

Group Member Life & Dental Enrollment Application

Dental / Life / AD&D / Disability



**Florida
Combined Life**

An Independent Licensee of the
Blue Cross and Blue Shield Association

Please write clearly in black or blue ink

Section A: Employer Provided Information																					
Group Name:			1.	Life Group #:		2.	Dental Group #		3.	Division #:	4.										
Coverage Effective Date:		5.	Date of Hire: mm dd yyyy		6.	Occupation:			7.	Class:	8.										
Work Status:			Paid: <input type="checkbox"/> Hourly <input type="checkbox"/> Salary		10.	Annual Salary:		11.	Hours worked per week:		12.	<input type="checkbox"/> Open Enrollment: (Dental Only)	13.								
<input type="checkbox"/> Actively at Work <input type="checkbox"/> COBRA <input type="checkbox"/> Retired						\$															
Section B: Employee Information (Refer to Section D for Dependent Information)																					
Last Name:			14.	First Name:			15.	M.I.:	16.	Gender:	17.	Date of Birth (DOB):		18.							
										<input type="checkbox"/> M <input type="checkbox"/> F											
Social Security No.:		19.	Address:			20.	Apt.#:	21.	City:		22.	State:	23.	Zip:	24.						
County:		25.	Home Phone #:		26.	Business Phone #:		27.	Marital Status:		28.	Email Address:			29.						
			()			()			<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced												
Section C: Dental Coverage Selection																					
(If yes, select one of the Plans below.)										Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage.			Child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage.			30.					
										Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage.											
Plan Type Requested:		<input type="checkbox"/> BlueDental Choice Plus (PPO) _____		<input type="checkbox"/> BlueDental Choice (PPO) _____		<input type="checkbox"/> BlueDental Choice Copayment (PPO) _____					31.										
		<input type="checkbox"/> BlueDental Care (Prepaid) _____		<input type="checkbox"/> BlueDental Freedom (Indemnity) _____																	
Section D: Employee and Dependent Information																					
Add additional dependents to the back of this form, sign and date it.																					
First Name		Middle Initial		Last Name		32.	Social Security No.		33.	Date of Birth		34.	Relation to You (DP = Domestic Partner)		35.	Gender		36.	BlueDental Care Only Facility ID #		37.
										mm/dd/yyyy									To see a list of dentists in the network visit www.bcbsfl.com		
Employee													<input type="checkbox"/> Spouse or <input type="checkbox"/> DP			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>		
													<input type="checkbox"/> Child or <input type="checkbox"/> DP Child			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>		
													<input type="checkbox"/> Child or <input type="checkbox"/> DP Child			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>		
													<input type="checkbox"/> Child or <input type="checkbox"/> DP Child			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/>		
Section E: Other Dental Insurance Information (This section must be completed for claims processing.)																					
In addition to this policy, do you or your dependents have any other dental insurance under a group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No										If yes, complete below.			38.								
Name of Person:			39.	Group Name & #:			40.	Policy #:			41.										
Insurance Co./Name and Address:										42.											
Section F: Life, AD&D and Disability Coverage Selection																					
(If yes, select coverages below.)										Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage.			Child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage.			43.					
										Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage.											
Coverage Requested:										44.											
<input type="checkbox"/> Basic Term Life \$ _____		<input type="checkbox"/> Supplemental Life \$ _____		<input type="checkbox"/> Supplemental AD&D		<input type="checkbox"/> Small Group Package 10															
<input type="checkbox"/> Accidental Death & Dismemberment (AD&D) \$ _____		<input type="checkbox"/> Short Term Disability (STD)		<input type="checkbox"/> STD Buy-Up		<input type="checkbox"/> Small Group Package 20															
<input type="checkbox"/> Dependent Life \$ _____		<input type="checkbox"/> Long Term Disability (LTD)		<input type="checkbox"/> LTD Buy-Up		<input type="checkbox"/> Small Group Package 35															
Voluntary Coverages: (If spouse Voluntary Life is selected, spouse information must be provided in Section D above.)																					
Life <input type="checkbox"/> Employee \$ _____		<input type="checkbox"/> Spouse \$ _____		<input type="checkbox"/> Child(ren) \$ _____		AD&D <input type="checkbox"/> Employee \$ _____		<input type="checkbox"/> Spouse _____		<input type="checkbox"/> Child(ren) _____											
<input type="checkbox"/> Voluntary Short-Term Disability (VSTD) _____												Have you or your spouse (if applying for coverage) used tobacco products in the past year? You: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No									
<input type="checkbox"/> Voluntary Long-Term Disability (VLTD) _____																					
Group Life Beneficiary Information																					
Add additional beneficiaries to the back of this form, sign and date it.										Total % must = 100%.			45.								
This will revoke any existing beneficiary designation you may have.																					
Primary Beneficiary:				DOB:		Relation to You:		% of Share:													
Primary Beneficiary:				DOB:		Relation to You:		% of Share:													
Secondary (Contingent) Beneficiary:				DOB:		Relation to You:		% of Share:													

Secondary (Contingent) Beneficiary:	DOB:	Relation to You:	% of Share:
Section G: Acceptance of Coverage (Please read before signing)		Section H: Refusal of Any/All Coverage (Please read before signing)	
I wish to apply for any coverage checked YES under Parts C and F on the front of this form. I have read and understand the Acceptance of Coverage on this form. I certify the statements on this application, including any attachment to it, are true and complete to the best of my knowledge and belief. <i>(If you checked NO for any coverage under Parts C or F, sign and date Part H also.)</i>		I do not wish to apply for any coverage checked NO under Parts C and F above. I understand there may be additional requirements if I decide to apply at a later time.	
Signature:	Date	Signature:	Date
FRAUD NOTICE: I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.			

Section I: Acceptance of Coverage Authorization	
<p>I hereby apply for the coverage checked "Yes" on the front of this form. My employer has selected the coverage through Florida Combined Life Insurance Company, Inc. (FCL). I authorize my employer to deduct from my earnings my premium contribution (if any). I understand all of the following: 1. If my coverage is to be issued and continued, I must meet all the group contract's requirements; 2. if my dependents' coverage, if any, is to be issued and continued, my dependents must meet all the group contract's requirements; and (3) if I am not actively at work on my proposed coverage effective date, my effective date for certain coverages may be deferred until the date I return to active work.</p> <p>I understand a dependent cannot be: (1) covered as both a dependent and an employee, including married employees of the same employer, (2) covered under more than one employee, or (3) full-time military.</p> <p>I understand that my employer is not an agent of FCL. I also understand that my employer is responsible for notifying all employees of: 1. all effective dates; 2. all termination dates; 3. any Employee Retirement Income Security Act (ERISA) rights or responsibilities; and 4. all other matters pertaining to coverage under the group contract.</p> <p>If an overpayment is made, I authorize FCL to recover the excess from any person or entity to which payment is made.</p> <p>I acknowledge that, if I apply for FCL dental coverage later, coverage will not be available until the next open enrollment. I also understand if I apply later for coverages, other than dental, I may be required to furnish evidence of insurability.</p> <p>I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I hereby certify that the statements on this application, including any attachment to it, are true and complete to the best of my knowledge and belief. I understand and agree that any misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage.</p> <p>A photocopy of this application shall be as valid as the original. However, the original application is required to evaluate this application. I agree to be bound by the group contract's terms and conditions. I understand that this application is hereby made a part of the group contract. I will attach it to my certificate of coverage, when issued.</p>	

Add additional dependents below. Be sure to include your signature and the date.							
First Name	Middle Initial	Last Name	Social Security No.	Date of Birth mm/dd/yyyy	Relation to You (DP = Domestic Partner)	Gender	BlueDental Care Only Facility ID # Check box if a current patient
					<input type="checkbox"/> Child or <input type="checkbox"/> DP Child	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>
					<input type="checkbox"/> Child or <input type="checkbox"/> DP Child	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>
					<input type="checkbox"/> Child or <input type="checkbox"/> DP Child	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/>

Add additional beneficiaries below. Be sure to include your signature and the date.				Total % must = 100%.
Primary Beneficiary:	DOB:	Relation to You:	% of Share:	
Primary Beneficiary:	DOB:	Relation to You:	% of Share:	
Secondary (Contingent) Beneficiary:	DOB:	Relation to You:	% of Share:	
Secondary (Contingent) Beneficiary:	DOB:	Relation to You:	% of Share:	

Signature

Date