



Group Dental Coverage Employee Application

Blue Cross DentalNet and Blue Cross Dental SelectHMO offered by Blue Cross of California.
Blue Cross PPO and FFS Dental offered by BC Life & Health Insurance Company.



1. You, the employee must complete this application. You are solely responsible for its accuracy and completeness.
2. All questions must be answered in full or the application may be returned to you resulting in a delay in processing.
3. **Type or print clearly using blue or black ink.**

Group No. _____

1 DENTAL PLAN SELECTION

High Option:

High Option PPO*

Medium Option:

Standard Option PPO*

Low Options:

Basic Option PPO*

DentalNet[®] – You must select a Dental Office No.

Blue Cross Dental SelectHMOSM – You must select a Dental Office No.

_____ Dental Office No.

* Fee-for-service dental coverage is substituted if the dental PPO member is outside of the PPO dental service area.

2 EMPLOYEE INFORMATION – Must be completed by employee.

New group enrollment

Late enrollment

Change of coverage

Family addition

New hire

Other - Specify: _____

COBRA Cal-COBRA*

COBRA / Cal-COBRA

* Cal-COBRA applicants must submit first month's premium.

Effective Date:

LAST NAME	FIRST NAME	M.I.	MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married	SOCIAL SECURITY NO. _____
HOME ADDRESS (P.O. Box not acceptable unless rural P. O. Box)			APT NO.	HOME PHONE NO. () _____
CITY		STATE	ZIP CODE	# OF DEPENDENTS INCLUDING SPOUSE _____
EMPLOYER NAME	OCCUPATION / JOB TITLE		<input type="checkbox"/> Part Time <input type="checkbox"/> Full Time	SPOUSE'S SOCIAL SECURITY NO. _____
BUSINESS PHONE NO. () _____	SALARY \$ _____	<input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly	# OF HOURS WORKED PER WEEK _____	HIRE DATE (MM/DD/YY) ____/____/____

3 EMPLOYEE / DEPENDENT INFORMATION – List yourself and only those eligible dependents who are enrolling.

An eligible "dependent" is an employee's lawful spouse/domestic partner; the unmarried children of the employee or of the employee's spouse who are under age 19; or the unmarried child of the employee or enrolled spouse, who is between the age of 19-24, is a full-time student, and is fully dependent on the employee for support.

If spouse's last name is different from yours, please explain: _____

Family addition: _____

Date of marriage: _____

Date of adoption: _____

SEX	LAST NAME	FIRST NAME	M.I.	BIRTHDATE MONTH DAY YEAR
<input type="checkbox"/> Male <input type="checkbox"/> Female	Employee			____/____/____
<input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse *			____/____/____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____
<input type="checkbox"/> Son <input type="checkbox"/> Daughter				____/____/____

Does any person applying for coverage have Dental insurance? Yes No

If yes, applicant/family member(s) name: _____ Type of continuous coverage: Group Individual

Insurance company: _____ Date coverage began: _____ Date ended: _____

4 AUTHORIZATION – The following Authorization Section is to be signed by all employees applying for coverage.

I agree: All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. I further authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by Blue Cross of California or BC life & Health Insurance Company. Even if this application is approved, any misstatements or omissions may result in future claims being denied and the policy being rescinded. I, the applicant, acknowledge that I have read and understand this Application in its entirety. I understand that information may be collected in connection with the review, investigation or evaluation of any application for coverage, of any claim for benefits, or of any inquiry or grievance. I understand that California law prohibits an HIV test from being required or used as a condition of obtaining medical or dental coverage.

I attest by signing below that I have reviewed the information provided on this application and confirm that it is true and accurate with no omissions or misstatements.

X

Signature of Employee

Date (Month / Day / Year)

5 DENTAL COVERAGE DECLINATION – To be completed if coverage is declined or refused by an eligible employee and/or their eligible dependent(s).

A. Dental Coverage declined for: Myself Spouse* Dependent(s)

B. Reason for declining coverage: (Check one)

Covered by spouse's group coverage – Carrier name and I.D. number: _____

Other (Explain): _____

Covered by Blue Cross Individual Dental Policy

Spouse covered by employer's group dental coverage – Carrier name: _____

Enrolled in any other insurance carrier plan – Carrier name: _____

I acknowledge that the available coverages have been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage. BY DECLINING THIS GROUP DENTAL COVERAGE (UNLESS EMPLOYEE AND/OR DEPENDENTS HAVE GROUP DENTAL COVERAGE ELSEWHERE) I ACKNOWLEDGE THAT MY DEPENDENTS AND I MAY HAVE TO WAIT TWELVE (12) MONTHS FROM THE DATE OF ANY FUTURE APPLICATION TO BE ENROLLED IN THIS GROUP DENTAL PLAN.

X

Signature if declining coverage for employee/dependent(s)

Date (Month / Day / Year)

* Spouse includes domestic partner ONLY if your employer has elected that coverage.

If coverage is available, domestic partner enrollment requires completion of the Domestic Partner Affidavit.

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