BlueCross BlueShield of Illinois

## DENTAL APPLICATION AND POLICY CHANGE
## INSTRUCTIONS FOR COMPLETING
## DENTAL APPLICATION AND POLICY CHANGE FORM

Please remove instructions from the application before completing. Print legibly using black ballpoint pen only. Do not abbreviate. **PRESS HARD.**

Complete all fields answering each question as accurately as possible. **If you are unsure or have questions about any of the information requested on this form, please see your GROUP ADMINISTRATOR.**

**ENROLLEE**
Select the reason you are completing this form and check the appropriate boxes.

- ***New Employee:*** Initial opportunity to enroll after eligibility.
- ***Open Enrollment:*** Period when you can elect to enroll in a specific group dental plan or make changes to your current membership.
- ***COBRA/ IL Continuation Privilege:*** Eligible for continuation of your group dental coverage.
- ***Retiree:*** Eligible for your group dental coverage as a retired employee.
- ***Membership Change:*** Any change to your current membership such as adding dependents, canceling dependents, changing your benefits or dental office. These changes may occur outside of Open Enrollment.

**COVERAGE APPLIED FOR**
Check the coverage that you are enrolling for based on the plans(s) offered by your employer. Select Employee, Employee + Spouse, Employee + Child(ren) or Family. If you are enrolling for coverage that includes eligible dependents, be sure to include information on eligible dependents in the DEPENDENT INFORMATION section.

If you are **declining** coverage, you **must** check the "Waive Coverage" box in the "Cancel Coverage" section at the top of the form and read and complete the WAIVER OF COVERAGE section at the bottom of the form.

**CHANGES TO EXISTING MEMBERSHIP**
Check all boxes that apply to a change in coverage such as add or cancel dependents or cancel coverage. If you are changing your contracting dental office, circle the reason(s) why at the bottom of this section.

- To ***add a dependent***, check the appropriate box. Members may add dependents within 31 days of a qualifying event (e.g., marriage, birth and/or adoption of a child or during Open Enrollment). Enter the effective date of the qualifying event. **NOTE:** List only those dependents to be added in the DEPENDENT INFORMATION section. If coverage is changing from Employee to Family, check the appropriate box in the EMPLOYEE INFORMATION section. See your Group Administrator for other requirements to add dependents.
- To ***cancel a dependent***, check the appropriate box. Enter the date the dependent is to be canceled from coverage. **NOTE:** List only those dependents to be canceled in the DEPENDENT INFORMATION section. If coverage is changing from Family to Employee, Check the appropriate box in the EMPLOYEE INFORMATION section.

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**EMPLOYEE INFORMATION**
To assist in processing this application, **you must fill this section out completely**.

Enter effective date and your Group, Section, Identification Number and Social Security Number.

- Include your ID number if you know it.
- Your Social Security Number is used for internal purposes only.

If changing name and/or address, check the appropriate box in the CHANGES TO EXISTING MEMBERSHIP section. Be sure to enter your **name** AND **address** in this section and complete the EFFECTIVE DATE section.

**If you selected dental HMO**, you **must** select a contracting dental office for you and your covered dependents. Until we receive this information you are not eligible to receive dental services and your claims will be denied.

**FAMILY INFORMATION**
If you are changing existing membership, list only those dependents to be added or canceled.

A) ***SPOUSE:*** Enter complete information for your spouse.

B) ***DEPENDENTS:*** Enter complete information for your child(ren). If you need additional space to list other dependents, use a separate piece of paper and attach it to this application.

**OTHER DENTAL COVERAGE**
If you have additional dental insurance coverage, please complete the information requested to ensure proper coordination of your dental care benefits.

**WAIVER OF COVERAGE**
If you are waiving coverage, please **read, date and sign** this section.

**AUTHORIZATION SIGNATURE FOR NEW/CHANGING COVERAGE**
Please **read, date and sign** this section.

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# DENTAL APPLICATION AND POLICY CHANGE

**ENROLLEE:** ☐ New Employee ☐ Open Enrollment ☐ COBRA/IL ☐ Retiree ☐ Membership Change

**COVERAGE APPLIED FOR:**

☐ Dental PPO

☐ Traditional Dental

☐ Dental HMO

☐ Other _____

_____

_____

_____

**CHANGES TO EXISTING MEMBERSHIP: Check all that apply:**

☐ Name ☐ Address
☐ Phone Number
☐ From DHMO to DPPO ☐ From DPPO to DHMO
☐ From DHMO to Traditional ☐ From Traditional to DPPO
☐ From DPPO to Traditional ☐ From Traditional to DHMO

☐ Dental Office Change;
**Circle Reasons for Provider Office Change**
**A.** Availability **B.** Dissatisfaction **C.** Provider Terminated
**D.** Provider Added With Provider to Network **E.** Office Moved **F.** Other _____

**Dependent Coverage:**
**(list only names that apply below)**
☐ **Add**
☐ Marriage
☐ Newborn
☐ Age Limit
☐ Adoption/Placement
☐ Legal Guardianship
☐ Other _____

☐ **Cancel**
☐ Marriage
☐ Divorce

**Cancel Coverage:**
☐ Terminate Coverage
☐ Waive Coverage
☐ Leave/Lay Off
☐ Other _____

**COBRA/IL Continuation Privilege:** Start Date: ___/___/___ Projected End Date: ___/___/___
Previously covered with group as:
☐ 1. Employee (termination of employment, reduction in hours, other.) ☐ 3. Dependent (reached age limit, married, no longer full time student, other.)
☐ 2. Spouse (divorce from employee, death of employee.) ☐ 4. Spouse & Dependents (divorce from employee, death of employee, other.)

**EMPLOYEE INFORMATION:** Company Name: | Date of Hire:

| Effective Date: / / | Group Number: | Section Number: | Identification Number (if known): | Social Security Number: — — |
|---|---|---|---|---|
| | | | | |

| Last name: | First Name: | Mid Initial: | Date of Birth: / / | Sex: ☐ Male ☐ Female |
|---|---|---|---|---|
| | | | | |

| Street Address: | Apt No: | City: | State: | Zip: |
|---|---|---|---|---|
| | | | | |

Telephone Number Day:
Evening:

Dental HMO Office ID Number:

**Are you eligible for family coverage:** ☐ No ☐ Yes **Coverage Elected:** ☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

| **DEPENDENT INFORMATION:** *List all Eligible Dependents* | **Date of Birth:** | **First Name:** | **Last Name: (only if different)** | **Full-Time Student** | | *Complete only when Instructed by the Enroller* **Provider Office ID Number:** |
|---|---|---|---|---|---|---|
| | | | | **Yes** | **No** | |
| ☐ Spouse | | | | | | |
| ☐ Son ☐ Daughter | | | | | | |
| ☐ Son ☐ Daughter | | | | | | |
| ☐ Son ☐ Daughter | | | | | | |
| ☐ Son ☐ Daughter | | | | | | |

If you or any of your family members have **OTHER DENTAL COVERAGE** please check which type here: ☐ Single Coverage ☐ Family Coverage

Policy # _____ Employed by: _____ Insured's Name _____ Date of Birth _____

Insurance Company Name _____ Address _____

City _____ State _____ Zip _____ Telephone Number _____

**WAIVER OF COVERAGE:**

**I DO NOT WISH TO ENROLL** at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

**Date Signed: (Mo/Day/Yr)** _____ **Signature of Employee/Applicant:** _____

**APPLICATION FOR COVERAGE:**

**I HEREBY MAKE APPLICATION** for the dental coverage now being offered to the group, through which I am enrolling to the extent I have indicated above, and I understand and agree that: The dental coverage applied for shall not be issued or in force unless this application is accepted by Health Care Service Corporation which is herein called the Company. All the information given in the application is complete and true to the best of my knowledge, and the Company believing it to be true shall rely and act upon it accordingly.

I also authorize my employer/group to deduct from my pay and remit the prevailing fee that may be required for the cost of said coverage. This authorization is to remain in effect until the Company is notified by me in writing to the contrary.

**Date Signed: (Mo/Day/Yr)** _____ **Signature of Employee/Applicant:** _____