BlueCross Dental℠ / BlueCross Vision℠
Issued by CAPITAL ADVANTAGE INSURANCE COMPANY®
A Capital BlueCross Company

BlueCross *Dental*℠ / BlueCross *Vision*℠
Enrollment - Short Form

Group Name: ______________________________

Group Number: ______________________________ **Effective Date:** ____/____/________

Contract Number	Social Security Number	Subscriber Name	Product Name: Dental	Product Name: Vision	Coverage Selection: Single	Husband/Wife	Parent/Child	Parent/Children	Family
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐
					☐	☐	☐	☐	☐

Policy Maker Signature: ______________________ **Title:** ____________________ **Date:** ____/____/________

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