Excellus

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HIOS ID# _____

EC _____

Commercial Group Dental Insurance Application/Change Form

CONFIDENTIAL

Please print clearly and complete all sections that apply. Signatures are required. Additional instructions included on Page 3.

Section 1: Employer Group & Benefit Information - To be completed with your Group Administrator

_____

Employer Name

Association/Chamber Name (if applicable)

_____ _____ _____ _____

Group Administrator's Signature (required) Date Employee Number Department Number

Dental Information

_____
Dental Group Number

_____
Dental Subgroup Number

_____
Dental Class

If enrolling in a Dental plan, who do you need coverage for?
- ☐Self Only
- ☐Self & Child(ren)
- ☐Self & Spouse, or Self & Domestic Partner
- ☐Family

____ /_____ /_____
Dental Effective Date

Subscriber Status:
- ☐Actively Working
- ☐Retired
- ☐Disability
- ☐Canceled
- ☐COBRA

Dental Plan Selection

☐ (EBA) DBO Orthodontics not covered

☐ (EBC) DBO Orthodontics to age 19

☐

☐

Section 2: Subscriber's Information

_____
Last Name

_____
First Name

_____ _____
Middle Initial **Title (e.g., Jr, Sr, III, etc.)**

_____
Street Address

_____ _____
City **State**

_____ _____
Zip Code **Phone**

Birthdate: _____ /_____ /_____

Gender assigned at birth:
- ☐Male
- ☐Female

Gender identity (optional):
- ☐Transgender Male
- ☐Transgender Female
- ☐Prefer not to say
- ☐Non-binary
- ☐Prefer to self-describe: _____

Social Security Number _____

Date of Hire/Rehire: _____ /_____ /_____

Retirement Date: _____ /_____ /_____

Section 3: Reason for enrollment or change - To be completed by the Group Administrator - Not required for cancelations

Enrollment Opportunity: ☐New Hire ☐Rehire ☐Open Enrollment

Special Enrollment Opportunity: ☐Newly Eligible Dependent: ☐Newborn ☐Marriage ☐Other

_____

- ☐Change in employment status
- ☐Involuntary loss of coverage
- ☐A move in or out of the service area
- ☐Former dependent regains eligibility

Date of Event ___ /___ /_____

COBRA Election - Please indicate the reason for COBRA if applicable:

- ☐Left Employment/Retired
- ☐Divorce/Legal Separation
- ☐Loss of Dependent Status
- ☐Death of Employee
- ☐Disability
- ☐Dependent Reached Max Age
- ☐ Other: _____

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for?

Subscriber

Cancel Code:	Dental Cancel Date:
	/ /

Coverage ends at 11:59 p.m. on the date you indicate

* = Not eligible for COBRA

Cancel Codes:
SB02-Left Employment SB58-Change in Employee Eligibility Status SB08-Subgroup Transfer*
SB06-Subscriber No Longer Wants Coverage* (subscriber request)
SB07-Deceased SB09-Enrolled in Error* SB44-Medicare Eligible (Moved to Medicare plan with same employer)

Dependent(s)

* = Not eligible for COBRA

Dependent Name:	Cancel Code:	Dental Cancel Date:
		/ /
		/ /
		/ /

Coverage ends at 11:59 p.m. on the date you indicate

Cancel Codes:
M002-Deceased* M005-Divorced M010-Overage Dependent M014-YA No Longer Qualifies* M013-Ineligible Dependent
M003-Subscriber No Longer Wants to Cover Dependent* M007-Dependent No Longer Wants Coverage* M009-Marriage
M011-No Longer a Student M004-Enrolled in Error* M008-Moved Out of Area* M040-Medicare Same Group*

Section 5: Information about who you would like coverage for (dependent information)

☐Spouse ☐Domestic Partner ☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other_______

Last Name (if different) Title **First Name** MI **Social Security Number**

Gender assigned at birth:
☐Male ☐Female

Birthdate ______ /______ /_________

Gender identity (optional):
☐Transgender Male ☐Non-binary ☐Prefer not to say
☐Transgender Female ☐Prefer to self-describe: ______

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other________________________

Last Name (if different) Title **First Name** MI **Social Security Number**

Gender assigned at birth:
☐Male ☐Female

Birthdate ______ /______ /_________

Gender identity (optional):
☐Transgender Male ☐Non-binary ☐Prefer not to say
☐Transgender Female ☐Prefer to self-describe: ______

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other________________________

Last Name (if different) Title **First Name** MI **Social Security Number**

Gender assigned at birth:
☐Male ☐Female

Birthdate ______ /______ /_________

Gender identity (optional):
☐Transgender Male ☐Non-binary ☐Prefer not to say
☐Transgender Female ☐Prefer to self-describe: ______

☐Dependent Child ☐Disabled Dependent Child (Separate application form required) ☐Other________________________

Last Name (if different) Title **First Name** MI **Social Security Number**

Gender assigned at birth:
☐Male ☐Female

Birthdate ______ /______ /_________

Gender identity (optional):
☐Transgender Male ☐Non-binary ☐Prefer not to say
☐Transgender Female ☐Prefer to self-describe: ______

Note: Use an additional application or addendum if more than four dependents need coverage

Section 6: Other coverage information (Required) - You may be contacted for additional information

Have you or any member of your family been enrolled in other dental coverage? ☐Yes ☐No
What is the effective date of the other coverage? Other Dental Policy Effective Date: ____ /____ /______
What is the name of the other carrier? ____________________________
Are you keeping the coverage? ☐Yes ☐No If no, when will the coverage end? _____ /_____ /________
Policyholder's name ______________________________ ID# ________________________
Who did the insurance cover? ☐Self Only ☐Self & Spouse/Domestic Partner ☐Self & Child(ren) ☐Family

Section 7: Release - You must sign and date this form to be eligible for health insurance

I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract you issue is bound by the terms and conditions of the contract applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgment and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents). I hereby accept responsibility for payment of any portion of the premium. I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge. Pediatric dental is an essential health benefit mandated by the ACA. If your employer group does not provide pediatric dental coverage through this Excellus BCBS plan, you agree to enroll in the dental plan offered to you by your employer.

PREFERRED PROVIDER ORGANIZATION (PPO) I understand that the Preferred Provider Organization (PPO) coverage is comprised of an in-network benefit that is dependent on the utilization of medical providers who participate with the PPO and out-of-network benefit that provides coverage for services of medical providers who do not participate with the PPO. I understand that the in-network benefit provides the highest level of coverage under the plan. I have thoroughly read, understand and agree to comply with the terms of the release in this section

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Subscriber Signature _____ **Date** _____

Instructions for completing the Group Dental Insurance Application

Section 1: Employer Group & Benefit Information - This section should be completed with your Group Administrator. Group Administrator's signature is required. Group numbers and information must be populated. Select who you need coverage for on the dental plan and indicate the subscriber's status. Next, select the dental plan you are enrolling in. All products may not be applicable to your employer group. Please check with your Group Administrator.

Section 2: Subscriber's Information - To be completed by the Subscriber.

Section 3: Reason for enrollment or change - Select the box(es) that describe(s) the reason for this enrollment or change regarding dental insurance coverage and include the date of the event. An event is a specific occurrence, due to change in status, marriage, divorce, birth or adoption, group's anniversary date, or rate change. Your request must be received within 30 days of the event date. Please see your Group Administrator for events that fall outside the 30-day period. You may be required to provide documentation of certain events.

Section 4: Cancel Information - If canceling coverage, who are you canceling coverage for? - If you are canceling coverage, complete the appropriate section for who you are canceling. List the cancel code and enter the date(s) the coverage is to be canceled. List each applicable dependent to be canceled.

Section 5: Information about who you would like coverage for (dependent information) - Please include information about all the people who you would like coverage for.

Qualified guidelines for coverage include: (a) A legal spouse/domestic partner (An ex-spouse no longer qualifies as of the date court documents are stamped and filed with the county clerk). (b) Must be under the eligible child age for your employer group including natural, adopted or stepchild(ren). (c) Qualified dependents and students are covered through the end of the month in which they turn 26 years of age. (d) There are additional eligibility requirements for dependents pending adoption, for which you are the legal guardian, and/or a disabled dependent who is over the maximum dependent age. Please contact your Group Administrator for the appropriate form.

Section 6: Other coverage information (Required) - Please include accurate information in this section. This could affect the processing of your application and/or claims.

Section 7: Release - Subscriber signature and date are required in this section. The subscriber must sign the application prior to or within 30 days of the effective date or qualifying event date.

Gender and gender identity: Excellus BlueCross BlueShield does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this **optional gender identity section** of the application. Excellus BlueCross BlueShield will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.

Please return to: P.O. Box 21146 Eagan, MN 55121-0146
If you have questions, please contact your Group Administrator. Or, visit us at: ExcellusBCBS.com