Application for Dental Insurance

Pediatric, silver, gold, gold plus vision, platinum and platinum plus vision

MUST BE SUBMITTED ELECTRONICALLY. PDF FOR RECORDING DATA ONLY.

Section 1 | Who is applying?

In the "Relationship" column below, please indicate **spouse, son, daughter, stepson, stepdaughter or dependent child** beside each dependent's name.

First name	M.I.	Last name	Suffix	Relationship	Sex	Date of birth	Social Security No.
				Self			

Section 2 | Parent/Guardian (if policy is only for a child under 18)

First name	M.I.	Last name	Relationship (Check One)
			☐ Mother ☐ Stepmother ☐ Guardian ☐ Father ☐ Stepfather

Section 3 | Marital status

☐ Single (including divorced or widowed) ☐ Married (including separated)

Section 4 | Residential address (Must be permanent address - No P.O. Box, please)

Residential street	City	State	ZIP	County

Section 5 | Mailing address (Complete only if different from residential address)

Street or P.O. Box	City	State	ZIP

Section 6 | Billing address (Complete only if different from residential address)

Street or P.O. Box	City	State	ZIP

FOR HOME OFFICE USE ONLY | (DO NOT WRITE IN THIS SPACE)

I.D. Number	Group number	Effective date

Section 7 | Contact information

Primary phone number	Alternate phone number	Email address

How do you prefer we communicate with you? ☐ Phone ☐ Email

*Arkansas Blue Cross and Blue Shield may contact you, either directly or through a business associate, using your postal or email addresses, telephone numbers or other personal information, regarding your health insurance plan, healthcare providers participating in our networks, disease management, health education and health promotion, preventive care options, wellness programs, treatment or care coordination or case management activities of Arkansas Blue Cross.

Section 8 | Household information

☐ Yes ☐ No Are all applicants permanent, legal residents of Arkansas? If "no," please provide:

Name:

Address:

Reason:

Section 9 | Previous coverage

☐ Yes ☐ No Have any of the proposed insureds had any other dental coverage within the last 12 months? If yes, list:

Name	Carrier Name	Effective date	Termination date

Section 10 | U.S. citizenship status

Additional information may be required.

☐ Yes ☐ No Are all applicants U.S. citizens?

If "No", please provide the name(s) of the applicant(s) who are not U.S. citizens.

Name:

Name:

Section 11 | Plan selection

Must choose only one box

☐ Pediatric (Age 18 or below) ☐ Silver ☐ Gold

☐ Gold Plus Vision ☐ Platinum ☐ Platinum Plus Vision

Waiting periods apply to dental benefits only (do not apply to children age 18 and under).

The **6-month waiting period** for Minor Restorative services (Silver, Gold or Platinum) and the **6-month waiting period** for Major Restorative services (Gold or Platinum) will be waived if you meet the following criteria:

1. Your application is received within **30 days** of the termination date of your previous coverage; and
2. No later than **60 days** from the effective date of your new policy with Arkansas Blue Cross and Blue Shield, you provide us with a copy of your previous dental policy Certificate of Coverage which reflects the policy's effective and termination dates.

You may include these documents with your application. If you are submitting these documents after submission of your application, please fax them to Arkansas Blue Cross at 501-378-3752 or email them to CRMCustomerService@arkbluecross.com.

Please read before signing

I UNDERSTAND: (1) This application may be declined. (2) If accepted, the insurance applied for shall not become effective until the date shown on my identification card and the initial premium is paid in full. (3) If my application is accepted relying on my representations in this document, any coverage which may be issued to me shall be invalid if based on false information. (4) Arkansas Blue Cross and Blue Shield may phone me for additional information that may help with the timely processing of my application. In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

☐ **I certify that I signed this application in the state of Arkansas.**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature Section | (please sign appropriate line only)

Proposed Insured OR **Parent/Legal Guardian's** (if policy for a minor)	**Date signed**

Custodial parent's name (please print)	**Phone number**

Custodial parent's address (Street or PO box)	**City**	**State**	**County**	**ZIP**

Custodial parent's signature	**Date signed**

This section to be completed by sales representatives

Sales Rep NPN (required)	**Sales Representative's Name** (please print)	**Date signed**
Agency Federal Tax ID No.	**Sales Representative's Signature**	**Date signed**

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Home Office Endorsement

This application is valid for 90 days only when completed and signed.

Pre-authorized bank draft | Monthly program sign-up form

Our monthly bank draft service makes premium payments easy and convenient for you. Just a few steps now help assure your payments are made accurately and timely.

Important: Please read before signing

I authorize Arkansas Blue Cross and Blue Shield and the BANK indicated below, to debit my Arkansas Blue Cross premium from my checking or savings account indicated below. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross coverage, UNLESS Arkansas Blue Cross has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

Proposed insured's information

First name	Last name			
Street address	**Apt. no.**	**City**	**State**	**ZIP**

Bank account information

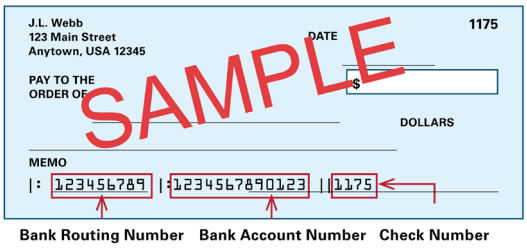
Bank name

Name on account (If different than the proposed insured)

Routing number	Account number

Type of account

☐ Checking ☐ Savings



Signature

Signature of bank account holder	Date

After Arkansas Blue Cross receives and processes this completed authorization form, you will receive a letter providing the effective date of your first scheduled draft. We hope you find this bank draft service of value. It is our privilege to serve you. Thank you for your business!

For office use only
(please do not write in this space)

ID No.
Effective date

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Policy effective date

All Arkansas Blue Cross Dental policies will be issued with a 1st of the month effective date based on the approval date (1st-15th **OR** 16th-31st) of your application. For example, if your application is approved on January 10, coverage will be effective February 1. If your application is approved on January 20, coverage will be effective March 1.

Application checklist

Have you . . .

☐ Answered all the questions?

☐ Signed and dated the application?

☐ Enclosed a completed Pre-authorized Monthly Bank Draft form signed by account holder (if monthly bank draft is requested)?

☐ Attached a voided check from account to be charged (if monthly bank draft is requested)?