blue of california

Dental Only Employee Application (No Medical)

Do not write in Shaded area

☐ New enrollment ☐ Re-hire ☐ Add family member to existing coverage	Group number	Plan type	Effective date

Please provide the following

Applicants Social Security number	Group name		
First name	M.I.	Last name	
Date of hire	Requested effective date	Date of birth	

Choose dental plan (check one box only)

☐ Dental PPO	☐ Dental HMO	If you are applying for the Dental HMO, you must choose a dental provider from the Blue Shield Dental Provider Directory (also available online at blueshieldca.com). The dental provider you choose will provide and arrange dental care for you and all covered dependents.	
Married/domestic partner ☐ Yes ☐ No		Applicant's business phone number	Applicant's home phone number
E-mail address			Language preference
Residential address		City	State ZIP
Mailing address (if different from above)		City	State ZIP

List applicant and all family members you wish to cover

(dependent children must be over 18, and less than 25, if full-time students)

1	☐ Male ☐ Female	Your first name	M.I.	Last name
	Dental HMO only: Dental provider number			Dental HMO only: Dental provider name
2	First name		M.I.	Last name
	☐ Husband ☐ Wife ☐ Domestic partner		Date of birth	Social Security number
	Dental HMO only: Dental provider number			Dental HMO only: Dental provider name
3	First name		M.I.	Last name
	☐ Son ☐ Daughter		Date of birth	Social Security number
	Dental HMO only: Dental provider number			Dental HMO only: Dental provider name
4	First name		M.I.	Last name
	☐ Son ☐ Daughter		Date of birth	Social Security number
	Dental HMO only: Dental provider number			Dental HMO only: Dental provider name

(see reverse)

5	First name		M.I.	Last name	
	☐ Son ☐ Daughter		Date of birth		Social Security number
	Dental HMO only: Dental provider number			Denatl HMO only: Dental provider name	
6	For certification, students must be over 18, and less than 25. I certify that my dependent listed below is currently enrolled as a full-time student: If you have more than one dependent over age 18 who is a full-time student, please attach an additional sheet with the required information and check here. ☐				
	Name	Hours/week	Units	School	Address

Disclosure statements (please read these conditions of membership and authorization and sign below)

1. To find Blue Shield dental provider by name, location and specialty, go to our Web site: **blueshieldca.com**. You can use the Web site to print out a listing of Blue Shield providers in your area. This directory is for information purposes only and is not to be considered a total representation of Blue Shield's Dental Provider Network.
2. **Parent or Legal Guardian** (if the applicant is a minor): I will assume all responsibility for dues payments and for managing the provision of benefits under the plan applied for by my child. Individuals authorized to make changes to my minor child's contract include:
   A. Parent or Legal Guardian only or,
   B. My designee _____ (include relationship), or
   C. Qualified Medical Child Support Order designee _____ (include relationship).
   I further request that all changes to this contract be made only upon Blue Shield's receipt of such written request.
   Please indicate only one: ☐ A ☐ B or ☐ C (court documents must be attached authorizing guardianship if the responsible adult is not the parent)
3. **Applicants with a spouse/domestic partner:** If you are applying for coverage and your coverage is approved, please specify whether or not you authorize your spouse/domestic partner, if also covered, to make inquiries or changes on your behalf to your contract. ☐ Yes ☐ No
   This authorization may be discontinued at any time upon Blue Shield's receipt of such written request.

Authorization (the following authorization section is to be signed by all employees applying for coverage)

I agree: All information on this form is correct and true. I understand that it is the basis on which coverage may be issued under the plan. I understand that if I have misrepresented or omitted any material fact that my coverage may be cancelled or my employer's contract rescinded. I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California.

Authorization for Disclosure of Personal Information – I authorize any "provider of care," insurer, or health plan to disclose to Blue Shield of California, or their representatives, all "medical information" (as those terms are defined in the California Civil Code), including any medical information regarding substance abuse, or mental or emotional conditions, regarding me, my spouse/domestic partner, or my children. This medical information is collected for the purpose of evaluating my employer's application, determining claims for benefits, or for quality assurance and peer review. This authorization will remain valid for the term of the coverage of the Blue Shield health service contract. A photocopy of this authorization is as valid as the original. My authorized representative or I am entitled to receive a copy of this authorization.

I, the applicant, acknowledge that I have read and understood this Application in its entirety.

Signature of employee _____ Date _____