BlueCross BlueShield of North Carolina

DENTAL Blue SELECT[SM]
Application / Change Form

☐ **NEW ENROLLEE (Please Complete A, C, D, E, F)**
☐ **CHANGE REQUEST (For changes, complete Sections A, B and all other applicable sections)**

A. EMPLOYEE INFORMATION

Social Security Number:	Date of Birth:	Sex: ☐ Male ☐ Female

Last Name:	First Name:	MI:	Marital Status: ☐ Single ☐ Married

Mailing Address:	City:	State:	Zip Code:

Date Employed (minimum of 30 hours):	Employee ID Number:	Dental Blue Select ID Number (if applicable):

Home Phone Number: ( )	Work Phone Number: ( )	E-Mail Address:

B. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

Check All That Apply:

☐ Name Change
☐ Open Enrollment
☐ Employee SSN Correction
☐ Add/Remove Dependent
☐ Address/Telephone Number Change
☐ Replace ID Card
☐ Date of Birth Correction
☐ E-Mail Address
☐ Late Enrollee
☐ COBRA
☐ Other: ____________________

Add Dependent(s):

	Date of Occurrence
☐ Marriage	________
☐ Newborn (up to age 1)	________
☐ Adoption	________
☐ Court Order	________
☐ Other	________

Remove Dependent(s):

	Date of Occurrence
☐ Marriage	________
☐ Divorce	________
☐ Student Status	________
☐ Death	________
☐ Obtained full-time employment	________
☐ Obtained other coverage	________
☐ Other ________	________

Reinstate Coverage:

Reason: ____________________

Cancel Coverage:

☐ Not Eligible
Reason: ____________________
date

☐ Subscriber Request
date

☐ Other ____________________
date

C. TO BE COMPLETED BY THE EMPLOYER

Name of Employer:	Dental Blue Select Group No:	Effective Date:	Dept. / Division:

☐ Active Employee (minimum of 30 hours) ☐ Elected Official	☐ COBRA	COBRA Qualifying Event: ☐ Termination of Employment ☐ Divorce ☐ Death of Subscriber ☐ Reduction in Hours ☐ Over Age Dependent

What was the date of the qualifying event?	Date Continuation Started:	Date Continuation Ends:

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D. COVERAGE SELECTION – Complete for BCBSNC Dental Blue Select

Options Selected:

☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child(ren) ☐ Employee and Family

E. PRIOR DENTAL COVERAGE (Dental Blue Select - Enhanced, Only)

If your Employer elected to offer the Dental Blue Select – Enhanced Plan, prior creditable dental coverage may apply towards the dental waiting periods. In order to obtain prior credit, you must attach a prior billing or certificate of prior creditable coverage that includes the names and effective dates of each covered person(s).

F. FAMILY INFORMATION – Complete for anyone taking or dropping Dental Blue Select Coverage

	Name (First, MI, Last Name)	Social Security Number	Date of Birth	Relationship	Sex	Check Status if Child is Over Age 19	Name of Accredited School
☐ Add / ☐ Delete					☐ F ☐ M	☐ Handicapped* ☐ Full-Time Student	
☐ Add / ☐ Delete					☐ F ☐ M	☐ Handicapped* ☐ Full-Time Student	
☐ Add / ☐ Delete					☐ F ☐ M	☐ Handicapped* ☐ Full-Time Student	
☐ Add / ☐ Delete					☐ F ☐ M	☐ Handicapped* ☐ Full-Time Student	
☐ Add / ☐ Delete					☐ F ☐ M	☐ Handicapped* ☐ Full-Time Student	
☐ Add / ☐ Delete					☐ F ☐ M	☐ Handicapped* ☐ Full-Time Student	
☐ Add / ☐ Delete					☐ F ☐ M	☐ Handicapped* ☐ Full-Time Student	

* Physically Handicapped Certificate Form must accompany this application, if applicable. Form is available at www.bcbsnc.com.

G. EMPLOYEE AUTHORIZATION

I understand that the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina contract and any changes provided for therein. I understand that BCBSNC may within two years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, BCBSNC may take legal action at any time.

I certify that all statements made herein are complete and true to the best of my knowledge and my signature authorizes all sections of this application.

______________________________ Signature of Employee

______________________________ Date