

INDIVIDUAL DentalOne ENROLLMENT FORM

All answers must be complete and accurate. Omissions or incomplete answers require the return of your application and may result in delays.



**Regence
BlueShield**

An Independent Licensee of the Blue Cross
and Blue Shield Association

P.O. Box 91053
1800 Ninth Avenue
Seattle, WA 98111-9153

TYPE OF APPLICATION (Check One): <input type="checkbox"/> New Application <input type="checkbox"/> Adding Dependents		PAYMENT TYPE: <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly If you currently have a Regence BlueShield Individual medical plan, your method of payment will be the same as your medical plan.		
SUBSCRIBER, LEGAL SPOUSE AND DEPENDENT INFORMATION (Please provide Social Security numbers for yourself and all dependents over 1 year of age.)				
Name (Last, First, Middle Initial)	Social Security Number	Sex	Birth Date	Relationship to Subscriber
				SUBSCRIBER
Home Address (Street, City, State, and ZIP)				
Billing Address (if different than home or mailing address)				P.O. Box (if applicable)
County				Home Telephone Number

(REGENCE BLUE SHIELD OFFICE USE ONLY)

Effective Date:

Fee:

Agent #

DENTAPP1

(CONTINUED ON REVERSE SIDE)

