



Dental Enrollment Application

(Type of Enrollment Dependent on Group Contract)

Requested Effective Date _____

Group Number _____

- PPO Traditional
 Voluntary Dental Blue Connect

Please complete each section of this application in ink.

<i>Type of Enrollment</i>	<i>Change Request</i>
<input type="checkbox"/> Self only <input type="checkbox"/> Self, spouse and two or more dependents <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self and one dependent <input type="checkbox"/> Self, spouse and one dependent <input type="checkbox"/> Self and two or more dependents	<p>Please indicate reason for change in current enrollment below:</p> <input type="checkbox"/> Involuntary loss of group coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption <input type="checkbox"/> Court order (copy of court order required) Other _____ Date event occurred _____ / _____ / _____ <div style="text-align: center;">mm dd yy</div>

<i>Applicant Information (Employee)</i>				
Your Name (first, initial, last)	Social Security Number	Blue Cross Identification No. (if currently enrolled)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
Mailing Address (street or route)	City, State, Zip Code		Country	
Name of Employer	Date Employed Full-time (mm/dd/yy)	Occupation	Phone Number	Email Address

Dependent Information (If you choose not to enroll all your eligible family members, you must complete a waiver form.)

List all eligible dependents you wish to enroll, including any child who is under the age of 26; or who is medically certified as disabled and dependent on parent for support (copy of certification required).

Name	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	Sex
Applicant/Employee		SELF	/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent's Name (first, initial, last)	/ /		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent's Name (first, initial, last)	/ /		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent's Name (first, initial, last)	/ /		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female
Dependent's Name (first, initial, last)	/ /		/ /	<input type="checkbox"/> Male <input type="checkbox"/> Female

Do you or any of your family members have other dental coverage? YES NO

Coordinating your insurance benefits could reduce the amount you owe a provider.

Current Coverage (For Coordination of Benefits, please complete the section below. Use extra paper if necessary.)

If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation that shows who is responsible for the dependent(s)' health care insurance so that the carrier can determine whose coverage is primary (please use additional paper if needed).

Other Carrier Information: Carrier Name, Policy Number, Phone Number	Policyholder Name	Names of Covered Members: Self and Dependent(s)	Coverage Start Date (mm/dd/yy)	Will this coverage continue?	Is your child eligible for other employer sponsored coverage through his/her employer or spouse?
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

OVER ➡

FOR OFFICE USE ONLY

Group Number	Subgroup	Effective Date	Plan ID	Class	Reason Code

3000 E. Pine Ave. • Meridian, Idaho 83642-5995 • (208) 345-4550
Mailing Address: P.O. Box 7408, Boise, Idaho 83707-1408

Statement of Understanding

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- I agree to abide by all of the terms and conditions of the group policy.
- No independent producer, agent or employee of Blue Cross of Idaho, or of my employer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
- Blue Cross of Idaho may, at its discretion, request supplemental information from me, any family member listed on this application or any dental care provider.
- Blue Cross of Idaho may deny benefits or terminate or rescind my coverage retroactive to its effective date for any misrepresentation, omission, or concealment of fact by, concerning, or on behalf of any persons listed on this application that was or would have been material to Blue Cross of Idaho's acceptance of a risk, extension of coverage, provision of benefits, or payment of any claim.
- If this application is approved, coverage for myself and any eligible family members named on this application will begin on the date assigned by Blue Cross of Idaho.
- I acknowledge and understand my dental plan may request or disclose dental information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating dental care treatment, payment or for the purpose of business operations necessary to administer dental care benefits; or as required by law. For more

information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at www.bcidaho.com.

- My employer's master group policy is the document that sets forth all terms of my coverage, and no independent producer, agent or other person can change the terms of the master group policy, any of its amendments, or this application, except with an amendment issued expressly for that purpose and signed by an authorized officer of Blue Cross of Idaho.
- **I understand that this policy may have waiting periods for basic and major services and such waiting periods have been outlined in the master group policy.**
- I agree that a facsimile or photocopy of my signature will serve the same as an original.
- I understand that this application will become part of the contract between Blue Cross of Idaho and my employer.
- **I affirm that I have reviewed all answers given on this application and, regardless of whether an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete.**

X _____

Applicant's Signature

Date