Application for Dental Insurance

Pediatric, Silver, Gold, Gold Plus Vision, Platinum And Platinum Plus Vision, Platinum Premium And Platinum Premium 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 during the application process? ☐ Phone ☐ Email

Note: By selecting your preferred contact method, you agree that all communication during the application process will be sent based on your selection; however, the alternate method(s) may be used if needed to reach you for purposes related to your application.

☐ **Important Opt-In Consent for Electronic Document Access and Delivery:** By providing your email address or by checking this box, you agree that after enrollment we may communicate with you and provide your policy information to you electronically for your convenience, such as your health insurance plan documents, benefits, ID cards, explanation of benefits, claim status, and legal notices regarding your financial, privacy and healthcare rights under federal law. Opting into electronic delivery also allows us to communicate with you electronically, either directly or through one of our contracted business associates, regarding your plan, identification of healthcare providers participating in our networks, disease management, health education and health promotion, preventive care options, wellness programs, treatment options, care coordination, and case management assistance for you in connection with your plan through [Arkansas Blue Cross Blue Shield, Health Advantage, Octave Blue Cross and Blue Shield or Skai Blue Cross and Blue Shield] ("Plan"). Please note that you are responsible for updating your contact information. This electronic delivery will continue through any policy renewals or other changes. Once you are an enrolled member of a plan, if you want to change your communication preferences, including to opt-out of electronic delivery, you may:

- Update your communication preferences and/or contact information at **blueprintportal.com**

OR

- Call the Customer Service number located on your member ID card

If you register for Blueprint portal access after enrollment, this allows you to access your documents and information electronically through your own password-protected account. With the Blueprint portal, your documents can be viewed or printed using your computer or mobile device. The website may be accessed with most versions of Chrome, Firefox, Microsoft Edge, or Safari. You may also set your preferences at **blueprintportal.com**.

Consent to electronic delivery is not a condition of purchase, enrollment, or coverage. At no cost to you, you also may request a paper copy of a document, regardless of whether it is or has been delivered electronically.

By providing your mobile phone number, you agree that automated, informational text messages may be sent to you by or on behalf of your Plan to update you about new plan products and programs. You can opt-out of receiving such text messages at any time by responding STOP in a response text message. Standard mobile phone and/or text message charges may apply from your wireless provider. Frequency will vary.

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, please 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)	☐ Gold Plus Vision	☐ Platinum Premium
☐ Silver	☐ Platinum	☐ Platinum Premium Plus Vision
☐ Gold	☐ Platinum Plus Vision	

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

If your application is received within 30 days of the termination date of your previous coverage and no later than 60 days from the effective date of your new Arkansas Blue Cross policy, the six-month waiting periods for minor restorative services for adult Silver, Gold, Platinum and Platinum Premium plans, and major services for adult Gold and Platinum plans, will be waived. For Platinum Premium plans, the 12-month waiting period will be reduced to six months. You must show proof of prior continuous comparable dental insurance by providing a copy of your previous dental policy Certificate of Coverage and benefit schedule, which lists the coverage for services provided.

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.

You may review our privacy and non-discrimination notices at arkbluecross.com/privacy, arkbluecross.com/financial-privacy and arkbluecross.com/notice.

Arkansas Blue Cross and Blue Shield, its affiliates and partners may contact you, either directly or through a business associate, using your email address or telephone number regarding your health insurance plan or other promotional opportunities. You can manage your preferences or unsubscribe in Blueprint Portal at blueprintportal.com.

☐ **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**

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

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

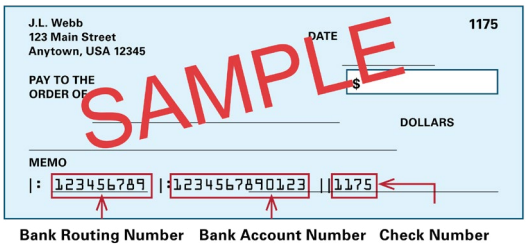
Bank name

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)?

NOTICE OF LANGUAGE ASSISTANCE, AUXILIARY AIDS/SERVICES AND NON-DISCRIMINATION NOTICE

We provide free language assistance, appropriate auxiliary aids and services, and reasonable modifications to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call or contact Customer Service at 1-800-238-8379 (TTY:771) or Civil Rights Coordinator.

ATTENTION: Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in assessable formats are available free of charge. Call 1-800-238-8379 (TTY: 711) or speak to your provider.

Spanish: ATENCIÓN: Disponemos de servicios gratuitos de asistencia lingüística. También hay disponibles de forma gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-800-238-8379 (TTY: 711) o hable con su proveedor.

Chinese Simplified: 注意：提供免费语言服务。此外，免费提供适合残障人士使用的辅助和支持服务。请致电 1-800-238-8379 (TTY: 711)或联系您的服务提供商。

Chinese Traditional: 注意：我們提供免費的語言協助服務，以及免費的適當輔助工具和其他服務，讓您能夠獲得無障礙格式的資訊。請撥打 1-800-238-8379 (TTY: 711)或諮詢您的服務提供者。

Tagalog: PAUNAWA: Available para sa iyo ang mga libreng serbisyo sa tulong sa wika. Available rin nang walang bayad ang mga naaangkop na auxiliary na tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-238-8379 (TTY: 711) o makipag-usap sa iyong provider.

French: ATTENTION : Des services d'assistance linguistique sont gratuitement mis à votre disposition. Des aides et services auxiliaires appropriés visant à vous informer dans des formats accessibles sont également mis à votre disposition gratuitement. Appelez le 1 800 238 8379 (TTY : 711) ou discutez avec votre prestataire.

Vietnamese: CHÚ Ý: Các dịch vụ hỗ trợ ngôn ngữ sẽ được cung cấp miễn phí cho quý vị. Các dịch vụ và hỗ trợ giao tiếp phù hợp nhằm cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp hoàn toàn miễn phí. Hãy gọi 1-800-238-8379 (TTY: 711) hoặc trao đổi với nhà cung cấp của quý vị.

German: HINWEIS: Ihnen stehen kostenlose Sprachmittlungsdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zum barrierefreien Zugang zu Informationen stehen ebenfalls kostenfrei zur Verfügung. Rufen Sie 1-800-238-8379 (TTY: 711) an oder sprechen Sie mit Ihrem Leistungserbringer.

Korean: 주의: 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구와 서비스도 무료로 제공됩니다. 1-800-238-8379 (TTY: 711)번으로 전화하거나 담당 서비스 제공자에게 문의하십시오.

Russian: ВНИМАНИЕ! Вам доступны бесплатные услуги языковой поддержки. Приемлемые вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-238-8379 (TTY: 711) или обратитесь к своему поставщику услуг.

Arabic: ملاحظة: خدمات المساعدة اللغوية متاحة لك مجاناً، كما أن وسائل وخدمات المساعدة الإضافية المناسبة لتوفير المعلومات بصيغ يسهل عليك الوصول إليها متاحة مجاناً أيضاً. يرجى الاتصال على الرقم: 1-800-238-8379 (TTY: 711) أو التحدث إلى مقدم الرعاية

Hindi: ध्यान दें: आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। आसान फ़ॉर्मैट में सूचना उपलब्ध कराने के लिए उचित सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-800-238-8379 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।

Italian: ATTENZIONE: Ha a disposizione servizi di assistenza linguistica gratuiti. Potrà usufruire gratuitamente anche di sussidi e servizi ausiliari appropriati per ottenere le informazioni in formati accessibili. Chiami il numero 1-800-238-8379 (TTY: 711) o chieda al suo operatore sanitario.

Portuguese: ATENÇÃO: Serviços gratuitos de assistência linguística estão disponíveis para você. Ajudas e serviços auxiliares apropriados para fornecer informações em formatos acessíveis também estão disponíveis gratuitamente. Ligue para 1-800-238-8379 (TTY: 711) ou fale com seu provedor.

French Creole: ATANSYON: Genyen sèvis asistans lang gratis disponib pou ou. Epitou, genyen lòt èd ak sèvis apwopriye disponib gratis pou ede moun jwenn enfòmasyon nan yon fòma ki aksesib. Rele 1-800-238-8379 (TTY: 711) oswa pale ak founisè w la.

Polish: UWAGA: może Pan/Pani skorzystać z bezpłatnych usług pomocy językowej. Odpowiednie dodatkowe pomoce i usługi w zakresie zapewniania dostępu do informacji w przystępnym formacie również są dostępne bezpłatnie. Prosimy dzwonić pod numer 1-800-238-8379 (TTY: 711) lub porozmawiać z lekarzem.

Japanese: 注意：無料の言語サポートサービスをご利用いただけます。アクセシブルなフォーマットで情報を提供するための適切な援助やサービスも無料でご利用いただけます。1-800-238-8379（TTY：711）にお電話いただくか、医療提供者にご相談ください

NON-DISCRIMINATION NOTICE

Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

If you believe that we have failed to provide these language assistance or auxiliary aids and services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex.

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276 (TTY: 711)
You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.