Blue Cross of Idaho®

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.*

Type of Enrollment

❑ Self only

❑ Self and spouse

❑ Self, spouse and one dependent

❑ Self, spouse and two or more dependents

❑ Self and one dependent

❑ Self and two or more dependents

Change Request

Please indicate reason for change in current enrollment below:

❑ Involuntary loss of group coverage ❑ Marriage ❑ Birth ❑ Adoption

❑ Court order (copy of court order required)

Other _____

Date event occurred _____

mm dd yy

Applicant Information (Employee)

Your Name *(first, initial, last)*		Social Security Number	Blue Cross Identification No. *(if currently enrolled)*	Marital Status ❑ Single ❑ Divorced ❑ Married ❑ 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).

	Social Security Number	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yy)	
Applicant/Employee		**SELF**		❑ Male ❑ Female
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female
Dependent's Name *(first, initial, last)*				❑ Male ❑ Female

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

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. For proper coordination of benefits please complete the section below. 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.

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?
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ 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**

Auditor _____

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 terminate or rescind an employer' group coverage for any intentional misrepresentation omission of fact by, concerning, or on behalf of any applicant by the employer that was or would have been material to the insurance carrier' 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 ***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.**
- **This certificate provides dental benefits only. Review your certificate carefully.**

X _____
Applicant's Signature

_____
Date