Group Dental Coverage Employee Application

Blue Cross Dental Net 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 PPO*
☐ Standard Option PPO*
☐ Basic Option PPO*

☐ Dental Net – You must select a Dental Office No.
☐ Blue Cross Dental SelectHMO – 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 - _____

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

COBRA / Cal-COBRA Effective Date:

Last Name	First Name	M.I.	Marital Status ☐ Single ☐ 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		☐ Part Time ☐ Full Time	Spouse's Social Security No.
Business Phone No.	Salary $ ☐ Hourly ☐ Monthly ☐ 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 or domestic partner (if employer has elected to cover domestic partners); the unmarried child(ren) of the employee or, of the employee's spouse who are under age 19, or, the unmarried child(ren) of the employee or enrolled spouse from the nineteenth (19th) to the twenty-fourth (24th) birthday who qualify as dependents for federal income tax purposes and are full time students. Blue Cross requires written proof of student status annually.

If spouse's last name is different from yours, is he/she a domestic partner? ☐ Yes ☐ No

Family addition: Date of marriage: **Date of adoption:**

Sex	Last Name	First Name	M.I.	Birthdate Mo Day Yr
☐ Male ☐ Female	Employee			
☐ Male ☐ Female	Spouse *			
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				
☐ Son ☐ 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: _____

** Spouse includes domestic partner ONLY if your employer has elected that coverage. If coverage is available, domestic partner enrollment requires submission of a signed and notarized Domestic Partner Affidavit or, if applicable, a copy of a valid Declaration of Domestic Partnership filed with and stamped by the Secretary of State of California.*

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

I agree: To the best of my knowledge and belief, 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 to the best of my knowledge and belief, 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: _____ I.D. number: _____
- ☐ 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: _____
- ☐ Other *(Explain):* _____

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)*

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