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

DENTAL
APPLICATION AND CHANGE FORM

Group Administrator Use Only
Multi-option: which _____

Group No.:	Employer:	DEPT.:	DATE OF FULL-TIME EMPLOYMENT:	ID No.:

GROUP EMPLOYEE APPLICATION

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	SEX	SOCIAL SECURITY NO.
APPLICANT			MO. DAY YEAR		

SECTION 1 | POLICY ELIGIBILITY

Check all applicable boxes below that support your eligibility, provide date of qualifying life event and documentation.

	Date		Date
☐ 1-Annual Open Enrollment Period		☐ 6-Marriage	_____
☐ 2-New Hire		☐ 7-New Adoption	_____
☐ 3-Waiving Coverage		☐ 8-New Guardianship/Legal Custody/Court Order to Add Child	_____
☐ 4-Loss of Minimum Essential Coverage	_____	☐ 9-Other Reason: Ex. Rehire, ACA (give specific reason)	_____
☐ 5-Newborn	_____	_____	

NOTE: If application is not received during Open Enrollment Period, we must receive appropriate documentation with this application to confirm qualifying life event/special election period (i.e. copy of marriage license, Certificate of Creditable Coverage from previous insurance company, legal guardianship/custody documentation, etc.).

SECTION 2 | WHO IS APPLYING

Coverage Desired: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee, Spouse & Child(ren)

Please indicate under the relationship column below whether dependent children are natural, step or adopted.

First Name	M.I.	Last Name	Relationship	Sex	Date of Birth	Social Security No.
			Self			

SECTION 3 | MARITAL STATUS

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

SECTION 4 | CONTACT INFORMATION

Street or P.O. Box _____ City _____ State _____ ZIP _____

Primary Phone Number ( ) _____ Work Phone Number ( ) _____ Email _____

SECTION 5 | EMPLOYMENT STATUS

Job Title _____

☐ Hourly Hours Worked Weekly_____

☐ Salaried ☐ Other

Are you a current, active employee? ☐ Yes ☐ No

FOR OFFICE USE ONLY

C/T	PKG	DATE

SECTION 6 | CURRENT/PREVIOUS DENTAL INSURANCE INFORMATION

(This section must be completed to process your enrollment application.)

For previous or continuing coverage please complete the following:
(If covered by more than one insurance plan, use additional paper)

Insurance Company	Address	Phone
Policyholder Name	Date of Birth	Member ID#

List the following information for all family members covered by this policy (indicate those not residing in your household with a check ✓ mark)

First Name	Last Name	Relationship	✓	Eff. Date of Coverage	End Date of Coverage

SECTION 7 | CHANGE REQUEST SECTION

Changes may be sent by: **Email:** bccaenrollment@arkbluecross.com
Fax: 501-378-3248

MAIL: Arkansas Blue Cross and Blue Shield
ATTN: Group Accounts, Riverfront Plaza, 9th Floor
P.O. Box 2181
Little Rock, AR, 72203-9974

Change to individual due to:

☐ Death – Date: _____

☐ Divorce – Date: _____

☐ Other: _____

Change coverage as indicated below:

☐ Name Change: _____

☐ Other – Explain: _____

Current Name: _____

New Name: _____

CHANGE IN DEPENDENT STATUS

Delete	Last Name	First Name	M.I.	Birthdate	Relationship	Sex	SSN	Date of Change	Reason (for deletion only)

SECTION 8 | AUTHORIZATION & SIGNATURES

I understand that no benefits for services of any kind are provided for treatment that was received prior to the effective date of my dental coverage.

I do hereby authorize any dentist, hospital or other provider of medical services or supplies to make available to Arkansas Blue Cross and Blue Shield upon request any and all medical records and facts pertaining to us and our physical condition.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits 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.

_____ Print Name of Applicant (Employee)

_____ Signature of Applicant (Employee)

_____ Date

_____ Print Name of Employer/Group Representative*

_____ Signature of Employer/Group Representative*

_____ Date

**Required for new hires and additions only.*