



Blue Cross Blue Shield of Georgia
 3350 Peachtree Road, NE
 Mail Code: G00302 Individual
 Atlanta, GA 30326

Please print legibly and use black ink.
 SmileNet is not an insurance plan — it is a dental discount program.

SmileNetSM Discount Dental Program Enrollment Application

Individual Family

Product Selection: Basic Ortho Cosmetic Basic, Ortho & Cosmetic
 Basic & Ortho Basic & Cosmetic Ortho & Cosmetic

Applicant information – all fields must be completed

APPLICANT'S NAME (LAST, FIRST, MIDDLE)

SEX: M F BIRTH DATE (MM/DD/YY) / / APPLICANT SOCIAL SECURITY NUMBER - -

BILLING ADDRESS CITY STATE ZIP

COUNTY DAY TELEPHONE () - EVENING TELEPHONE () -

SPOUSE'S NAME (IF TO BE COVERED) SEX: M F BIRTH DATE (MM/DD/YY) / /

CHILDREN, FULL NAME (IF TO BE COVERED)	SEX	BIRTH DATE (MM/DD/YY)	CHILDREN, FULL NAME (IF TO BE COVERED)	SEX	BIRTH DATE (MM/DD/YY)
1. <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/> / <input type="text"/> / <input type="text"/>	3. <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/> / <input type="text"/> / <input type="text"/>
2. <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/> / <input type="text"/> / <input type="text"/>	4. <input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/> / <input type="text"/> / <input type="text"/>

Total Amount Due: (Refer to page 5 in brochure for the rate of your selected plan)

Annual Membership Fee \$ + \$19.95 (one-time admin. fee) = \$ total amount due BCBSGa.

Payment Options:

CHECK (Please make your check payable to Blue Cross Blue Shield of Georgia)
 CREDIT CARD MC VISA Discover Credit Card # Exp. Date month/year
 Name as it appears on Credit Card
 Signature of Card Holder

I have read and understand the Terms and Conditions of the SmileNet program.

Signature (Required)

Signature of Applicant/Parent or Legal Guardian Today's Date

FOR INTERNAL USE: DGN ACN

REP NO. <input type="text"/>	CITY CODE <input type="text"/>	AREA <input type="text"/>	DEDUCTIBLE <input type="text"/>	AMT RECEIVED <input type="text"/>	AGENT SIGNATURE <input type="text"/>
10356					Keith@AfordableHealthplan.com
				PRINT NAME: K. NABB	FAX NO: MD-831-7826