BlueCross BlueShield of Oklahoma

A Member of the Blue Cross and Blue Shield Association,
an Association of Independent Blue Cross and Blue Shield Plans.
1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

SECTION GA – GROUP APPLICATION FOR BLUESELECT VOLUNTARY GROUP DENTAL CONTRACT

Application is hereby made

TO: Blue Cross and Blue Shield of Oklahoma, Home Offices: 1215 South Boulder, P.O. Box 3283, Tulsa, Oklahoma 74102-3283 (herein called the "Plan")

BY: APPLICANT (BUSINESS NAME)_____

CONTACT AT FIRM _____ PHONE _____

ADDRESS OF FIRM _____

CITY AND STATE _____ ZIP CODE _____

☐ Corporation ☐ Proprietorship ☐ Partnership

☐ Other (specify) _____

IT IS UNDERSTOOD AND AGREED THAT NO AGENT HAS THE AUTHORITY TO ALTER OR AMEND THE CONTRACT OR BIND THE PLAN BY MAKING ANY PROMISE OR REPRESENTATION. IT IS FURTHER UNDERSTOOD THAT NO COVERAGE WILL BECOME EFFECTIVE WITHOUT THE WRITTEN APPROVAL OF THE PLAN.

This Application is not a binder and the Group will be notified by the Plan of acceptance of this Application and the date coverage will be effective. In the event this Application is not accepted, any deposits received by the Plan will be returned to the Applicant. **Coverage shall be effective at 12:01 a.m. on the Contract Date and shall continue until terminated in accordance with the Contract.**

®Registered Marks Blue Cross and Blue Shield Association

A. APPLICANT STATEMENTS

1. Applicant understands that, unless otherwise specified in this Contract, only Employees and their Dependents are eligible for coverage. Applicant further agrees that eligibility and participation requirements have been discussed with the agent and have been explained to all Eligible Persons.
2. Applicant agrees to notify the Plan of ineligible persons immediately following their change in status from eligible to ineligible.
3. Applicant agrees to review all applications for completeness prior to submission to the Plan.
4. Applicant applies for the coverages selected and provided in the Group Contract and agrees that the obligation of the Plan shall only include the part of the Benefits described or as amended by any Amendments or Endorsements.
5. Applicant agrees to pay to the Plan, in advance, the dues specified in the Group Billing Statement on behalf of each Eligible Person covered under the Contract.
6. Applicant agrees that, in the making of this Application, it is acting for and in behalf of itself and as the agent and representative of its Eligible Persons, and it is agreed and understood that the Applicant is not the agent or representative of the Plan for any purpose of this Application or any Contract issued pursuant to this Application.
7. Applicant agrees to deliver to its Eligible Persons covered under the Contract individual certificates and Identification Cards and any other relevant materials as may be furnished by the Plan for distribution.
8. Applicant agrees to receive on behalf of its covered Eligible Persons all notices delivered by the Plan and to forward such notices to the person involved at their last known address.

B. ELIGIBILITY PROVISIONS

1. Are any subsidiary or affiliated units to be included in the Contract?

   ☐ No ☐ Yes If yes, list: _____

2. Eligible Person and Effective Date

   An Eligible Person is defined as an Employee who works on a full-time basis and has a normal work week of 24 or more hours, except as specified below under "Other Eligibility Provisions".

   a. The date the person becomes eligible is:

      ☐ The date of employment.

      ☐ The day following the date the Eligible Person completes _____
      _____
      of continuous employment.

      ☐ Other (specify special eligibility provisions) _____
      _____
      _____
      _____
      _____

b. The Effective Date for persons who become eligible after the Group's Contract Date is:

☐ The date the person becomes eligible.

☐ The first billing cycle coinciding with or next following the date the person becomes eligible.

☐ Other (specify Effective Date) _____
_____

c. Other Eligibility Provisions (specify) _____
_____
_____
_____

3. Eligible Dependent

An Eligible Dependent is defined as:

a. the Eligible Person's spouse.

b. the Eligible Person's unmarried child. The limiting age for the child is as follows:

☐ Unmarried Dependent children under age 19 are eligible for coverage until January 1 of the year following their 19th birthday. Unmarried Dependant children who are enrolled as Full-Time Students, and who are financially dependent upon the Eligible Person or his/her spouse, are eligible for coverage until their 23rd birthday.

☐ Other (specify special Dependent age provisions) _____
_____
_____
_____
_____
_____

4. Group Contributions

The percentage of premiums which is paid by the Group is as follows:

a. Member Only Coverage (Single Coverage) _____ %

b. Member and Spouse Only Coverage _____ %

c. Member and Children Coverage _____ %

d. Member, Spouse and Children Coverage (Family Coverage) _____ %

5. Minimum Group Participation Requirements

The percentage of enrollment and number of Eligible Persons which must be maintained is _____% or _____ (No.) enrolled Eligible Persons, whichever is greater.

C. **BENEFITS**

☐ Option 1a (Skip remaining Benefit questions)

☐ Option 2 ☐ Option 3 ☐ Option 4

COMPLETE THE FOLLOWING SECTION FOR OPTIONS 2-4 ONLY:

1. Deductible Amount per Benefit Period per Subscriber
   a. Diagnostic and Preventive Services
      ☐ None ☐ Other (specify) _____
   b. Primary Services, Prosthetic and Complex Restorative Services
      ☐ $50 ☐ Other (specify) _____
2. Benefit Percentage Amount
   a. Diagnostic and Preventive Services
      ☐ 100% Participating Dentist Services/80% Out-of-Network Dentist Services
      ☐ Other (specify) _____
   b. Primary Services
      ☐ 80% Participating Dentist Services/60% Out-of-Network Dentist Services
      ☐ Other (specify) _____
   c. Prosthetic and Complex Restorative Services
      ☐ 50% Participating Dentist Services/30% Out-of-Network Dentist Services
      ☐ Other (specify) _____
   d. Maximum Amount per Benefit Period per Subscriber
      ☐ $1,000
      ☐ $1,250 (NOTE: If this option is selected, the Group must enroll and maintain a minimum of 10 Eligible Persons or 75% of total Eligible Persons, whichever is greater.)
      ☐ Other (specify) _____
3. Waiting Period for Covered Dental Services
   a. Diagnostic and Preventive Services – None
   b. Primary Services – None

c. Prosthetic and Complex Restorative Services

☐ None (NOTE: If this option is selected, the Group must enroll and maintain a minimum of 10 Eligible Persons or 50% of total Eligible Persons, whichever is greater.)

☐ The Subscriber's coverage must be in effect for 12 consecutive months before Benefits are available for Prosthetic and Complex Restorative Services.

d. Optional Orthodontic Services – The Dependent child Subscriber's coverage must be in effect for 24 consecutive months before Benefits are available for Orthodontic Services.

4. Optional Orthodontic Services ☐ No ☐ Yes (complete below)

a. Deductible Amount per Benefit Period per Dependent Child Subscriber

☐ None ☐ Other (specify) _____

b. Benefit Percentage Amount

☐ 50% Participating Dentist Services/30% Out-of-Network Dentist Services

☐ Other (specify) _____

c. Maximum Amount per Lifetime per Dependent Child Subscriber

☐ $1,000 ☐ Other (specify) _____

I HAVE REVIEWED THE BENEFITS AND ELIGIBILITY REQUIREMENTS AS STATED IN THIS GROUP APPLICATION WITH MY BLUE CROSS AND BLUE SHIELD OF OKLAHOMA REPRESENTATIVE. IF THIS APPLICATION IS ACCEPTED, THE CONTRACT AND ANY ENDORSEMENTS THERETO WILL CONTAIN ALL OF THE TERMS AND CONDITIONS.

APPLICANT (BUSINESS NAME) _____

AUTHORIZED SIGNATURE _____ **DATE SIGNED**_____

OFFICE OR POSITION _____

THE UNDERSIGNED BLUE CROSS AND BLUE SHIELD OF OKLAHOMA REPRESENTATIVE ACKNOWLEDGES THAT THIS GROUP APPLICATION HAS BEEN REVIEWED WITH AND EXPLAINED TO THE APPLICANT NAMED ABOVE.

REPRESENTATIVE'S SIGNATURE _____ **DATE SIGNED**_____

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.