Excellus BlueCross BlueShield
A nonprofit independent licensee of the Blue Cross Blue Shield Association

Everybody Benefits

For Internal Use

Individual & Family Dental Insurance Application/Change Form

- Please print clearly and complete all sections that apply to you
- Additional instructions are included

FOR INTERNAL USE ONLY

HIOS ID# _____

EC _____

Section 1: Your Information (REQUIRED)

_____ Subscriber ID# _____

Last Name First Name MI (For changes and cancellations)

Social Security # ** _____ Birthdate: _____ , _____ , _____

Gender:
☐Female ☐Male
☐Gender X

_____

Street Address City State Zip County
Where taxes are paid

_____

Mailing Address (if different) City State Zip County

_____

Billing Address (if different) City State Zip County

_____

Phone

Section 2: What do you need to do?

☐Enroll in a new plan ☐ Add a dependent(s) ☐ Change current coverage
☐Cancel coverage ☐ Remove a dependent(s) ☐ Change name or address

Section 3: If enrolling in a new plan, who do you need coverage for?

☐Self Only ☐Self & Spouse/Domestic Partner ☐Self & Child(ren) ☐Family ☐Child(ren) Only

Effective Date _____, _____, _____

Section 4: If canceling coverage, who are you canceling coverage for?

Who	Name	Birth Year	Cancel Date*
Subscriber			
Dependent			
Dependent			
Dependent			____, ____, ____
Dependent			
Dependent			

*Notice must be received at least 14 days ***prior*** to the cancel date
**Additional documentation may be requested

Why are you canceling coverage?
☐ Subscriber's request ☐ Deceased ☐ Divorce**
☐ Moved out of area
Other coverage: ☐ Through spouse ☐ Through Medicare
☐Through Medicaid** ☐ Other

Section 5: Special Enrollment Period

If you are applying outside of the annual Open Enrollment Period, please check one of the events below that applies to you. The Special Enrollment Period begins on the date of the event checked and continues for 60 days.

☐Adoption ☐Birth ☐Change in employment status ☐Change to new employer that does not offer insurance ☐Death
☐Dependent reached maximum age of coverage ☐Divorce/annulment/legal separation ☐Domestic Partnership
☐Domestic Violence ☐Loss of coverage ☐Marriage ☐Moved in/out of service area ☐Pregnancy

☐Other _____ **Date of Event** _____, _____, _____

Section 6: Dental plan options

☐ Blue Select Dental (ENA) 78124NY1160001-00
☐ Blue Select Premier Dental (ENB) 78124NY1160002-00
☐ Blue Blue Select Children's Dental

Section 7: Other coverage information (Must be completed – you may be contacted for additional information)

Have you or your family had other dental coverage in the past 12 months? ☐Yes ☐No (if no, move to Section 8)

What is the effective date of the other coverage? Dental: ____ , ____ , ______
What is the name of the other carrier(s)? ______________________________ ______________________________
Are you keeping the coverage? ☐Yes ☐No
If no, when will the coverage end? Dental: ____ , ____ , ______

Policyholder's name ________________________________ ID#(s) __________________________________
Did the insurance cover ☐Insured ☐Insured and family

Section 8: Information about who you would like coverage for

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent ☐Child Only ☐Other__________________

Birthdate _____ , _____ , ________ Gender: ☐Female ☐Male ☐Gender X

Last Name (if different) ____ First Name ____ MI ____ Social Security # ____

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent ☐Child Only ☐Other__________________

Birthdate _____ , _____ , ________ Gender: ☐Female ☐Male ☐Gender X

Last Name (if different) ____ First Name ____ MI ____ Social Security # ** ____

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent ☐Child Only ☐Other__________________

Birthdate _____ , _____ , ________ Gender: ☐Female ☐Male ☐Gender X

Last Name (if different) ____ First Name ____ MI ____ Social Security # ** ____

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent ☐Child Only ☐Other__________________

Birthdate _____ , _____ , ________ Gender: ☐Female ☐Male ☐Gender X

Last Name (if different) ____ First Name ____ MI ____ Social Security # ** ____

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Adult Disabled Dependent ☐Child Only ☐Other__________________

Birthdate _____ , _____ , ________ Gender: ☐Female ☐Male ☐Gender X

Last Name (if different) ____ First Name ____ MI ____ Social Security # ** ____

Section 9: Third party administrator must complete this section (Broker, Agent, Internal Sales, and Certified Application Counselor (CAC)/Marketplace Facilitated Enroller (MFE) – If a broker, license # for the agency must be completed to be eligible for commission)

Name of Broker/Agent/CAC/MFE Person assisting _____

Agency Name (if applicable_____

Agency License # (if applicable) _____ Agency Tax ID (if applicable) _____

Section 10: Release – You must sign and date this form to be eligible for dental insurance.

Pursuant to federal rules that implement the Affordable Care Act, individual dental insurance policies must be written on a calendar year basis. This means that if your effective date of coverage is a date later than January 1st of a year, the initial term of coverage for your policy will be for less than a full year and will end on December 31st of the same year. Please be advised that all benefits and cost sharing under your policy, including the full annual deductible, apply to the partial year of coverage.
I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).
I hereby accept responsibility for payment of any portion of the premium.
I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge.
PREFERRED PROVIDER ORGANIZATION (PPO) I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan.
I have thoroughly read, understand and agree to comply with the terms of this Release section.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber Signature_____ **Date**_____

YOUR PREMIUM PAYMENT MUST BE INCLUDED WITH THE APPLICATION

Please mail application and payment to:

Enrollment Operations
PO Box 31790
Rochester, NY 14603-1790

If you have questions, please contact our dedicated Insurance Advisors at 1-888-579-0327
Learn about exclusive member benefits at ExcellusBCBS.com/FindAPlan

Instructions for Completing the Individual & Family Dental Insurance Application

Section 1: The entire section is REQUIRED to be completed by the subscriber. **We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.
Health Equity: Health care should meet the needs of everyone—no matter who you are, where you live, or who you love. To learn more about health equity and view our privacy policy, visit ExcellusBCBS.com/HealthEquity.

Section 2: Select the box that describes what you need to do regarding dental insurance coverage.

Section 3: Select the box that describes who you need coverage for. Please complete section 8 if you select any box other than self only. Effective dates are determined based upon the date your selection is received. If received between the first and fifteenth day of the month, coverage will begin on the first day of the following month, as long as applicable premium payment is received by then. If selection is received between the sixteenth day and the last day of the month, coverage will begin on the first day of the second month, as long as applicable premium payment is received by then. Retroactive requests for coverage and other effective dates may be allowed for certain qualifying events.

Section 4: If you are canceling coverage, list the names and birth year of those you are canceling coverage for and the date the coverage will cancel. Then select your reason for canceling. Additional documentation may be requested for certain reasons.

Section 5: There are certain life changes that make you eligible for a Special Enrollment Period (SEP) such as having a baby, getting married or your coverage under another plan is ending. Select the event that applies to you and include the date of the event. You may be required to provide documentation of certain events. *Please contact our dedicated Insurance Advisors at 1-888-579-0327 for a list of documentation required.

Section 6: Select one plan option only

Section 7: Please include accurate information in this section. This could affect the processing of your application and/or claims. Medicaid is a public aid program for those with a limited income. This is not the same as Medicare.
If you are Medicare eligible and enrolled in Medicare Part A and/or Medicare Part B, do not complete this application. Please contact one of our dedicated Insurance Advisors at 1-888-579-0327 for the Supplemental Medicare Eligible Enrollment Form or a Medicare Advantage plan enrollment application.

Section 8: Please include information about all the people for whom you would like coverage. Use an additional application if more than five people need coverage. There are additional eligibility and documentation requirements for coverage of dependents noted with an asterisk (*) below. Qualified guidelines for coverage include:

- A legal spouse*/domestic partner* (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the court)
- Dependent under the age of 26 – Natural, adopted* or stepchild
- Child (ren) Only coverage is available for children up to age 21
- Disabled Dependents* over the dependent age
- Dependents by legal guardianship*
- *Please contact our dedicated Insurance Advisors at 1-888-579-0327 or visit our website ExcellusBCBS.com for information and any required form(s). Eligibility Requirements are outlined in the Member Contract.

**We are required to ask for your social security number in order to meet our reporting obligations under the Affordable Care Act.

Section 9: This section is to be completed by the Third Party Administrator who may be assisting you with your enrollment process. A third party administrator can be an authorized agent or broker and to the extent permitted by the Federal and State law and regulation, any other third party assistors. If you are not working with a Third Party Administrator, you can disregard this section.

Section 10
Subscriber signature and date are required in this section.