DENTAL BLUE® PPO
INDIVIDUAL ENROLLMENT APPLICATION

Applicant Information *(Applicants age 65 and older are not eligible)*

Your Name *(first, initial, last)*	Date of Birth *(mm/dd/yy)* / /	Social Security Number / /	Business Phone	Home Phone
Mailing Address *(street or route)*	City, State, Zip Code			County
Billing Address *(if different from mailing address)*	City, State, Zip Code			County
Name of Employer	Your Occupation	Idaho resident? ❐ Yes ❐ No If yes, how long? _______	Marital Status: ❐ Single ❐ Married ❐ Divorced ❐ Widowed	❐ Male ❐ Female

Program Information

❐ Dental Blue 1000 ($1,000 Benefit Period Max)
❐ Dental Blue 1500 ($1,500 Benefit Period Max)

(six-month waiting period for basic care/12-month waiting period for major care)

Requested Effective Date ________/________/________ *(Earliest effective date will be the 1st of the month following approval.)*

Other Coverage Information

Is any person listed on this application now covered or has he or she been covered by any kind of dental insurance ? ❐ **YES** ❐ **NO** If **YES:**

Name(s) of other dental insurance carrier(s) ______________________ Policy number(s) ______________

City/State ______________________ ______________

Person(s) covered under the policy ______________________

Is any person on the application covered by a medical health insurance policy? Applicant ❐ YES ❐ NO Family Member ❐ YES ❐ NO

Change Request

Change current enrollment because of:

❐ Marriage ❐ Divorce ❐ Birth ❐ Death ❐ Court Order *(copy required)* ❐ Other Date of event ______/______/______

Additional Family Member Information *(Family members age 65 and older are not eligible)*

List additional enrolling family members including any unmarried child who is under age 19; or who is under age 23 and a full-time student and financially dependent upon you; or who is medically certified as disabled and dependent upon you for support (copy of certification required).

Family Member's Name *(first, initial, last)*	Relationship to Applicant *(spouse, child, stepchild, etc.)*	Date of Birth *(mm/dd/yy)* / /	Age	❐ Male ❐ Female
Family Member's Name *(first, initial, last)*		Date of Birth *(mm/dd/yy)* / /	Age	❐ Male ❐ Female
Family Member's Name *(first, initial, last)*		Date of Birth *(mm/dd/yy)* / /	Age	❐ Male ❐ Female
Family Member's Name *(first, initial, last)*		Date of Birth *(mm/dd/yy)* / /	Age	❐ Male ❐ Female
Family Member's Name *(first, initial, last)*		Date of Birth *(mm/dd/yy)* / /	Age	❐ Male ❐ Female

Parental or Guardian Consent to Application *(Only if applicant is under age 18)*

I represent that the person listed as the applicant on this application is under 18 years of age and is applying for Blue Cross of Idaho health coverage with my full knowledge and consent. I accept full responsibility for the payment of premiums and the information provided on this application.

Signature	Print Name	Date

Independent Producer's Name ______________________ **BCI** ______________

Office Use Only

Program No.	Enrollee ID	Effective Date	Class	Plan
Reason Code	Bill Mode	Payment Received	Receipt ID	Auditor

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

An Independent Licensee of the Blue Cross and Blue Shield Association

Payment Options *(1st months premium required with application – No $2 service fee required on first month)*

❒ Automatic monthly bank withdrawal *(complete authorization below)* ❒ Monthly – direct coupon (*payment must include $2 monthly service fee*)

Authorization Agreement for Bank Withdrawal

I or we, meaning my spouse if applicable, authorize and request Blue Cross of Idaho (hereafter called BCI) to affect payment for premiums I or we owe to BCI as they become due by initiating debit entries (hereafter called deductions) to my or our account in the institution named (hereafter called the bank). I or we authorize and request the bank to accept any deductions initiated by BCI to my or our account. BCI assumes full responsibility for correctly informing the bank of the specific amount of each deduction. I or we may terminate this agreement at any time by notifying BCI or the bank in writing. Termination will take effect after BCI or the bank has received the written notice and had a reasonable amount of time to act on it.

Bank Name ____________________

Bank Address *(city, state)* ____________________

Customer Bank Account No. ____________________ Company I.D. No. 0000500005

Signed ____________________ Date __________

Signed ____________________ Date __________

Transit Routing No. Account Number

Transit ABA

❒ Checking ❒ Savings

Please attach voided check for automatic bank withdrawal.

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:

- No Independent Producer, agent or employee of Blue Cross of Idaho may alter any part of this application or waive the requirement that I answer all questions completely and accurately, nor may any such person change the terms of the policy, except by endorsement issued expressly for that purpose over the signature or facsimile signature of the President of Blue Cross of Idaho.
- Blue Cross of Idaho may deny benefits or terminate or rescind my policy 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 not approved, any payment submitted with this application will be refunded. Upon the refund of the payment, Blue Cross of Idaho will have no further obligations to me or any family member listed on this application.
- 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.
- If this application is approved, I understand a copy of the application will be attached to my policy. I approve the inclusion of any needed alterations to the application as long as I have been consulted by a duly authorized employee of Blue Cross of Idaho or a licensed and duly appointed Independent Producer representing me, and I have had an opportunity to review the application that will be attached to my policy.
- This plan includes waiting periods. Preventive and diagnostic services do not have a waiting period. Basic services have a six month waiting period. Major services have a 12 month waiting period.
- I acknowledge and understand my health plan may request or disclose health 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 health care treatment, payment or for the purpose of business operations necessary to administer health 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***.
- ***I affirm that I have reviewed all answers given on this application and, if an independent producer or other person has filled out the answers for me, I verify that the answers are true and complete. I understand that this application is a legal document and will become part of the contract between Blue Cross of Idaho and the enrollee.***

X____________________ __________

Applicant's Signature *Date*

(Parent or Guardian's signature if applicant is under age 18)

X____________________ __________

Spouse's Signature (if listed on application) *Date*

For Independent Producers Only

Independent Producer Checklist

❒ Is the application completed in ink and signed by the applicant, and spouse, if applicable? (A dependent's signature is not acceptable.)
❒ Are all questions regarding other coverage information completed?
❒ Is all the legal paperwork to add special dependents, including the Judge's signature in the case of adoptions, attached to the application?
❒ Is the requested effective date on the first page filled in?
❒ Is the Authorization Agreement for Bank Withdrawal section filled out and signed, and a voided check attached, if monthly automatic bank withdrawal is requested in the Payment Option section?
❒ Are all payments attached to the front of the application?
❒ If one check is written for split applications, is a breakdown of amounts that apply to each application included?

Independent Producer Certification

1. Who actually completed this application? ❒ Applicant ❒ Independent Producer ❒ Other
   If Independent Producer or Other, please explain ____________________
2. Were you present at the time the application was filled out? ❒ **YES** ❒ **NO**
   If **NO,** please explain ____________________
3. Was money collected from the applicant? ❒ **YES** ❒ **NO** **Amount $** ____________________

I have explained the eligibility provisions to the applicant. I have not made any representations about benefits, conditions, or limitations of the policy except through written material furnished by Blue Cross of Idaho. I hereby certify that the information supplied to me by the applicant has been completely and accurately recorded.

Independent Producer's Printed Name *Independent Producer's Signature* *Date* *Blue Cross of Idaho No.*

Type of Company Appointment ❒ *Personal* ❒ *Agency (Name)* ____________________