BlueCross BlueShield of North Carolina

Dental Blue for Students Insurance Application Form

2009-2010

Please visit our web site at ***bcbsnc.com/student***

PLEASE PRINT CLEARLY.

Section I Student Dental Insurance Application Form

LAST NAME | FIRST NAME | MIDDLE INITIAL

MAILING ADDRESS *(STREET, ROUTE, BOX NUMBER, ETC.)*

BIRTH DATE MONTH | DAY | YEAR

SEX ☐ MALE ☐ FEMALE

CITY | STATE | ZIP

SOCIAL SECURITY NUMBER

STUDENT I.D. NUMBER *(Required)*
P.I.D. NUMBER *(Optional, if applicable)*

EMAIL ADDRESS

AREA CODE | **TELEPHONE NUMBER**

NAME OF UNIVERSITY

Section II Application for Dependents' Coverage*

I also hereby apply for the following members of my family:

SPOUSE

SEX ☐ MALE ☐ FEMALE

LAST NAME | FIRST NAME | MIDDLE INITIAL | **BIRTHDATE** MONTH | DAY | YEAR

SOCIAL SECURITY NUMBER

CHILD 1

SEX ☐ MALE ☐ FEMALE

LAST NAME | FIRST NAME | MIDDLE INITIAL | **BIRTHDATE** MONTH | DAY | YEAR

SOCIAL SECURITY NUMBER

CHILD 2

SEX ☐ MALE ☐ FEMALE

LAST NAME | FIRST NAME | MIDDLE INITIAL | **BIRTHDATE** MONTH | DAY | YEAR

SOCIAL SECURITY NUMBER

CHILD 3

SEX ☐ MALE ☐ FEMALE

LAST NAME | FIRST NAME | MIDDLE INITIAL | **BIRTHDATE** MONTH | DAY | YEAR

SOCIAL SECURITY NUMBER

DEPENDENTS INCLUDE SPOUSE AND UNMARRIED DEPENDENT CHILDREN FROM BIRTH TO THE 26TH BIRTHDAY

C295, 4/09

Section III Premium Rate Selection

Please check one. Payment may only be made on a semi-annual basis. The first semi-annual payment is due with enrollment and provides coverage from September 1, 2009 to February 28, 2010. The second semi-annual payment will be due by February 28, 2010 and provides coverage from March 1, 2010 to August 31, 2010.

	First Payment Due With Enrollment	Second Payment Due February 28, 2010
☐ Student	$ 156.00	$ 156.00
☐ Student and Spouse	$ 312.00	$ 312.00
☐ Student and Child/Children	$ 294.00	$ 294.00
☐ Student, Spouse and Child/Children	$ 522.00	$ 522.00

My check for $ _____ is enclosed.
Make check payable to Blue Cross and Blue Shield of North Carolina.

Section IV Statement of Understanding

I understand that by signing below, I am agreeing to the following:

I certify that all statements on this application are complete and true. ***I understand that for a period of two years from the date coverage is issued, Blue Cross and Blue Shield of North Carolina (BCBSNC) may void or terminate my 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 understand that any coverage provided according to this application will be subject to the provisions of the contract, including the benefit booklet provided to me by BCBSNC.

I understand that to maintain dental coverage the semi-annual premium amount will be submitted with this application and that I must proactively reenroll each year. I understand that no refunds will be given.

DATE MONTH | DAY | YEAR

SIGNATURE

Mailing Address: Blue Cross and Blue Shield of North Carolina, PO Box 9565 Chapel Hill, NC 27515-9565
Questions? Call Student Blue at 800-579-8022 or email@studentbluenc.com

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