BlueChoice® HealthPlan South Carolina

BlueChoice Individual Coverage List Bill Cover Sheet

Requested Effective Date: _____

List Bill Owner's Name: _____

Address: _____

_____

Phone Number: _____

List Bill Contact Person: _____

E-mail Address: _____

Applications Submitted (Please Print Clearly)

Member's Name:	ID Card Number:	MAR Number:	Monthly Premium:	Plan Number:

Check Number: _____ **Check Amount:** _____

Agency's Name: _____

Agent's Name: _____ **Agent Number:** _____

P.O. Box 6170 Columbia, SC 29260-6170 www.BlueChoiceSC.com
(803) 786-8466 (800) 327-3183

An independent licensee of the Blue Cross and Blue Shield Association