An Independent Licensee of the Blue Cross and Blue Shield Association

Request for Individual Product Chamber of Commerce Discount

[To be submitted with original Application for BCBSAZ coverage]

Applicant Name: ______________________________

Applicant Social Security Number: ________ / ________ / ________

Chamber of Commerce Name: ______________________________

Applicant's Chamber of Commerce Membership Number: ____________

BCBSAZ Chamber of Commerce Number: 149

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

______________________________ ______________

Applicant Signature **Date**

______________________________ ______________

Broker Signature **Date**