Employee Application for Group Dental Insurance

Florida Combined Life

SECTION 1: To be completed by Group Insurance Administrator or Employer

FCL Group No. 1	Group Name 2	Business Phone No. 3
251L49	SANTA ROSA COUNTY BOCC	(850) 981-2027
Division No. 4	Class 5	Effective Date MM DD YYYY / / 6

SECTION 2: To be completed by Employee (Please print.)

Part A: Complete the following part with information on yourself.

Full legal name of employee (Last, First, MI) 7	Social Security No. 8	Birthdate MM DD YYYY / / 9
Street Address 10	City 11 / County 12	State 13 / Zip Code 14

Home Phone No. 15 ( )	Business Phone No. 16 ( )	Occupation/Job Title 17	Gender 18 ☐M ☐F	Marital Status 19 ☐Single ☐Divorced ☐Legally Separated ☐Married ☐Widowed

Full-time Hire date MM DD YYYY / / 20	Are you 21 ☐Actively at work ☐Retired ☐COBRA	How Paid? 22 ☐Hourly ☐Salary	Hours worked per week 23

Part B: Coverage Selection *(Note: Consult your group insurance administrator for benefits available to you.)*

A Dependent cannot be covered as both a dependent and an employee, covered under more than one employee, in full-time military service, or enrolled for coverages declined by the employee. Married employees of the same employer may not be covered as both an employee and a dependent.

Employee 24	Spouse 25	Child(ren) 26
☐Yes ☐No, **I decline** coverage	☐Yes ☐No, **I decline** coverage	☐Yes ☐No, **I decline** coverage. If selected, all children must be enrolled.

If you checked **YES** in the Employee Coverage selection box, select one of these plans. 27

☐**BlueDental Freedom (Indemnity)**________

☐**BlueDental Care (Prepaid)** ________

BlueDental Choice (PPO) ☐**Choice** ____ ☐**Copayment** ____ ☐**Plus** X

Part C: Identify each individual to be covered below. **Attach additional sheet of paper, if necessary. Sign and date it.**

First Name, M.I., Last Name (Please provide information in the corresponding numbered spaces below.) 28 / Social Security Number (Please provide in spaces below) 29	Relation to You (DP = Domestic Partner) 30	Gender (M/F) 31	Birthdate mm/dd/yyyy 32	Check If: Marital Status – Married 33	Marital Status – Unmarried No Children 33	Disabled 34	Lives With You 35	You Support Financially 36	Student FT/PT 37	Florida Resident 38	Covered By Medicaid 39	BlueDental Care Facility ID# Check box if a current patient (Select from provider directory) 40
Employee												☐
28 / _ _ _ - _ _ - _ _ _ _	☐Spouse or ☐DP											☐
28 / _ _ _ - _ _ - _ _ _ _	☐Child *or* ☐DP Child			☐	☐	☐	☐	☐	☐	☐	☐	☐
28 / _ _ _ - _ _ - _ _ _ _	☐Child *or* ☐DP Child			☐	☐	☐	☐	☐	☐	☐	☐	☐
28 / _ _ _ - _ _ - _ _ _ _	☐Child *or* ☐DP Child			☐	☐	☐	☐	☐	☐	☐	☐	☐

Do any dependents listed above reside at a different address than indicated above? ☐ Yes ☐ No 41
If **yes**, list name(s):

Do you or any of your dependents listed above have Dental insurance under another group plan? ☐ Yes ☐ No 42
If you answered **yes** to other group dental insurance, complete 43 through 47 below. If more than one dependent, attach a separate sheet of paper with the additional information.

Dependent Name 43	Other Group Plan Name & Plan No. 44	Insured/Member Name	Birthdate / / 45
Insurance Co. Name & Address	Phone No. ( ) 46	Policy No. 47	

Part D: Coverage Acceptance of ANY Coverage (Please read before signing.)

I wish to apply for any coverage checked **YES** under Part B Coverage Selection. I have read and accept the "Acceptance of Coverage" on the reverse side of this form. I hereby certify that the statements on this application, including any attachment to it, are true and complete. (If you checked NO for any dependent coverage under Part B, sign and date Part E also.) 48

Employee Signature Date

Part E: Coverage Refusal of ANY/ALL Coverage (Please read before signing.)

I do not wish to apply for any coverage checked NO under Part B Coverage Selection. I understand that if I decide to apply at a later time, coverage will not be available until the next open enrollment. 49

Employee Signature Date

Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

FRAUD NOTICE: 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.