

Please Mail This Form To:
 DBS, P.O. Box 2400, Winston-Salem, NC 27102

Dental **Blue 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:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Last Name:		First Name:		MI:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> 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: <input type="checkbox"/> Name Change <input type="checkbox"/> Employee SSN Correction <input type="checkbox"/> Add/Remove Dependent <input type="checkbox"/> Address/Telephone Number Change <input type="checkbox"/> Replace ID Card <input type="checkbox"/> Date of Birth Correction <input type="checkbox"/> E-Mail Address <input type="checkbox"/> Late Enrollee <input type="checkbox"/> COBRA <input type="checkbox"/> Other: _____ _____ _____ _____	Add Dependent(s): <input type="checkbox"/> Marriage _____ <input type="checkbox"/> Newborn (up to age 1) _____ <input type="checkbox"/> Adoption _____ <input type="checkbox"/> Court Order _____ <input type="checkbox"/> Other _____ _____	Date of Occurrence _____ _____ _____ _____	Reinstate Coverage: Reason: _____ _____ _____
	Remove Dependent(s): <input type="checkbox"/> Divorce _____ <input type="checkbox"/> Death _____ <input type="checkbox"/> Obtained full-time employment _____ <input type="checkbox"/> Obtained other coverage _____ <input type="checkbox"/> Other _____ _____	Date of Occurrence _____ _____ _____ _____	Cancel Coverage: <input type="checkbox"/> Not Eligible Reason: _____ _____ _____ date <input type="checkbox"/> Subscriber Request _____ date <input type="checkbox"/> Other _____ _____ date

C. TO BE COMPLETED BY THE EMPLOYER

Name of Employer:		Dental Blue Select Group No:	Effective Date:	Dept. / Division:
<input type="checkbox"/> Active Employee (minimum of 30 hours) <input type="checkbox"/> Elected Official	<input type="checkbox"/> COBRA	COBRA Qualifying Event: <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Divorce <input type="checkbox"/> Death of Subscriber <input type="checkbox"/> Reduction in Hours <input type="checkbox"/> 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 Child(ren)

Employee/Spouse/Domestic Partner Employee/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 Dental Blue Select - (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. 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, Middle Initial, Last, Suffix)	Social Security Number	Birthdate mm/dd/yyyy	Sex	Child Status (please check if applicable for any dependent under the age 26)
<input type="checkbox"/> Add / <input type="checkbox"/> Delete	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped**
<input type="checkbox"/> Add / <input type="checkbox"/> Delete	Child 1			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped**
<input type="checkbox"/> Add / <input type="checkbox"/> Delete	Child 2			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped**
<input type="checkbox"/> Add / <input type="checkbox"/> Delete	Child 3			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped**
<input type="checkbox"/> Add / <input type="checkbox"/> Delete	Child 4			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped**
<input type="checkbox"/> Add / <input type="checkbox"/> Delete	Child 5			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped**
<input type="checkbox"/> Add / <input type="checkbox"/> Delete	Child 6***			<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Foster <input type="checkbox"/> Adopted <input type="checkbox"/> Handicapped**

**Additional
Dependent form
attached.**

* Application does not guarantee enrollment.

** A request for coverage (form P24) is required if your child is 26 years or older and will be reviewed to determine eligibility. Physically Handicapped Certificate Form must accompany this application, if applicable. Form is available at www.bcbsnc-dental.com.

*** If you have more than six children, complete an Additional Dependent form.

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 (BCBSNC) 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 BCBSNC 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, BCBSNC may take legal action at any time.

Signature of Employee

Date