Empire BlueCross BlueShield

Empire BlueCross BlueShield
Dental Enrollment Department
PO Box 838
Minneapolis MN 55440-0838

Dental Membership Enrollment Form

PART A - EMPLOYEE INFORMATION - Employee complete parts A through E and return form to benefit administrator.

Employee's Name:	Last		First			Middle Initial		Social Security Number / /
Gender:	Male ☐	Female ☐	Marital Status:	Single ☐	Married ☐	Widowed ☐	Divorced ☐	Legally Separated ☐	Date of Birth (Month-Day-Year) / /
Employee's Address:	Address					Home Phone Number		Work Phone Number
	City			State		Zip Code		

PART B - ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):

- ☐ Employee Only*
- ☐ Employee and Spouse
- ☐ Employee and Dependent Child(ren)
- ☐ Family
- ☐ No Coverage*

* If waiving coverage for employee and/or any eligible family members, you must complete Part D.

Complete If Multiple Plan Options Are Offered

I elect to participate in the following Plan:

ODentalXPO D Dental Complete

PART C - DEPENDENT INFORMATION

Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender		Date of Birth Month/DayNear	Full Time Student?		Unmarried?	
Spouse		M	F	/ /				
Dependent Child		M	F	/ /	y	N	y	N
Dependent Child		M	F	/ /	y	N	y	N
Dependent Child		M	F	/ /	y	N	y	N

PART D - EMPLOYEE SIGNATURE - Select One

Do you (the employee) have other dental coverage? D Yes D No Do your dependents have other dental coverage? D Yes D No

Name of Carrier: _____ Policy/Identification Number: _____

D I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Empire BlueCross BlueShield reserves the right to decline any further dental enrollment changes.

Employee Signature: Date:

D I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. I have read, or have had read to me, the completed application and I realize 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

Employee Signature: Date:

PART E - GROUP ENROLLMENT INFORMATION •THIS PART TO BE COMPLETED BY EMPLOYER

D New Group
Hire Date: ____/____/____
Prior Coverage Start Date (if applicable): ____/____/____
Coverage Effective Date: ____/____/____

D Existing Dental Group
Hire Date: ____/____/____
Prior Coverage Start Date (if applicable): ____/____/____
Coverage Effective Date: ____/____/____

D New Hire - Apply Probationary Period (if applicable) to determine Effective Date
Hire Date: ____/____/____
Effective Date: ---/____/____

D Open Enrollment
Effective Date:
---/____/____

D Rehire Date Lay Off Began: ____/____/____
Date Rehired: ____/____/____

D Return from Leave of Absence
Date Leave Began: ____/____/____
Date Returned to Work: ____/____/____

D Employee Change Part Time to Full Time
Date of Status Change: ____/____/____
Effective Date: ____/____/____

D Previously Waived Coverage or Loss of Coverage
Qualifying Event Reason: _____
Hire Date: ____/____/____
Event Date: ____/____/____
Effective Date: ____/____/____

Group Name: Group & Subgroup Numbers:

Group Representative's Signature: Date: Phone Number: ( )

Services provided by Empire HealthChoice Assurance, Inc. a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Employer Instructions

- Review Parts A, B, C, and D to be sure all information is complete, accurate and legible.
- When reporting effective dates use contractual start and stop guidelines as defined in your contract (i.e., first of month, end of month, or actual dates).

Employer Complete Part: E - Group Enrollment Information

- Check one reason for enrollment and provide requested information including coverage effective dates.
- New Group - New customer initial employee enrollment. Complete the Prior Coverage Start Date if your plan benefits include waiting periods and credit for prior creditable coverage applies.
- Existing Dental Group - Enrolling additional employees from an acquisition/merger who were not previously offered/enrolled in your dental plan. Complete the Prior Coverage Start Date only if your plan benefits include waiting periods and credit for prior creditable coverage applies.
- New Hire - Enroll newly hired employee. If a probationary period applies, the coverage effective date is after the probationary period.
- Open Enrollment - An employee is enrolling during group's open enrollment period.
- Rehire - A former employee was rehired.
- Return From Leave of Absence - An employee is returning from leave of absence.
- Employee Status Change - The employee's employment status changed and the employee is now eligible for dental benefits.
- Previously Waived Coverage or Loss of Coverage - If an employee waives coverage; he/she can only enroll at a later date if the group contract includes an Open Enrollment period or if the individual has a loss of other insurance coverage. If an employee or dependent involuntarily losses coverage and are now eligible to enroll, complete this section.
- Group Name - Provide group name as listed in your contract.
- Group and Subgroup Number - Provide applicable numbers for individual employee.
- Group Representative - Sign, date, and provide your phone number.

Send Completed Forms To:
Empire BlueCross BlueShield
Attn: Dental Enrollment
Department PO Box 838
Minneapolis MN 55440-0838