



**BlueCrossDental**<sup>SM</sup>  
Issued by  
 CAPITAL ADVANTAGE INSURANCE COMPANY\*  
 A Capital BlueCross Company



**BlueCrossVision**<sup>SM</sup>  
Issued by  
 CAPITAL ADVANTAGE INSURANCE COMPANY\*  
 A Capital BlueCross Company

**BlueCross Dental<sup>SM</sup> / BlueCross Vision<sup>SM</sup>**

**Enrollment - Short Form**

**Group Name:** \_\_\_\_\_

**Group Number:** \_\_\_\_\_ **Effective Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Contract Number	Social Security Number	Subscriber Name	Product Name		Single	Husband/Wife	Parent/Child	Parent/Children	Family
			Dental	Vision					
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Coverage Selection**

**Policy Maker Signature:** \_\_\_\_\_ **Title:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

If additional lines are needed, please write on the back of this form.

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