------------|---|--------------|

Agent Information

| | | |
|--------------------------------|---|---|
| SIGNATURE OF AGENT X | AGENT NAME (PRINT) Joseph John Turkovich Jr | AGENT NUMBER 146404RILMIRP121 |
|--------------------------------|---|---|

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