



NEW ENROLLEE (Please Complete A, C, D, E, F)

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 _____	Reinstate Coverage: Reason: _____ _____ _____
	Remove Dependent(s): <input type="checkbox"/> Marriage _____ <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 _____	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:	

An Independent licensee of the Blue Cross and Blue Shield Association ©, SM Marks of the Blue Cross and Blue Shield Association. SM1 Mark of Blue Cross and Blue Shield of North Carolina.



D. COVERAGE SELECTION – Complete for BCBSNC Dental Blue Select

Options Selected: Employee Only Employee and Spouse Employee and Child(ren) Employee and 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 & 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, MI, Last Name)	Social Security Number	Date of Birth mm/dd/yyyy	Relationship	Sex	Check Status (if applicable)
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Adopted <input type="checkbox"/> Under the age of 26*** <input type="checkbox"/> Foster <input type="checkbox"/> Handicapped**
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Adopted <input type="checkbox"/> Under the age of 26*** <input type="checkbox"/> Foster <input type="checkbox"/> Handicapped**
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Adopted <input type="checkbox"/> Under the age of 26*** <input type="checkbox"/> Foster <input type="checkbox"/> Handicapped**
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Adopted <input type="checkbox"/> Under the age of 26*** <input type="checkbox"/> Foster <input type="checkbox"/> Handicapped**
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Adopted <input type="checkbox"/> Under the age of 26*** <input type="checkbox"/> Foster <input type="checkbox"/> Handicapped**
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Adopted <input type="checkbox"/> Under the age of 26*** <input type="checkbox"/> Foster <input type="checkbox"/> Handicapped**
<input type="checkbox"/> Add / <input type="checkbox"/> Delete					<input type="checkbox"/> F <input type="checkbox"/> M	<input type="checkbox"/> Adopted <input type="checkbox"/> Under the age of 26*** <input type="checkbox"/> Foster <input type="checkbox"/> Handicapped**

* 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.

*** Consult your employer regarding dependent eligibility requirements. Supporting documentation may be required.

G. EMPLOYEE AUTHORIZATION

I understand that the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina contract and any changes provided for therein. I understand that BCBSNC may within two years of the date of this application, void or terminate this coverage or deny claims for coverage if incorrect information has been given on this application. If fraudulent misstatements were made, BCBSNC may take legal action at any time.

I certify that all statements made herein are complete and true to the best of my knowledge and my signature authorizes all sections of this application.

Signature of Employee

Date

Questions? Call Blue Cross and Blue Shield of North Carolina at 1-888-471-2738