# Group Member Life & Dental Enrollment Application

Dental / Life / AD&D / Disability

Florida Combined Life

An Independent Licensee of the Blue Cross and Blue Shield Association

Please write clearly in black or blue ink

**Section A: Employer Provided Information**

| Group Name: 1. | Life Group #: 2. | Dental Group # 3. | Division #: 4. |
|---|---|---|---|
| Coverage Effective Date: 5. | Date of Hire: mm dd yyyy 6. | Occupation: 7. | Class: 8. |
| Work Status: 9. ☐ Actively at Work ☐ COBRA ☐ Retired | Paid: ☐ Hourly ☐ Salary 10. | Annual Salary: $ 11. | Hours worked per week: 12. |
| ☐ Open Enrollment: *(Dental Only)* 13. | | | |

**Section B: Employee Information** *(Refer to Section D for Dependent Information)*

| Last Name: 14. | First Name: 15. | M.I.: 16. | Gender: ☐M ☐F 17. | Date of Birth (DOB): 18. |
|---|---|---|---|---|
| Social Security No.: 19. | Address: 20. | Apt.#: 21. | City: 22. | State: 23. Zip: 24. |
| County: 25. | Home Phone #: ( ) 26. | Business Phone #: ( ) 27. | Marital Status: ☐ Single ☐ Married ☐ Divorced 28. | Email Address: 29. |

**Section C: Dental Coverage Selection**

*(If yes, select one of the Plans below.)* Employee: ☐ Yes ☐ No, I decline Coverage. Child(ren): ☐ Yes ☐ No, I decline Coverage. 30.
Spouse: ☐ Yes ☐ No, I decline Coverage.

**Plan Type Requested:** ☒ BlueDental Choice Plus (PPO) ____ ☐ BlueDental Choice (PPO) ____ ☐ BlueDental Choice Copayment (PPO) ____ 31.
☐ BlueDental Care (Prepaid) ____ ☐ BlueDental Freedom (Indemnity) ____

**Section D: Employee and Dependent Information** Add additional dependents to the back of this form, sign and date it.

| First Name / Middle Initial / Last Name 32. | Social Security No. 33. | Date of Birth 34. | Relation to You (DP = Domestic Partner) 35. | Gender 36. | BlueDental Care Only Facility ID # To see a list of dentists in the network visit www.bcbsfl.com Check box if a current patient 37. |
|---|---|---|---|---|---|
| Employee | | | | | ☐ |
| | | | ☐ Spouse or ☐ DP | ☐ M ☐ F | ☐ |
| | | | ☐ Child or ☐ DP Child | ☐ M ☐ F | ☐ |
| | | | ☐ Child or ☐ DP Child | ☐ M ☐ F | ☐ |
| | | | ☐ Child or ☐ DP Child | ☐ M ☐ F | ☐ |

**Section E: Other Dental Insurance Information** (This section must be completed for claims processing.)

In addition to this policy, do you or your dependents have any other dental insurance under a group plan? ☐Yes ☐ No If yes, complete below. 38.

| Name of Person: 39. | Group Name & #: 40. | Policy #: 41. |
|---|---|---|
| Insurance Co./Name and Address: 42. | | |

**Section F: Life, AD&D and Disability Coverage Selection**

*(If yes, select coverages below.)* Employee: ☐ Yes ☐ No, I decline Coverage. Child(ren): ☐ Yes ☐ No, I decline Coverage. 43.
Spouse: ☐ Yes ☐ No, I decline Coverage.

**Coverage Requested:** 44.

☐ Basic Term Life $_____ ☐ Supplemental Life $_____ ☐Supplemental AD&D ☐ Small Group Package 10
☐ Accidental Death & Dismemberment (AD&D) $_____ ☐ Short Term Disability (STD) ☐ STD Buy-Up ☐ Small Group Package 20
☐ Dependent Life $_____ ☐ Long Term Disability (LTD) ☐ LTD Buy-Up ☐ Small Group Package 35

**Voluntary Coverages:** (If spouse Voluntary Life is selected, spouse information must be provided in Section D above.)

Life ☐ Employee $_____ ☐ Spouse $_____ ☐ Child(ren) $_____ AD&D ☐ Employee $_____ ☐ Spouse_____ ☐ Child(ren)_____
☐ Voluntary Short-Term Disability (VSTD) _____
☐ Voluntary Long-Term Disability (VLTD) _____
Have you or your spouse (if applying for coverage) used tobacco products in the past year? You: ☐Yes ☐No Spouse: ☐Yes ☐No

**Group Life Beneficiary Information** Add additional beneficiaries to the back of this form, sign and date it. 45.
This will revoke any existing beneficiary designation you may have. **Total % must = 100%.**

| | | | |
|---|---|---|---|
| Primary Beneficiary: | DOB: | Relation to You: | % of Share: |
| Primary Beneficiary: | DOB: | Relation to You: | % of Share: |
| Secondary (Contingent) Beneficiary: | DOB: | Relation to You: | % of Share: |
| Secondary (Contingent) Beneficiary: | DOB: | Relation to You: | % of Share: |

| Section G: Acceptance of Coverage (Please read before signing) | Section H: Refusal of Any/All Coverage (Please read before signing) |
|---|---|
| I wish to apply for any coverage checked **YES** under Parts C and F on the front of this form. I have read and understand the Acceptance of Coverage on this form. I certify the statements on this application, including any attachment to it, are true and complete to the best of my knowledge and belief. *(If you checked NO for any coverage under Parts C or F, sign and date Part H also.)* 46. | I do not wish to apply for any coverage checked **NO** under Parts C and F above. I understand there may be additional requirements if I decide to apply at a later time. 47. |
| Signature: Date | Signature: Date |

**FRAUD NOTICE: I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

## Section I: Acceptance of Coverage Authorization

I hereby apply for the coverage checked "Yes" on the front of this form. My employer has selected the coverage through Florida Combined Life Insurance Company, Inc. (FCL). I authorize my employer to deduct from my earnings my premium contribution (if any). I understand all of the following: 1. If my coverage is to be issued and continued, I must meet all the group contract's requirements; 2. if my dependents' coverage, if any, is to be issued and continued, my dependents must meet all the group contract's requirements; and (3) if I am not actively at work on my proposed coverage effective date, my effective date for certain coverages **may** be deferred until the date I return to active work.

I understand a dependent cannot be: (1) covered as both a dependent and an employee, including married employees of the same employer, (2) covered under more than one employee, or (3) full-time military.

I understand that my employer is not an agent of FCL. I also understand that my employer is responsible for notifying all employees of: 1. all effective dates; 2. all termination dates; 3. any Employee Retirement Income Security Act (ERISA) rights or responsibilities; and 4. all other matters pertaining to coverage under the group contract.

If an overpayment is made, I authorize FCL to recover the excess from any person or entity to which payment is made.

I acknowledge that, if I apply for FCL dental coverage later, coverage will not be available until the next open enrollment. I also understand if I apply later for coverages, other than dental, I **may** be required to furnish evidence of insurability.

I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I hereby certify that the statements on this application, including any attachment to it, are true and complete to the best of my knowledge and belief. I understand and agree that any misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage.

A photocopy of this application shall be as valid as the original. However, the original application is required to evaluate this application. I agree to be bound by the group contract's terms and conditions. I understand that this application is hereby made a part of the group contract. I will attach it to my certificate of coverage, when issued.

**Add additional dependents below. Be sure to include your signature and the date.**

| First Name | Middle Initial | Last Name | Social Security No. | Date of Birth | Relation to You (DP = Domestic Partner) | Gender | BlueDental Care Only Facility ID # Check box if a current patient |
|---|---|---|---|---|---|---|---|
| | | | | | ☐ Child or ☐ DP Child | ☐ M ☐ F | ☐ |
| | | | | | ☐ Child or ☐ DP Child | ☐ M ☐ F | ☐ |
| | | | | | ☐ Child or ☐ DP Child | ☐ M ☐ F | ☐ |

**Add additional beneficiaries below. Be sure to include your signature and the date.** **Total % must = 100%.**

| | | | |
|---|---|---|---|
| Primary Beneficiary: | DOB: | Relation to You: | % of Share: |
| Primary Beneficiary: | DOB: | Relation to You: | % of Share: |
| Secondary (Contingent) Beneficiary: | DOB: | Relation to You: | % of Share: |
| Secondary (Contingent) Beneficiary: | DOB: | Relation to You: | % of Share: |

Signature Date