

GROUP DENTAL APPLICATION/REQUEST FOR CHANGE IN DENTAL MEMBERSHIP FORM



BlueCross BlueShield of Oklahoma



Blue Cross and Blue Shield of Oklahoma

SOCIAL SECURITY NUMBER AND GROUP #* ARE REQUIRED TO PROCESS APPLICATION

--	--	--	--	--	--	--	--	--	--	--	--

SOCIAL SECURITY NUMBER

--	--	--	--	--	--	--	--

GROUP # (*IF ASSIGNED)

--	--	--	--	--	--

SECTION #

--	--	--	--

DEPT #

CATEGORY _____

SECTION 1 — ENROLLMENT EVENTS PLEASE CHECK ALL THAT APPLY

- NEW ENROLLEE ADD DEPENDENT
- OTHER CHANGE(S): INDICATE CHANGE(S) IN APPROPRIATE SECTION BELOW CHANGE ADDRESS/NAME
- ARE YOU APPLYING AS A RESULT OF A SPECIAL ENROLLMENT EVENT? NO YES, EVENT DATE: ____ / ____ / ____
- EVENT: MARRIAGE BIRTH
- ADOPTION OR PLACEMENT FOR ADOPTION (ATTACH ADOPTION PAPERS)
- COURT ORDER (ATTACH COURT ORDER)
- LOSS OF COVERAGE (PROVIDE CERTIFICATE OF CREDITABLE COVERAGE)
- INSURE OKLAHOMA (O-EPIC)
- OTHER (SEE INSTRUCTIONS) EXPLAIN: _____

- CANCEL ENROLLEE CANCEL DEPENDENT
- LIST NAMES OF THOSE CANCELING IN SECTION 4 BELOW
- EVENT: DIVORCE DEATH
- TERMINATED EMPLOYMENT
- OTHER
- INDICATE EVENT DATE: ____ / ____ / ____

SECTION 2 — PLEASE TELL US WHO YOU WANT TO ENROLL (CHECK ONE BOX ONLY)

- ENROLLEES (SELECT ONE) EMPLOYEE ONLY — COMPLETE SECTIONS 3, 5 & 7
- EMPLOYEE/CHILD(REN) — COMPLETE SECTIONS 3 THROUGH 7 (EXCLUDING SPOUSE)
- EMPLOYEE/SPOUSE/CHILD(REN) — COMPLETE SECTIONS 3 THROUGH 7
- EMPLOYEE/SPOUSE — COMPLETE SECTIONS 3, 4, [EXCLUDING DEPENDENT CHILDREN] 5 & 7

OPTION _____
(REQUIRED ONLY WHEN INSTRUCTED BY EMPLOYER)

SECTION 3 — PLEASE TELL US ABOUT YOURSELF

LAST NAME	FIRST	MIDDLE	BIRTH DATE (MM/DD/YYYY) / /	HOME PHONE NO.
HOME ADDRESS — NO. AND STREET ADDRESS	CITY	STATE	ZIP	WORK PHONE NO.
NAME OF EMPLOYER		EMPLOYMENT DATE (MM/DD/YYYY) / /		HOW MANY HOURS PER WEEK DO YOU WORK?
SOCIAL SECURITY NO. - -	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			

SECTION 4 — TELL US ABOUT YOUR DEPENDENTS

DEPENDENT'S NAME HUSBAND WIFE

DEPENDENT'S SOCIAL SECURITY NO. - -	DOB (MM/DD/YYYY) / /	ADDRESS (IF DIFFERENT) — NO. AND STREET ADDRESS	CITY	STATE	ZIP
DEPENDENT'S NAME <input type="checkbox"/> SON/STEPSON <input type="checkbox"/> DAUGHTER/STEPDAUGHTER <input type="checkbox"/> OTHER _____	IF DEPENDENT IS OVER AGE 19 AND UNDER AGE 23 AND A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY, PLEASE COMPLETE SECTION 6.				
DEPENDENT'S SOCIAL SECURITY NO. - -	DOB (MM/DD/YYYY) / /	ADDRESS (IF DIFFERENT) — NO. AND STREET ADDRESS	CITY	STATE	ZIP
IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, OR ADOPTED CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ATTACH COPY OF SIGNED COURT DECREE	IF NOT YOUR NATURAL CHILD, STEPCHILD OR ADOPTED CHILD, ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DEPENDENT'S NAME <input type="checkbox"/> SON/STEPSON <input type="checkbox"/> DAUGHTER/STEPDAUGHTER <input type="checkbox"/> OTHER _____	IF DEPENDENT IS OVER AGE 19 AND UNDER AGE 23 AND A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY, PLEASE COMPLETE SECTION 6.				
DEPENDENT'S SOCIAL SECURITY NO. - -	DOB (MM/DD/YYYY) / /	ADDRESS (IF DIFFERENT) — NO. AND STREET ADDRESS	CITY	STATE	ZIP
IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, OR ADOPTED CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ATTACH COPY OF SIGNED COURT DECREE	IF NOT YOUR NATURAL CHILD, STEPCHILD OR ADOPTED CHILD, ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DEPENDENT'S NAME <input type="checkbox"/> SON/STEPSON <input type="checkbox"/> DAUGHTER/STEPDAUGHTER <input type="checkbox"/> OTHER _____	IF DEPENDENT IS OVER AGE 19 AND UNDER AGE 23 AND A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY, PLEASE COMPLETE SECTION 6.				
DEPENDENT'S SOCIAL SECURITY NO. - -	DOB (MM/DD/YYYY) / /	ADDRESS (IF DIFFERENT) — NO. AND STREET ADDRESS	CITY	STATE	ZIP
IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, OR ADOPTED CHILD? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, ATTACH COPY OF SIGNED COURT DECREE	IF NOT YOUR NATURAL CHILD, STEPCHILD OR ADOPTED CHILD, ARE YOU (OR YOUR SPOUSE) LEGALLY AND FINANCIALLY RESPONSIBLE FOR THIS DEPENDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO		IS DEPENDENT MARRIED? <input type="checkbox"/> YES <input type="checkbox"/> NO		

SECTION 5 – DOES ANYONE LISTED ON THIS APPLICATION HAVE DENTAL INSURANCE? ■ YES ■ NO IF YES, COMPLETE THE FOLLOWING				
POLICYHOLDER NAME	BIRTH DATE (MM/DD/YYYY) / /	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	RELATIONSHIP TO APPLICANT	GROUP NO. OR POLICY/ID NO.
EMPLOYER'S NAME	EMPLOYMENT DATE (MM/DD/YYYY) / /	EFFECTIVE DATE (MM/DD/YYYY) / /	WILL COVERAGE BE CONTINUED? <input type="checkbox"/> YES <input type="checkbox"/> NO IF NO, EXPECTED CANCEL DATE	
NAME AND ADDRESS OF OTHER INSURANCE COMPANY, TPA, HMO			TYPE OF POLICY <input type="checkbox"/> SELF <input type="checkbox"/> FAMILY <input type="checkbox"/> EMPLOYEE/SPOUSE <input type="checkbox"/> EMPLOYEE/CHILD	
LIST ALL THOSE COVERED BY PREVIOUS/OTHER CARRIER				

SECTION 6 – STUDENTS OVER AGE 19
PLEASE COMPLETE THIS SECTION FOR ALL DEPENDENTS LISTED ON PREVIOUS PAGE AND APPLYING FOR COVERAGE THAT ARE OVER AGE 19 AND UNDER AGE 23 AND ARE FULL-TIME STUDENTS AT AN ACCREDITED SCHOOL, COLLEGE OR UNIVERSITY.

NAME OF STUDENT (FIRST, LAST)	NAME OF SCHOOL, CITY, STATE	CURRENT SEMESTER ENROLLED <input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER	<input type="checkbox"/> UNDERGRADUATE <input type="checkbox"/> GRADUATE PROGRAM	# HOURS ENROLLED
NAME OF STUDENT (FIRST, LAST)	NAME OF SCHOOL, CITY, STATE	CURRENT SEMESTER ENROLLED <input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER	<input type="checkbox"/> UNDERGRADUATE <input type="checkbox"/> GRADUATE PROGRAM	# HOURS ENROLLED
NAME OF STUDENT (FIRST, LAST)	NAME OF SCHOOL, CITY, STATE	CURRENT SEMESTER ENROLLED <input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER	<input type="checkbox"/> UNDERGRADUATE <input type="checkbox"/> GRADUATE PROGRAM	# HOURS ENROLLED
NAME OF STUDENT (FIRST, LAST)	NAME OF SCHOOL, CITY, STATE	CURRENT SEMESTER ENROLLED <input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER	<input type="checkbox"/> UNDERGRADUATE <input type="checkbox"/> GRADUATE PROGRAM	# HOURS ENROLLED
NAME OF STUDENT (FIRST, LAST)	NAME OF SCHOOL, CITY, STATE	CURRENT SEMESTER ENROLLED <input type="checkbox"/> SPRING <input type="checkbox"/> FALL <input type="checkbox"/> SUMMER	<input type="checkbox"/> UNDERGRADUATE <input type="checkbox"/> GRADUATE PROGRAM	# HOURS ENROLLED

SECTION 7 – DENTAL APPLICATION AGREEMENT

I and any other persons whose names appear on this application hereby apply for coverage from Blue Cross and Blue Shield of Oklahoma as indicated in this application.

I understand and agree to the items listed below:

- This is an application only, and I should not cancel any existing dental coverage unless and until I am notified in writing by Blue Cross and Blue Shield of Oklahoma if my acceptance.
- I, on behalf of myself and any persons whose names appear on this application, hereby apply for coverage from Blue Cross and Blue Shield of Oklahoma as stated in this application. I have read all the statements on this application and represent that they are true and complete. I understand that any false or incomplete information can result in retroactive cancellation of coverage for all persons under the membership, and I will repay promptly any benefit payments to which persons covered under this membership were not entitled.
- Any insurance agent, dentist, or other person who knowingly and willfully makes a false or fraudulent statement or representation relative to any application for insurance, or who makes any such statement to obtain a fee, commission, money or benefit shall be guilty of a misdemeanor (title 36, section 1204 of the Oklahoma state statutes).
- I authorize any dentist, physician, practitioner, hospital or other institution to release, disclose and furnish Blue Cross and Blue Shield of Oklahoma for its review and retention in connection with any application for dental coverage and future claims, all information, records, or copies of records relating to medical history and conditions, including, but not limited to diagnosis, treatment, care, surgery, and the dates thereof.
- I authorize my employer, as my agent, to deduct the amount of charges from my wages or salary for the purpose of paying my membership charges to the plan.

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

PLEASE READ AND REVIEW THE TERMS OF THIS APPLICATION BEFORE SIGNING

SIGNATURE OF APPLICANT (EMPLOYEE) – I AGREE TO ALL THE TERMS OF THIS APPLICATION X	DATE SIGNED / /
---	--------------------