



BlueCross BlueShield
of Oklahoma

App
Social Secur
Member ID

Sign Up for a **2026 Health** for You and Your Family.



You can visit **BluePlanCompareOK.com** to sign up. If you are an authorized Blue Cross and Blue Shield of Oklahoma agent, please contact your agent for more information on the last page.

Help us process your Application

If applying during Open Enrollment, leave page 3 blank except for name and address. If you are applying outside annual Open Enrollment, check with your agent for a Special Enrollment Period before filling out this Application. To receive language assistance, call **855-710-6984**.

BE SURE TO:

- Download and follow the Application Checklist at **bcbsok.com/app-checklist**
- Include name and SSN at the top of all 12 pages.
- Answer **all** questions that apply to you and any dependents.
 - Print all answers in **black ink**. Pencil will not be accepted.
 - Cross out **any answer you wish to change** and add your initials by the new answer.
- Complete the Application for the Primary Applicant and all **current and new** dependents on an existing plan. If you need more dependent sections, please download and complete any overflow page(s) when you submit your Application. See **bcbsok.com/more**

- Include the **first month's payment**, or complete the payment details on page make monthly payments.
- Sign the Application everywhere a signature is required (pages 7, 8, 10 and 12). use. Fax to **800-279-7419**.
 - If the primary applicant is a minor child, or an individual legally unable to sign representative should make all signatures.
- Once you have submitted your application you can track its progress and see w **bcbsok.com/application-tracker**. You will receive an email with an access co application has been received.

Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporat
an Independent Licensee of the Blue Cross and Blue Shield Association

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We MUST

What do you want to do?

Appli

- Become a **NEW** member.
- CHANGE** my 2026 health plan.
- ADD** a dependent to my current health plan.
(You may add a newborn within 60 days of birth by calling 866-520-2507.)

How we will contact you.

If you want to get information from us electronically, we must have your email address. **agree we may send your policy information electronically**, such as policy kit. This electronic delivery will continue through any policy renewals or changes.

You can change to paper delivery at any time with no penalty. To make or change your preferences, you may:

- Update your preferences and contact information at **mybam.bcbsok.com**.

OR

- Call Customer Service at the number on your member ID card.

Your documents can be viewed or printed using your computer or mobile device. We recommend the latest versions of Chrome, Firefox, Microsoft Edge or Safari.

Will you use a reimbursement a

Are any of the applicants purchasing this plan using an Individual Coverage Health (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEH

If yes, please complete the below.

Select one: ICHRA QSEHRA

Effective Date of the ICHRA or QSEHRA

Monthly Contrib

Employer Name

Signing up outside Open Enrollment?

Appli



If you are signing up during Open Enrollment, enter y then skip to the next page. You can also apply online

DO YOU QUALIFY FOR SPECIAL ENROLLMENT?

You may sign up for coverage during a Special Enrollment Period. An SEP is a chan

- **You must apply within 60 days before or after the qualifying life event,**
- Check more than one event if more than one happened to you.
- **You must give us valid proof of a qualifying life event with this Applicat**
 - BCBSOK will review this proof to confirm that you qualify for an SEP.
 - Without valid proof, we **cannot** process your form or sign you up for a healt
- Once your plan has been issued, your SEP cannot be reused to apply for a diffe

Details about documents you need to provide are at bcbsok.com/sep. Please cor call BCBSOK at **866-303-2583** for examples of proof we can accept.

- 1.** My dependent(s) and/or I lost Minimum Essential Coverage as of this date. Fo
- For reasons beyond my control (not including reasons like failure to pay my disregard on my part for the plan's rules).¹
 - Because I turned age 26.^{1,2}
 - Because the plan holder became eligible for Medicare.¹
 - Because the plan holder died.³
 - Because I lost my job, I lost hours, my employer stopped making payments: ended.¹
 - Because someone on my plan was legally separated or divorced.¹
 - Because my plan stopped covering people in my situation.¹

- 2.** Because I got married on this date.³

- 3.** Because I had a baby, adopted a child, had a child placed with me for adoptic me during the pendency of an adoption proceeding, took in a foster child, or dependent through a court order as of this date.³

- 4.** Because there was a mistake when I signed up for my last health plan, or I ha previous health plan or issuer broke its contract with me as of this date.³

5. Because someone on my plan had a change in income and lost advance payroll credit, cost-sharing reductions, or Medicaid, or my last non-Marketplace plan as of this date.¹

6. Because I got new health plan options when I moved on this date.¹

7. Because my current plan ends on a date other than December 31, which is the end of the plan year.

8. Because my employer offered to help with the cost of coverage either through a Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Plan (QSEHRA). **Select one:** **ICHRA** **QSEHRA**

a. My employer is newly offering participation in an ICHRA or QSEHRA as a result of a change in my employer's health plan.

b. I am a new employee and my employer is offering participation in an ICHRA or QSEHRA.

9. Because of an allowed reason I do not see on this list that happened on this date. (Please work with your agent or contact our sales center at **866-303-2583**.)¹

¹ You must apply within 60 days before or after the qualifying life event.

² A dependent covered under a parent's Marketplace plan has until December 31 of the year following the event.

³ You must apply within 60 days after the qualifying life event.

Tell us about you.

Appli

(PLEASE ANSWER FOR **EVERY** PERSON TO BE COVERED.)

PRIMARY APPLICANT¹ (Who should be listed first on the health plan)			
First Name	Middle Initial	Last Name	
Social Security Number		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date
Do you prefer to speak a language other than English? <input type="checkbox"/> Y <input type="checkbox"/> N If YES, what language? _____		Do you prefer to read a language other than English? <input type="checkbox"/> Y <input type="checkbox"/> N If YES, what language? _____	
Within the past six months, have you used tobacco?² 4 or more times per week for ceremonial uses <input type="checkbox"/> Y <input type="checkbox"/> N If YES, when did you last use tobacco? _____			
Home Address		City	
Mailing Address (if different than home address)		City	
What is the best phone number to reach you?³ _____			
By providing your mobile phone number on this Application, you agree to receive text messages and calls from BCBSOK, including from third-party vendors or providers directly contracted with BCBSOK to provide additional information about health plan products, benefits and programs available through mybam.bcbsok.com . Standard mobile phone and/or text message charges may apply. Frequency will vary. Consent is not a condition of purchase or enrollment.			
Email Address^{3,4} _____			
Primary Care Provider (FOR HMO ONLY)		10-character PCP ID	
See FindADoctorOK.com to find a PCP. If you do not list a PCP above, BCBSOK will assign you to a PCP in your plan service area. PCP assignment may delay arrival of your member ID card. Do not seek care for a PCP that is not on your member ID card or for care from a provider not listed on your member ID card. For more information on PCPs and OB-GYNs on page 6.			
OPTIONAL: If you are Hispanic/Latino, do you identify as any of the following?			

Mexican Mexican American Chicano Puerto Rican C

OPTIONAL: Are you or do you identify as any of the following? (check all th

White Black or African American American Indian or Alaska Nati
 Filipino Japanese Korean Vietnamese Other Asia
 Guamanian or Chamorro Samoan Other Pacific Islander C

¹ **If you are adding one or more dependents to your existing plan, please con
AND the Primary Applicant. Proof of ineligibility for Medicare is required if**

² Age 21 and older for tobacco use.

³ Age 18 and older for mail, phone and email.

⁴ You **must** provide your email address if you want to get information electronically or i

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We MUST

Tell us about you.

Appli

(PLEASE ANSWER FOR **EVERY** PERSON TO BE COVERED.)

If you need more dependent sections, please download and complete the next page. See bcbsok.com/more-dependents-2026.

SPOUSE, PARTNER OR DEPENDENT CHILD^{1,2} (Who else do you want to cover?)

First Name	Middle Initial	Last Name
Relationship	Social Security Number	
Do you prefer to speak a language other than English? <input type="checkbox"/> Y <input type="checkbox"/> N If YES, what language? _____	Within the past six months, have you used a health care provider 4 or more times per week on average? <input type="checkbox"/> Y <input type="checkbox"/> N If YES, when did you last use the provider? _____	
Mailing Address⁴	City	
What is the best phone number to reach you?⁴ _____		
By providing your mobile phone number on this Application, you agree to receive a text message from BCBSOK, including from third-party vendors or providers directly contracted with BCBSOK, to provide additional information about health plan products, benefits and programs available through mybam.bcbsok.com . Standard mobile phone and/or text message charges may apply. Frequency will vary. Consent is not a condition of purchase or enrollment.		
Email Address^{4,5} _____		
Primary Care Provider (FOR HMO ONLY)	10-character PCP ID	
See FindADoctorOK.com to find a PCP. If you do not list a PCP above, BCBSOK will assign you to a PCP in your plan service area. PCP assignment may delay arrival of your member ID card. If you need care for a PCP that is not on your member ID card or for care from a provider not on your member ID card, see PCPs and OB-GYNs on page 6.		

If a dependent (other than spouse) is 26 or older, does dependent have a medical condition?
If YES, a Disabled Dependent Authorization Form is required. You can find the form at [www.bcbsok.com](#).

OPTIONAL: If you are Hispanic/Latino, do you identify as any of the following?

Mexican Mexican American Chicano Puerto Rican Cuban

OPTIONAL: Are you or do you identify as any of the following? (check all that apply)

White Black or African American American Indian or Alaska Native
 Filipino Japanese Korean Vietnamese Other Asian
 Guamanian or Chamorro Samoan Other Pacific Islander Other

¹ **If you are adding one or more dependents to your existing plan, please complete the form for the Primary Applicant AND the Primary Applicant. Proof of ineligibility for Medicare is required if you are adding a dependent who is 65 or older.**

² "Spouse" includes domestic partners. Non-spouse dependents can be up to age 26 for medical coverage with BCBSOK.

³ Age 21 and older for tobacco use.

⁴ Age 18 and older for mail, phone and email (if different from the Primary Applicant).

⁵ You **must** provide your email address if you want to get information electronically.

Choose your health plan.

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Your coverage will start on the 1st of the month, unless otherwise specified. Application must be received by BCBSOK within the defined time period.

Please review your options below and **SELECT ONLY ONE OPTION:**

PLAN SELECTION	INDIVIDUAL DEDUCTIBLE
<input type="checkbox"/> Blue Advantage Bronze PPO SM 202	\$6,800
<input type="checkbox"/> Blue Advantage Bronze PPO SM 203	\$4,500
<input type="checkbox"/> Blue Advantage Bronze PPO SM Standard	\$7,500
<input type="checkbox"/> Blue Advantage Silver PPO SM 204	\$1,025
<input type="checkbox"/> Blue Advantage Silver PPO SM 306	\$1,300
<input type="checkbox"/> Blue Advantage Silver PPO SM 501	\$3,500
<input type="checkbox"/> Blue Advantage Silver PPO SM Standard	\$6,000
<input type="checkbox"/> Blue Advantage Gold PPO SM 309	\$1,050
<input type="checkbox"/> Blue Advantage Gold PPO SM 604	\$1,100
<input type="checkbox"/> Blue Advantage Gold PPO SM Standard	\$2,000

PLAN SELECTION
<input type="checkbox"/> Blue Prefer
<input type="checkbox"/> Blue Prefer Standard
<input type="checkbox"/> Blue Prefer
<input type="checkbox"/> Blue Prefer Standard
<input type="checkbox"/> Blue Prefer
<input type="checkbox"/> Blue Prefer
<input type="checkbox"/> MyBlue Bro
<input type="checkbox"/> MyBlue Bro
<input type="checkbox"/> MyBlue Bro
<input type="checkbox"/> MyBlue Bro
<input type="checkbox"/> MyBlue Bro
<input type="checkbox"/> MyBlue Silv
<input type="checkbox"/> MyBlue Silv
<input type="checkbox"/> MyBlue Silv
<input type="checkbox"/> MyBlue Silv
<input type="checkbox"/> MyBlue Silv
<input type="checkbox"/> MyBlue Gol
<input type="checkbox"/> MyBlue Gol
<input type="checkbox"/> MyBlue Gol

“CATASTROPHIC” PLAN OPTION BELOW

Here's what that means.

This plan covers essential health benefits, but generally only after you pay the high amount. **You qualify for this plan only if:**

- 1) you are under age 30 before the plan year begins, **or**
- 2) you have a waiver from the Health Insurance Marketplace®.
Your Exemption Certificate Number is required to process your form. **Exemption**

Blue Preferred Security PPOSM 200

OB-GYN ACCESS



You may get OB-GYN services from your Primary Care

- You do not need a referral from your PCP to see an OB-GYN for pre
- HMO plans will cover your OB-GYN visits only if your OB-GYN is in y
- You do not have to tell us your choice of OB-GYN before a preventi

Choose your dental plan.

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The Affordable Care Act requires that we seek reasonable assurance from you that you have dental coverage for pediatric dental services (for children). The ACA considers coverage for pediatric dental services a minimum health benefit that every policy must provide, even if there is no one on the policy who is a child. Companies like BCBSOK offer this dental coverage for children through "Marketplace" plans. These plans are also known as Dental Qualified Health Plans or Dental QHPs.



- For more information about these dental plan options, go to [www.bcbsok.com/dental](#).
- Dependents 19 to 26 are considered adults for dental coverage.
- If you already have dental coverage with us, whatever you choose will replace your current dental coverage.

Please **SELECT ONLY ONE OF THE THREE OPTIONS:**

OPTION 1 Covers ADULTS WITH OR WITHOUT CHILDREN (choose one)



FOR
ADULTS



OR
ADULTS WITH
CHILDREN

BlueCare DentalSM

BlueCare Dental 1A

BlueCare Dental 1B

BlueCare Dental 1C

BlueCare Dental 1D

OPTION 2 Covers ONLY CHILDREN, UP TO AGE 19 (choose one) DO NOT CHOOSE if you chose a plan in option 1.



FOR CHILDREN
ONLY

BlueCare Dental 4 Kids

BlueCare Dental 4 Kids

BlueCare Dental 4 Kids

OPTION 3 Choose this option only if you already have den

Check the box and sign here to tell us that you have what is known as a "Mark
Our records will show that you have the Pediatric Dental essential health bene

Note: Checking this option will NOT result in a change or cancellat

I/we already have coverage for pediatric dental essential health

Signature (REQUIRED if selecting Option 3)



If you do not make a choice, you and each member on the policy will
our Limited Dental QHP, so you will have the required pediatric dental be
BCBSOK may find that pediatric dental coverage must be included with
case, you may owe an additional monthly payment for pediatric dental
part of your first payment and will be included in your monthly bill.

Tell us how you will make your payments.

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Please be sure to read the important billing rules on

- Your plan may be canceled if you don't make a payment.
- **A valid personal email address is REQUIRED for ele**
- **If billing emails sent to the email address provided removed from EFT and bills will be mailed via USPS**
- **If you are a current member paying your premium Payment Information, even if there are no changes.**

FIRST PAYMENT

You may make your **first payment** by EFT, check or money order. Choose one:

- EFT (First payment will be taken from your account immediately.) Check



TIP: Write the name of the Primary Applicant in the memo, different from name of account owner. **NOTE:** Use of a bus compliance with Third Party Payment Rules on page 9.

MONTHLY PAYMENTS

You may make your **monthly payments** by electronic funds transfer (Auto Bill Pa Select your choice:

- EFT (Auto Bill Pay - valid email required) Bill by email (valid email requirec

PREMIUM PAYMENT INFORMATION (ALL fields required if payin

Please check one Checking account
 Savings account

Name(s) on account

Bank routing number (please verify)

Account numb

Email address

AGREEMENT (See full Auto Bill Pay Terms of Use on page 9.)

I confirm I want BCBSOK and/or its designee to take out monthly premium payments named above. Funds will be taken out on the last business day of the month before the usual business day (any M-F) of the month is a holiday or other nonbanking day, full business day. Withdrawals may be in the form of checks, share drafts or electronic debit entries from the institution named here to honor the same payments from my account.

I have read and accept this agreement

Account owner's signature

Date



Do not cancel any current coverage you may have until your new plan is effective.

Your first month's payment is due when you sign up. If you do not pay, **your coverage will not be in effect until we receive your payment.**

Important billing rules.

Appli

AUTO BILL PAY TERMS OF USE (email address required)

If you allow EFT, you understand and agree that BCBSOK and/or the company may take monthly payments from your checking or savings account in accordance with the following terms:

- By signing up for Auto Bill Pay you authorize us and our service providers to store your selected payment method on a monthly basis unless you take timely steps to cancel. Payments will be charged to your selected payment method on the last day of the month preceding the billing date for Auto Bill Pay. If that day occurs on a weekend day or Federal holiday, the draft will be processed on the business day prior. The amount you will be charged will be based on your premiums and other charges. You will be notified by email if the amount of your payment changes.
- If you would like to cancel Auto Bill Pay please log into your Blue Access for Members. Payment cancellations must be received no later than 3 days before the billing date. Cancellations are effective the next month.
- If your statement shows transfers that you did not make, including those made by ATM, you do not tell us within 60 days after the statement was sent to you, you may not get a refund. If we can prove that we could have stopped someone from taking the money (if you were on a long trip or a hospital stay) kept you from telling us, we will extend the time to 90 days.
- If you have told us in advance to make regular payments out of your account, you are responsible. Here's how:
 - Call us at the phone number found on the back of your member ID card or let us know how to receive your request 3 business days or more before the payment is scheduled.
 - If these regular payments may vary in amount, we will tell you, 10 days before the payment is scheduled how much it will be.
 - If you order us to stop one of these payments 3 business days or more before the payment is scheduled, so, we will be liable for your losses or damages.
- We may at any time and without notice amend these Auto Bill Pay Terms of Use. Your continued use of the Auto Bill Pay function after any such amendment constitutes your agreement to the change(s). We may discontinue Auto Bill Pay functionality for any reason and with or without notice if terms or conditions are modified.

THIRD PARTY PAYMENT RULES

BCBSOK follows the premium payment process established by the Affordable Care Act and other federal requirements.

1. BCBSOK accepts premium payments from the following third-party entities on behalf of members:
 - A Ryan White HIV/AIDS Program under title XXVII of the Public Health Service Act

- a. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
 - b. An Indian tribe, tribal organization or urban Indian organization; and
 - c. A local, state, or federal government program, including a grantee directed by its behalf.
2. BCBSOK may accept premium payments on behalf of enrollees from private, not
 - a. For the entire coverage period of the enrollee's policy;
 - b. Based solely on the financial status of the enrollees;
 - c. Regardless of the financial status of the enrollee;
 - d. Regardless of the financial status of the enrollee.
 3. BCBSOK may accept premium payments on behalf of enrollees from a Trust, Poverty, or other special needs organization.
 4. BCBSOK will not construe payments from an employer as impermissible third-party payments and will not create an Employee Retirement Income Security Act (also known as ERISA) grandfathered plan if:
 - a. The employer facilitates premium payment collection through payroll deduction and the employer is not paying any part of the premium either directly or through a third party; or
 - b. The employee is participating in an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) offered by their employer.
 5. BCBSOK will accept payments on behalf of an enrollee directly from an employer or a third party payment coordination service, when such payments are made using allowed methods.

Tell us about other coverage.

Appli

COVERAGE YOU ARE REPLACING

Will this plan replace health coverage for 2026 you already have? **If yes, list all coverage you are replacing, terminate and replace with a plan from BCBSOK and read KNOW YOUR RIGHTS.**

COVERED PERSON(S)	NAME OF INSURANCE COMPANY

KNOW YOUR RIGHTS WHEN YOU REPLACE COVERAGE

If you chose "Yes" above, BCBSOK may NOT automatically cancel your old policy. This will cancel your current accident and health plan and replace it with a plan from BCBSOK. For more information, you should know how this decision may affect the coverage available to you in a new plan.

1. You may want to ask the company that offers the plan you are replacing about your rights. This is your right. It is in your best interest. You should be sure you understand the terms of the new plan before you replace the coverage you have now.
2. If you still wish to cancel your present plan and replace it with new coverage, be sure to ask the company questions on this Application about any person applying for coverage. If you learn that the company may have a legal basis to deny any future claims and to refund your premium as of the date of cancellation, you may have a legal basis to deny any future claims and to refund your premium as of the date of cancellation. Before you sign the completed Application, re-read it carefully to be sure you understand the terms of the new plan.

OTHER COVERAGE YOU OR YOUR DEPENDENT(S) MAY HAVE

Does any person applying for coverage currently have, or did they previously have

- Coverage with BCBSOK?
- Health coverage with any other insurance company?
- Coverage under a tax-supported or government program, including Medicare?

If yes, please provide details below:

Applicant Name	Name on Other Policy (if different)
Applicant Name	Name on Other Policy (if different)

Draw Statement

PROXY STATEMENT (OPTIONAL)

By purchasing a BCBSOK health plan, I become a member of Health Care Service Corporation. By signing this Proxy Statement, I ask the Board of Directors of HCSC to act on my behalf. I understand that:

- This permission will apply to any company that replaces HCSC.
- The Board of Directors may appoint someone to vote for me.

The annual meeting of members is scheduled to take place each year in the corporate headquarters (Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members or any special meeting will be given within 30 to 60 days before the meeting.

My assignment of my member vote to the Board of Directors will be in effect:

- Until or if I cancel it in writing at least 20 days before any meeting of members, or
- Unless I attend and vote in person at any meeting of members

Primary Applicant's (your) proxy signature:

NOTE: Whether you sign for proxy or not, you must sign on page 12 to complete this Application.

Print your name as you signed it:

Please read and sign on next page.

BY COMPLETING AND SIGNING THIS FORM, I UNDERSTAND AN

- This Application is not coverage. Coverage will not begin until (1) the effective date and (2) the first premium payment is made.¹
- If I use an agent, they cannot accept risks or change the policies or rules of BCBSOK.
- If an agent helps me purchase a new or renew a health plan, BCBSOK may pay the agent a commission per month. My agents may also get bonus and marketing payments. These payments are paid per month for my plan.
- If any person knowingly submits a false claim for payment of a loss or benefit or a false statement on this Application, coverage may be rescinded. This includes false claims or facts about my health that cancels the coverage back to the first day it became effective. I will be given at least 30 days to appeal the coverage or that of my dependents is rescinded.
- My monthly premium will be calculated using factors approved by the state's department of insurance and state and federal laws and regulations. Rates are calculated based on age, tobacco use, and other factors. Rates for any dependents covered on my plan are also based on these factors.
- I authorize any of the following people or organizations to share my health information with BCBSOK or its representative:
 - o Health professionals, hospitals, or clinics
 - o Other health or health-related facilities
 - o Government agencies
 - o Pharmacy benefit managers, clearinghouses, or retail stores
 - o Any other persons or firms required by law
- This information may include:
 - o Copies of records about advice, care or treatment that were given to me or my dependents
 - o Information about the prescription and use of drugs or alcohol
 - o Information about mental illness
- BCBSOK may review and research its own records for information.
- BCBSOK will share collected information only as needed with medical entities.
- Information shared with my authorization may be re-shared by BCBSOK as a condition of coverage. If required, the person or agency getting the information will be responsible for protecting the information.
- This authorization is valid for two years from today, or until I cancel coverage.
 - o I have the right to cancel the authorization at any time, in writing, by contacting BCBSOK.
 - o I or anyone I authorize to represent me will receive a copy of this authorization.

- o If anyone I authorize to represent me will receive a copy of this authorization
- o Any cancellation will not affect the activities of BCBSOK before the date such

- I present any statements and answers on this Application as FACTS. To the best of my knowledge, these facts are complete. These facts are the basis of my Application.
- The Application will become a part of the contract between BCBSOK and me.
- My agent (if I have one) and I confirm that I have read and understood the Application.
- This individual or family plan is meant to be paid as my personal expense.
- Only I or a family member, or an allowed third party as outlined in the Application, may pay for the plan.
- BCBSOK does not accept payments directly from third parties except from those listed in the Application.
- If these rules are broken, any payments made by a third party will not be credited to my account. Any such payments may not be refunded to me. This may result in the cancellation of my plan.

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUDS OR MAKES A FALSE CLAIM FOR THE PROCEEDS OF A HEALTH PLAN CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

¹ Some exceptions apply during a Special Enrollment Period. Check with your agent for details.

Did you work with an agent? Appli

AGENTS, COMPLETE THIS SECTION (IF APPLICABLE)

I certify that:

- I provided the Application to the Applicant(s) for completion, or I personally asked them to complete it.
- I provided written material to explain the benefits to the Applicant(s). This includes any special details about their coverage.
- I have reviewed the required plan document(s) with the Applicant. This includes:

Agent's Signature

Agent's Printed Name

Agent ID

Agent's Phone

Agent's Email

Please read and sign below. (REC)

YOUR SIGNATURE MAKES THIS A CONTRACT IF/WHEN FULLY PR

Primary Applicant's Printed Name AND Signature

Parent or Legal Guardian of a Minor Child Printed Name AND Signature (if child)

If this authorization is signed by a personal representative on behalf of an minor child), complete the following:

Personal Representative's Printed Name AND Signature

Send us your Application.

TO MAKE SURE YOUR FORM IS PROCESSED AS QUICKLY AS POSS



- Sign your form.
- Send **ALL PAGES** of this form.
 - **INCLUDE EVEN BLANK PAGES.**
- If you are working with an agent, please include your agent's information above.
- Please
- If you listed a sign

PLEASE SUBMIT THIS FORM BY:

MAIL

Blue Cross and Blue Shield of Oklahoma, Attn: Individual Enrollment, PO B

FAX

800-279-7419

Questions? If you have any questions, please call your agent or call 800-279-7419. Visit **discoverbcbsok.com** for frequently asked questions about our plans.

