



Group Stand Alone Dental Enrollment Application

(Type of Enrollment Dependent on Group Contract)

Requested Effective Date _____

Group Number _____

PPO Traditional Voluntary

Please complete each section of this application in ink.

Applicant Information (Employee)			
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
Home Address (street or route)	City, State, Zip Code		County
Name of Employer	Date Employed Full-time (mm/dd/yy) ____/____/____	Occupation	Phone Number (____) _____

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

List all family members you wish to enroll, including any unmarried child who is under age 19; or who is under age 23, 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).

	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	Height	Weight	
Applicant/Employee		SELF	/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female
Family Member's Name (first, initial, last)	/ /		/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female
Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of school if student is over age 19					
Family Member's Name (first, initial, last)	/ /		/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female
Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of school if student is over age 19					
Family Member's Name (first, initial, last)	/ /		/ /			<input type="checkbox"/> Male <input type="checkbox"/> Female
Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of school if student is over age 19					

Coordination of Coverage Information

Is any person listed on this application now covered, or has he or she been covered, by any other health and/or dental insurance, including Medicare, Medicaid, or other Blue Cross of Idaho policy, during the 12 months prior to the requested effective date of this application (excluding any employee's probationary period)? Yes No

If **YES**, please complete all information below for **each** person listed on this application.
(Please use extra paper if necessary.)

Applicant's Name	Name of Carrier	Policy Number	Type of Policy (Group or Individual)	Date of Policy		Will Current Policy Continue?	
				From (mm/dd/yy)	To Last Date (mm/dd/yy)	Yes	No
Employee							
Spouse							
Child							
Child							

If any person listed on this application is covered by Medicare, please complete the following:

Name _____ Medicare Beneficiary Number _____ Reason for Medicare Entitlement (age, disability or ESRD) _____

Part A
Part B

Date of Medicare Entitlement _____ _____ _____

mm dd yy
mm dd yy

- If you have had other coverage with another carrier within 63 days (excluding any employee's probationary period) of this request, please attach a copy of your **Certificate of Health Coverage**; this will ensure proper credit for any preexisting conditions, if applicable.
- If your coverage is terminated, please state reason: _____
- If your current coverage will remain active, please indicate if coverage is for: Medical Dental Vision

Termination Date
____/____/____
mm dd yy

Type of Enrollment	Change Request
<input type="checkbox"/> Self only <input type="checkbox"/> Self, spouse and two or more children <input type="checkbox"/> Self and spouse <input type="checkbox"/> Self and one child <input type="checkbox"/> Self, spouse and one child <input type="checkbox"/> Self and two or more children	Change current enrollment because of the following event: <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Birth <input type="checkbox"/> Death <input type="checkbox"/> Court order (copy of court order required) Other _____ Date event occurred ____/____/____ mm dd yy

FOR OFFICE USE ONLY										OVER
Group Number	Subgroup	HIPAA			Effective Date	Plan ID			Class	Reason Code
		Credit Days	Start	End		M	D	V		

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, 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 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