BlueCross BlueShield of North Carolina

Please Mail This Form To:
DBS, P.O. Box 2400, Winston-Salem, NC 27102
Visit us at **BlueCrossNC.com**

DentalBlue Select℠
Application / Change Form

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

A. EMPLOYEE INFORMATION

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

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

Mailing Address:	City:	State:	Zip Code:

Date of Full Time Employment:	Employee ID Number:	Dental Blue Select ID Number (if applicable):

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

By sharing your phone number, you agree to calls or text from Blue Cross NC or its partners. Calls could include prerecorded, or robot voiced calls.

B. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

Check All That Apply:

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

Add Dependent(s):

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

Remove Dependent(s):

☐ Divorce — Date of Occurrence
☐ Death — Date of Occurrence
☐ Obtained full-time employment — Date of Occurrence
☐ Obtained other coverage — Date of Occurrence
☐ Other _____ — Date of Occurrence

Reinstate Coverage:

Reason: _____

Cancel Coverage:

☐ Not Eligible Reason: _____ Date
☐ Subscriber Request Reason: _____ Date
☐ Other _____ Date

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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:

D. COVERAGE SELECTION

Options Selected:
☐ Employee Only ☐ Employee and Child(ren) ☐ Employee and Spouse / Domestic Partner ☐ Employee and Family

Plan Option Selected:
☐ Standard Plan ☐ Complete Plan ☐ Complete Plan with Orthodontia ☐ Enhanced Plan ☐ Enhanced Plan with Orthodontia

Benefit Period Maximum Amount Selected:
☐ $1,000 ☐ $1,500 (available on all plans except Standard Plan)

E. PRIOR DENTAL COVERAGE – (Enhanced and Complete Only)

If your Employer elected to offer the Dental Blue Select – Enhanced or Complete Plan, prior creditable dental coverage may apply towards the dental waiting periods. Prior dental coverage will not count as creditable coverage towards waiting periods on the Standard plan. If you did not have prior coverage, or you and your dependents do not apply as a timely enrollee, you are considered a late enrollee and may be subject to up to a 24 month WAITING PERIOD. WAITING PERIODS are waived, or reduced by the number of months of prior coverage. However, WAITING PERIODS will not be waived or reduced if more than 63 days have passed between the termination of the prior coverage and your enrollment date of this coverage.

Letter of Prior Creditable Coverage Attached? ☐ **Yes** ☐ **No**

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

	Name (First, Middle Initial, Last, Suffix)	Social Security Number	Birthdate (mm/dd/yyyy)	Gender	Child Status (please check if applicable)
☐ Add ☐ Delete	☐ Spouse ☐ Domestic Partner			☐ F ☐ M	N/A
☐ Add ☐ Delete	Child 1			☐ F ☐ M	☐ Intellectually or physically disabled
☐ Add ☐ Delete	Child 2			☐ F ☐ M	☐ Intellectually or physically disabled
☐ Add ☐ Delete	Child 3			☐ F ☐ M	☐ Intellectually or physically disabled
☐ Add ☐ Delete	Child 4			☐ F ☐ M	☐ Intellectually or physically disabled
☐ Add ☐ Delete	Child 5			☐ F ☐ M	☐ Intellectually or physically disabled
☐ Add ☐ Delete	Child 6			☐ F ☐ M	☐ Intellectually or physically disabled

☐ Additional Dependent form attached.
Dependent children include foster, adopted or a child placed by court or administrative order.

* Application does not guarantee enrollment.
** If you have more than six children, complete an Additional Dependent form.

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G. EMPLOYEE AUTHORIZATION

I understand the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina (Blue Cross NC) contract (including the benefit booklet) and changes provided for therein. I certify that all statements made herein and on all sections of this application are complete and true to the best of my knowledge. I understand that Blue Cross NC may, within two years of the date of this application, rescind my policy for any of my acts or practices that constitute fraud or if I make an intentional misrepresentation of material fact. If fraudulent misstatements were made, Blue Cross NC may take legal action at any time.

Signature of Employee

Date

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact the Customer Service number on the back of your ID card for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Comuníquese con el número para servicio al cliente que aparece en el everso de su tarjeta del seguro para obtener ayuda.