Application

FOR DENTAL COVERAGE

Blue Cross and Blue Shield of Alabama
Attention: Payment Processing Department
P.O. Box 11551
Birmingham, Alabama 35282-9722

Blue Cross and Blue Shield of Alabama

New Applicants: 1-855-204-4729 (TTY: 711)
Existing Contract Holders: 1-855-880-6350

Dental **Blue®** **Premier**

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

ENR28-1909

BlueCross BlueShield of Alabama

APPLICATION FOR DENTAL COVERAGE

Please complete all items on this application by firmly printing uppercase letters in dark ink. Any information missing may delay processing your application. To be eligible for this coverage, the applicant must be a resident of the state of Alabama and at least 19 years of age. The presence of an asterisk (*) indicates a required field.

Existing Blue Cross and Blue Shield of Alabama Contract Number

CONTRACT TYPE: Select the type of coverage needed: ☐ **SELF - ONLY** ☐ **SELF + ONE** ☐ **FAMILY**

APPLICANT INFORMATION

☐ **DR.** ☐ **MR.** ☐ **MRS.** ☐ **MS.** ☐ **REV.** *REQUIRED FIELDS

*LAST NAME | *FIRST NAME

MAIDEN/MIDDLE NAME | SUFFIX (Jr, Sr, III, IV) | *SOCIAL SECURITY NUMBER

*PHYSICAL/RESIDENTIAL ADDRESS (Where you live - PO Boxes are not allowed)

*CITY | *STATE | *ZIP

*COUNTY | *DATE OF BIRTH (MM/DD/YYYY) | *GENDER ☐ MALE ☐ FEMALE

*PRIMARY TELEPHONE NUMBER ☐ HOME ☐ WORK ☐ CELL | ALTERNATE TELEPHONE NUMBER ☐ HOME ☐ WORK ☐ CELL

Please tell us the best time to contact you: ☐ MORNING ☐ AFTERNOON ☐ EVENING

*BILLING ADDRESS (Where you receive the bill, if different from Physical Address)

*CITY | *STATE | *ZIP

*E-MAIL ADDRESS

DEPENDENT INFORMATION

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBERS.

NOTE: The Social Security number for the applicant and all dependents must be provided in order for this application to be processed. By signing this application, you certify that all dependents are eligible for coverage under the terms of the Plan for which you are applying.

DEPENDENT

*RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ STEPCHILD ☐ ADOPTED CHILD ☐ FOSTER CHILD ☐ GRANDCHILD

*LAST NAME

*FIRST NAME | MAIDEN/MIDDLE NAME

SUFFIX (Jr, Sr, III, IV) | *SOCIAL SECURITY NUMBER | *GENDER (Check One) ☐ MALE ☐ FEMALE | *DATE OF BIRTH (MM/DD/YYYY)

DEPENDENT

*RELATIONSHIP ☐ SPOUSE ☐ CHILD ☐ STEPCHILD ☐ ADOPTED CHILD ☐ FOSTER CHILD ☐ GRANDCHILD

*LAST NAME

*FIRST NAME | MAIDEN/MIDDLE NAME

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***LAST NAME**

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SUFFIX (Jr, Sr, III, IV) | ***SOCIAL SECURITY NUMBER** ___ - ___ - ___ | ***GENDER** (Check One) ☐ MALE ☐ FEMALE | ***DATE OF BIRTH** (MM/DD/YYYY) ___ / ___ / ___

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SUFFIX (Jr, Sr, III, IV) | ***SOCIAL SECURITY NUMBER** ___ - ___ - ___ | ***GENDER** (Check One) ☐ MALE ☐ FEMALE | ***DATE OF BIRTH** (MM/DD/YYYY) ___ / ___ / ___

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***LAST NAME**

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SUFFIX (Jr, Sr, III, IV) | ***SOCIAL SECURITY NUMBER** ___ - ___ - ___ | ***GENDER** (Check One) ☐ MALE ☐ FEMALE | ***DATE OF BIRTH** (MM/DD/YYYY) ___ / ___ / ___

ELIGIBILITY: COORDINATION OF BENEFITS

For coordination of benefits purposes, will any person to be insured be covered under another dental plan or policy ***at the time this policy becomes effective?***
If yes, please provide the information below. Use additional paper if necessary.

NAME OF CONTRACT HOLDER/DEPENDENT

NAME OF INSURANCE COMPANY

EFFECTIVE DATE OF OTHER COVERAGE ___ / ___ / ___ | **POLICY, ID, CONTRACT OR CERTIFICATE NUMBER**

GROUP NUMBER | **TYPE COVERAGE:** ☐ SELF-ONLY ☐ SELF + ONE ☐ FAMILY

PAYMENT & BILLING

We will accept your premium payments only if they are made from your personal **(non-business)** account. Premiums are payable in advance on a monthly basis.

PREMIUM – I agree to pay you in advance the monthly premium in the amount due before the 1st day of the coverage effective date.

Please select either an Automatic Payment Method OR a Billing Method. **Failure to select either an Automatic Payment Method or a Billing Method will delay the processing of your application.**

BILLING METHOD Select **ONE** billing method.

☐ **E-Statement**

You will receive an email notification each month when your billing statement is available. Email address is required.

☐ **Billing Statement**

You will receive a billing statement each month which includes an invoice to return with your premium payment. Courtesy notification will be sent to your email.

AUTOMATIC PAYMENT METHOD*

☐ **E-Check**

Once you have your contract number, you can set up automatic payments with a debit or credit card online at *my*BlueCross or by calling the number on the back of your member ID card.

* *Please complete the included Payment Authorization Agreement and submit it along with this application. If approved, your payment will be charged monthly to your account. It may take up to 30 days to implement automatic payment. You will receive a bill for your premiums until your payment method is established. Courtesy notification will be sent to your email.*

To ensure your e-check is processed, please mail a blank voided check to:

Blue Cross and Blue Shield of Alabama
Attention: Payment Processing Department
P.O. Box 11551
Birmingham, Alabama 35282-9722

PREFERRED EFFECTIVE MONTH MONTH YOU WOULD LIKE TO START

M M Y Y Y Y

Please note that if your preferred effective month is not available for any reason, your contract will be effective on the next available month based on applicable guidelines.

BINDING ARBITRATION NOTICE

THE CONTRACT YOU ARE APPLYING FOR INCLUDES FINAL AND BINDING ARBITRATION. THIS MEANS ANY DISAGREEMENT NOT SETTLED BY THE EXTERNAL REVIEW PROCESS DESCRIBED IN THE DENTAL PLAN BOOKLET WILL BE SETTLED BY ARBITRATION—NOT A COURT. THE ARBITRATOR'S DECISION IS BINDING. AN ARBITRATOR IS AN INDEPENDENT, NEUTRAL PARTY WHO MAKES A DECISION AFTER LISTENING TO BOTH PARTIES. THE DECISION OF THE ARBITRATOR CANNOT BE REVIEWED BY A COURT, EXCEPT IN CERTAIN CIRCUMSTANCES AS DESCRIBED IN THE CONTRACT. THE ARBITRATOR ACTS AS JUDGE AND JURY. BY SIGNING BELOW YOU AGREE TO SETTLE ANY DISAGREEMENT BY ARBITRATION INSTEAD OF A COURT TRIAL.

AGREEMENT TO ARBITRATE - AFTER READING THIS, I AGREE TO THE ARBITRATION PROVISIONS IN THE CONTRACT.

I acknowledge by my signature that I have read and understand the front and back of this application, that all statements made by me are true and complete, and that I agree to **binding arbitration** with respect to the dental plan as described in this application and my Blue Cross and Blue Shield of Alabama dental plan contract booklet.

THIS APPLICATION IS NOT COMPLETE UNLESS IT IS SIGNED AND DATED.

CONTRACT HOLDER'S SIGNATURE

DATE SIGNED

REPRESENTATIVE CODE 1: *(For Office Use Only)*					

REPRESENTATIVE CODE 2: *(For Office Use Only)*					

NOTICE OF EXCLUSIONS AND OTHER LIMITATIONS

For the first 365 days you are covered under this plan there are no plan benefits for Orthodontic Services. The entire 365-day benefit exclusion period must be served before any benefits for Orthodontic Services are available under the plan. No credit will be given for any time served under any Orthodontic Services benefit exclusion period under any prior plan.

TIMELY PAYMENT OF PREMIUMS

Initial Payment of Premiums For Annual Open Enrollment Period
Your initial payment of premiums during the annual open enrollment period must be made no later than your scheduled effective date of coverage. If we do not receive your initial payment of premiums on time, your scheduled effective date of coverage under the plan will be canceled and you will have no coverage under the plan.

Initial Payment of Premiums For Special Open Enrollment Period
In most cases, your initial payment of premiums during a special open enrollment period must be made no later than your scheduled effective date of coverage. In some cases (such as retroactive coverage in the case of birth and other circumstances), your initial payment of premiums during these special open enrollment periods must be made no later than 30 days from the date of your premium statement date. If we do not receive your initial payment of premiums on time, your scheduled effective date of coverage under the plan will be canceled and you will have no coverage under the plan.

Subsequent Monthly Payment of Premiums
After you make your initial payment for plan coverage, you must make timely periodic payments for each subsequent month.

Each of your monthly periodic payments is due on the 1st day of the month for that monthly coverage period. There is a grace period of 30 days for all monthly premium payments after the initial premium payment. If you fail to pay in full a monthly payment before the end of the grace period for that coverage period, your coverage under the plan will be canceled as of the last day of the month before that monthly coverage period. Failure to timely pay premium payments is not a special open enrollment event for later coverage under the plan.

BEGINNING OF COVERAGE

Your Initial Enrollment
If we accept your application, you will receive an identification card. Your coverage begins on the effective date shown on your identification card provided that you timely pay your initial premiums before your scheduled effective date of coverage. If you fail to timely pay your initial premiums in full, your coverage will be canceled as of the effective date.

No Annual Open Enrollment Period for Dependents
There is no open enrollment period under the plan for adding a spouse or dependent to your plan. You may, however, add a spouse or dependent to your plan under limited circumstances described below. In addition, if you are covering yourself under the plan, you will first have to convert your coverage to family coverage and pay any additional premiums.

Special Enrollment Period for Dependents Losing Other Coverage
A dependent (1) who does not enroll during your initial enrollment because the eligible dependent has other coverage, (2) whose other coverage was either COBRA coverage that was exhausted or other dental coverage which ended due to "loss of eligibility" (as described below), and (3) who requests enrollment within 60 days of the exhaustion or termination of coverage, may enroll in the plan. Coverage will be effective no later than the first day of the first month beginning after the date the request for special enrollment is received (assuming you timely pay your premiums in full).

Loss of eligibility with respect to a special enrollment period includes loss of coverage as a result of legal separation, divorce, cessation of dependent status, cessation of pediatric dental coverage, death, termination of employment, reduction in the number of hours of employment, failure of your employer to offer dental coverage to you and any loss of eligibility that is measured by reference to any of these events, but does not include loss of coverage due to failure to timely pay premiums or termination of coverage for fraud or intentional misrepresentation of a material fact.

An eligible individual or dependent whose other coverage has a non-calendar year plan year or policy year may also enroll in the plan at the end of the other coverage's plan year if coverage is requested within 60 days of the end of the other coverage's plan year. Coverage will be effective no later than the first day of the first calendar month beginning after the date the request for special enrollment is received.

Special Enrollment Period for Newly Acquired Dependents
If you have a new dependent as a result of birth, placement for adoption, adoption, or placement as an eligible foster child, you may enroll your spouse and your new dependent as special enrollees provided that you request enrollment within 60 days of the event. The effective date of coverage will be the date of birth, placement for adoption, adoption, or placement as an eligible foster child, (assuming you timely pay your premiums in full).

If you have a new dependent as a result of marriage, you may enroll your spouse and your new dependent as special enrollees provided that you request enrollment within 60 days of the event. In the case of a dependent acquired through marriage, the effective date will be no later than the first day of the first month beginning after the date the request for special enrollment is received (assuming you timely pay your premiums in full).

If you are required to provide dental coverage to a dependent through a qualified medical child support order or other court order, you may enroll this dependent as a special enrollee provided that you request enrollment within 60 days of the date of the court order. The effective date of coverage will be the date of the court order (assuming you timely pay your premiums in full).

CONDITIONS OF ENROLLMENT

I understand that I have the right to return the dental plan contract to you during the first thirty days of coverage if I am not satisfied for any reason. If I do this, you will refund any fees that I have paid with respect to the dental contract and retroactively revoke any benefit payments that you have made under the plan.

I understand that by giving 30 days written notice to me, Blue Cross and Blue Shield of Alabama (Blue Cross) may change the premiums or any specified provisions of the contract. If I pay any premium after notice to me of the change in the premiums or the contract, I accept the new premiums or changes in the contract. Notwithstanding the foregoing, if Blue Cross and Blue Shield of Alabama changes the plan benefits other than in connection with a renewal and that change is a material reduction in benefits that cause a change in the Summary of Benefits and Coverage for the plan, Blue Cross and Blue Shield of Alabama will give you 60 days prior written notice of the change. Finally, Blue Cross and Blue Shield of Alabama may not establish an index rate and make the market-wide or plan-level adjustments more or less frequently than annually.

I apply for coverage under your Blue Cross dental plan with such terms and conditions as Blue Cross now issues. I understand that the plan will not be effective until you accept this application. If you accept this application, you will send me the plan booklet along with an identification card showing the date my plan coverage begins.

This application, the Blue Cross dental plan booklet and changes to the plan, along with any supplemental applications, make up my entire contract with you. The contract can be changed by my submission of another application, which you accept, or by an amendment, rider or other written change to the plan contract signed by an officer of Blue Cross.

I understand and agree that all information I give in this application is true and complete. I understand that you are relying on its truth and completeness when you accept it and issue a contract to me. Any intentional misrepresentation of a material fact by me will make the contract invalid from the beginning of its coverage. Any intentional material misrepresentation will be fraud and prosecuted by Blue Cross under all laws, state or federal, civil or criminal, to the fullest extent provided by such laws. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

If my application is not accepted for any reason, I understand I will receive a letter of rejection. If accepted, you will send me a bill and I must pay according to the effective/due date of my contract. If the application is accepted but is not paid, the contract will be canceled as null and void.

I understand that applying for this coverage does not cancel existing contracts. If I wish to cancel my current coverage with Blue Cross and Blue Shield of Alabama, I will contact the customer service number on the back of my ID card.

BLUE CROSS AND BLUE SHIELD ASSOCIATION

Applicant on behalf of itself and its members hereby expressly acknowledges its understanding that this agreement constitutes a contract solely between Applicant and Blue Cross and Blue Shield of Alabama, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the “Association”) permitting Blue Cross and Blue Shield of Alabama to use the Blue Cross and Blue Shield Service Marks in the State of Alabama, and that Blue Cross and Blue Shield of Alabama is not contracting as the agent of the Association. Applicant on behalf of itself and its members further acknowledges and agrees that it has not entered into this agreement based upon representations by any person other than Blue Cross and Blue Shield of Alabama and that no person, entity, or organization other than Blue Cross and Blue Shield of Alabama shall be held accountable or liable to Applicant for any of Blue Cross and Blue Shield of Alabama’s obligations to Applicant created under this agreement. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Alabama other than those obligations created under other provisions of this agreement.

FOREIGN LANGUAGE ASSISTANCE

If you, or someone you are helping, has questions about this application for dental coverage from Blue Cross and Blue Shield of Alabama, you have the right to get some help and information in your language at no cost. To talk to an interpreter, please see MKT-215 Foreign Language Assistance document included with your application.