BlueCross BlueShield Minnesota

Application For Individual Dental Coverage

Please Complete Steps 1-5.

If you are an agent/producer, please complete Steps 1-6.

Step 1) Tell us about yourself.

Step 2) Tell us about your household.

Step 3) Choose your plan.

Step 4) Tell us if you have other dental coverage.

Step 5) Sign, authorize, and date your Application.

Step 6) If you are an agent/producer, please complete and return the Producer Certificate with the rest of the completed Application.

General Information

- You must be a resident of Minnesota. You must obtain our Residency Policy at www.bluecrossmn.com/residencypolicy or call 1-800-531-6685 and one of our Blue Cross representatives will be happy to assist you.
- If eligible, coverage will be provided under an individual contract. Blue Cross does not issue individual coverage through any arrangement with an employer.
- This plan does NOT meet the minimum essential health benefit requirements for pediatric oral health as required under the Affordable Care Act.
- Your coverage will begin on the first day of the month following receipt of your completed application unless you indicate a different first of the month effective date on page 3 – whichever is later. Requested effective dates must be within 90 days following receipt of your completed application.
- Complete this entire application including all explanations as requested and all required documents. Print clearly using black or blue ink. Incomplete applications will be returned to you to be completed. This may affect the date your coverage starts. Processing of your application may be delayed if this application is NOT completed in its entirety*.
- Sign and date this application. This application must be received at the home office of Blue Cross within 15 days of your signature.
- Incomplete applications are null and void after 30 days.

To submit your application faster, you can enroll by calling the following phone number:

- By phone: 1-877-293-7040

Need Help?

This information is available in other ways for people with disabilities or who need it translated into another language by calling 1-800-531-6685 (toll free). For TTY, call 711.

Customer Service Hours: 8 a.m. to 6 p.m., Central Time, Monday through Friday.

For in-person help: Visit your local Blue Cross store

If you work with an agent/producer: Please contact your Agent or Broker for assistance or call 1-800-531-6685 and one of our Blue Cross representatives will be happy to assist you.

Attention: If you want free help translating this information, call the above number.
Atención: Si desea ayuda gratis para traducir esta información, llame al número que aparece arriba.

Send Your Completed Application and Payment to Blue Cross

Send in your completed application and payment to Blue Cross by one of the following methods. PLEASE RETURN ALL PAGES OF THE APPLICATION. If a specific section does not apply to you, please mark as 'N/A'.

U.S. Mail:

Include your completed, signed Application along with your first premium payment to:

Blue Cross and Blue Shield of Minnesota
P.O. Box 64024
St. Paul, MN 55164

Fax or email:

Fax your completed, signed Application to 651-662-6439 or email to enrollment.forms@bluecrossmn.com -- *and* -- mail your first premium payment with completed remittance slip to:

Blue Cross and Blue Shield of Minnesota
P.O. Box 64024
St. Paul, MN 55164

Drop Your Application and Payment Off In Person At Your Local Blue Cross Retail Store:

For locations, please visit www.bluecrossmn.com or call 1-800-531-6685. You may also visit bluecrossmn.com/store to make an appointment near you.

STEP 1 Contractholder's Information

Contractholder's First Name, Middle Name, Last Name & Suffix			Preferred Phone Number
Email Address			Date of Birth *(mm/dd/yyyy)* / /
*Social Security Number (if no SS#, write N/A)	Gender ☐ Male ☐ Female		County
Home Address (No P.O. Box #)	City	State	Zip Code
Mailing address (If different from home address)	City	State	Zip Code

STEP 2 Additional Information (Additional Individuals To Be Covered) - *Social Security Numbers (SSN) for you and your dependents are requested for benefit administration. Please include SSNs with your application.

First Name, Middle Name, Last Name	*Social Security Number	Relationship to you?	Gender	Date of Birth (mm/dd/yyyy)
				Disabled? Yes ☐ No ☐
				Disabled? Yes ☐ No ☐
				Disabled? Yes ☐ No ☐
				Disabled? Yes ☐ No ☐
				Disabled? Yes ☐ No ☐
				Disabled? Yes ☐ No ☐

☐ Additional dependent(s) on attached page

STEP 3 Coverage and Payment Selection

Coverage Option:

☐ Freedom ☐ Value Standard
☐ Preferred ☐ Value Enhanced
☐ Value Premium

Premium Payment ($): _____

My Coverage will be for:

☐ Contractholder only
☐ Contractholder and One Dependent
☐ Family

Requested Effective Date: _____ (mm/yyyy)

☐ First of the month following
☐ Add a dependent

List reason for adding dependent outside of renewal. Permitted reasons; newborn, newborn grandchild, adoption/ placement for adoption, court ordered:

_____

STEP 4 Tell Us About Your Other Dental Coverage Information

Complete the information requested about your current dental coverage.

1. Are you or any of your family members who are applying for this coverage enrolled in any private or governmental group or individual dental plan or program at the time of this Application? ☐ Yes ☐ No
2. Is this coverage for which you are applying intended to replace any other dental coverage you or any family members applying currently have? This includes any current Blue Cross dental coverage. By indicating yes, any current Blue Cross dental coverage for you and/or any family member applying for coverage under this application will be terminated as of the Effective Date of the new dental coverage. ☐ Yes ☐ No
3. Have you or any family members applying for coverage under this application had prior Blue Cross dental coverage within the past 3 years? ☐ Yes ☐ No

If Yes, to any question above, complete question 4. **If No,** skip question 4 and go to the next section.

4. Please provide the following information about any other dental coverage you and/or your family members currently have or have applied for:

   Name of Insurance Carrier: _____ Policy Number: _____

   Name of Contractholder: _____ Effective Date: _____

   Contractholder's Date of Birth: _____ Relationship to Applicant: _____

STEP 5 Authorization Language

My/our signature on this Application indicates that I/we have read and fully understand the following statements when applying for dental coverage through Blue Cross and Blue Shield of Minnesota (Blue Cross): I understand and agree that coverage, if approved, will begin as specified on page 3.

I authorize Blue Cross either to use information from my check to make a one-time electronic funds transfer from my account or to process the payment as a check transaction. When Blue Cross uses information from my check to make an electronic funds transfer, funds may be withdrawn from my account as soon as the same day Blue Cross receives my check and I will not receive my check back from my financial institution.

I understand that coverage will be provided under an individual contract. I understand that Blue Cross does not issue individual coverage through any arrangement with an employer. Blue Cross is not responsible for any action taken by an employer that results in this coverage being considered group coverage under state or federal law. The employer is solely responsible for any such finding.

For purposes of obtaining information in connection with this Application, reinstatement, or change in coverage benefits, this release is valid as long as I am continually insured with the insurer. I am entitled to receive a copy of any release I sign.

Blue Cross primarily relies upon the information provided and full disclosure of the information listed on this Application in the decision whether to accept the enrollee and/or dependent(s) listed on this Application for coverage. I acknowledge the importance of providing accurate and complete information. I acknowledge I must answer all questions in the application, even if I and/or dependent(s) listed on this Application, currently have coverage or had prior coverage with Blue Cross. I understand I must be a permanent resident of Minnesota to be eligible for this coverage and I hereby attest that as of the effective date of my contract I am a permanent resident of Minnesota and am eligible for this coverage. I also understand that if this attestation is determined not to be true, Blue Cross will rescind my contract and coverage, and no claims will be paid.

I agree to notify Blue Cross immediately of any change in my (or my dependent(s)) enrollment information between the date of this Application and the effective date of coverage. Failure to notify Blue Cross of any change in the information contained on this Application may result in the denial of a claim(s), rescission of the contract, the issuance of a contract amendment, or a premium adjustment.

Upon request, I agree to furnish additional information needed concerning my (or my dependent(s)) eligibility enrolling for coverage. I have read the preceding instructions, statements and answers and represent them to be true and complete to the best of my knowledge and belief. I understand that my (or my dependent(s)) enrollment eligibility and coverage of benefits under this dental coverage may be subject to waiting periods or a lock-out period. I understand and agree Blue Cross will act in reliance upon the information I have provided on this Application which materially affect enrollment eligibility and may result in the denial of a claim(s), rescission of the contract, the issuance of a contract amendment, or a premium adjustment.

STEP 5 Authorization Language - continued

I understand and agree that payment of a claim does not preclude the right of Blue Cross to deny future claims or take any action it determines appropriate, including rescission of the contract and seeking repayment of claims already paid.

I understand that this Agreement renews on an annual basis. I acknowledge that if my first payment is not made with this application, the first premium payment is due by the due date printed on my first invoice. I understand that failing to pay before this due date will result in my application being voided. I understand that payments in advance of the monthly amount will be credited to my future payments. I understand my payment must be received and processed in full before claims can be paid for any eligible services received. I acknowledge that if my on-going monthly premium payments are not received within the plan grace period, my plan will be terminated.

If this Application is completed as an electronic or online application, both parties agree to conduct this transaction electronically.

Applicant's Signature _____ Date _____

Spouse/Parent's Signature_____ Date _____

This Application Is Valid Only When Completed and Signed By The Enrollee.

REMITTANCE SLIP

Please complete the form below.

Contractholder Name (First, Middle, Last): _____

Phone Number: (_____) _____ Zip Code: _____ Social Security Number (last 4 digits): _____

Monthly Premium for the plan you selected, based on applicants indicated on this Application: _____

Payment Enclosed: $ _____

If you plan to fax/email your application, mail in this page with your first month premium payment. Failure to do so may result in a delay in application processing and incorrect crediting of your payment.

Applicant's Last Name	**First Name**

Step 6 - For Producer Use Only

PRODUCER'S CERTIFICATE

ATTENTION PRODUCER: If you have questions about completing this Application, please call the Producer Line at 1-888-878-0138.

If this section is not fully completed, we will not pay a commission.

Blue Cross Blue Shield Agency No.						
					R	I

Producer No.						
			4	3	1	0

Agency Name Walter J. Palmer Agency

Producer's Name Palmer, Walter J.

Producer's Signature _____

LAST *FIRST* *MI*

Business Phone (612) 825-4990

Area Code

A PRODUCER must complete this section to act on the applicant's behalf.

1. Consider how the applicant answered your questions. Do you know of any factors impacting the applicant's eligibility? What about his/her dependents applying for this coverage? ☐ No ☐ Yes

Producer Signature Date

Walter J. Palmer Agency

Agency

2. Have you provided the applicant with all relevant marketing materials? ☐ No ☐ Yes
3. Have you advised the applicant of the features of the product that he/she has selected, including satisfying his/her deductible(s)? ☐ No ☐ Yes
4. Is this applicant a current customer of Blue Cross? ☐ No ☐ Yes
5. Have you retained a signed copy of this Application for your records? ☐ No ☐ Yes

Note: No producer may:

1. Accept risk or pass on any eligibility requirements;
2. Make or alter the terms of the Application or coverage; or
3. Waive any of Blue Cross's rights or requirements.

BlueCross BlueShield Minnesota

Blue Cross Blue Shield of Minnesota
3535 Blue Cross Road
Eagan, MN 55122