



Request for Individual Product Association Discount

[To be submitted with original Application for BCBSAZ coverage]

BLUE CROSS BLUE SHIELD OF ARIZONA APPLICANT INFORMATION

BCBSAZ Applicant Name: _____

Applicant ID Number: _____

ASSOCIATION INFORMATION

Association Name: _____

Member's Name: _____

Association Member Relationship to BCBSAZ Applicant: _____

The undersigned acknowledges that the applicant is a current member of the above Association. The undersigned also agrees to notify the BCBSAZ Enrollment Department of termination in membership in the above Association.

Applicant Signature

Date

Association Member Signature

Date

Insurance Broker Signature

Date

Internal Use Only

BCBSAZ Association Number: _____

Please note: BCBSAZ reserves the right, upon 30 days notice to the contract holder, to terminate the **premium discount** if the contract holder's affiliation with the Association terminates. Termination of the Association premium discount does not terminate a subscriber's contract with BCBSAZ.