



Application for Individual Dental Coverage

PLEASE PRINT CLEARLY

Choose your dental plan: Personal Blue Dental Personal Blue Dental Plus

To be eligible for this coverage, you must be enrolled in a medical plan and reside in Michigan at least six months a year.

Requested Coverage Start Date (N/A if you answered "Yes" to question 2.)
MMDDYYYY - Must be Future Date

Your Last Name	First Name	Initial	Marital Status <input type="checkbox"/> S <input type="checkbox"/> M	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Requested Coverage Start Date (N/A if you answered "Yes" to question 2.) MMDDYYYY - Must be Future Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Street Address	City		State	Zip Code	
<input type="text"/>	<input type="text"/>		<input type="text"/>	<input type="text"/>	
Social Security Number	County	Telephone Number with Area Code		Date of Birth MM/DD/YYYY	
<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>	
Drivers License Number	Issuing State	Email Address			
<input type="text"/>	<input type="text"/>	<input type="text"/>			

If you wish to apply for coverage for a spouse and/or unmarried children who are under age 19, please list them below. Provide last name if different from yours. (Please use an additional sheet of paper for more than three children.)

Last name (Spouse)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
Last name (Child/Dependent)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
Last name (Child/Dependent)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
Last name (Child/Dependent)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>

If you wish to apply for coverage for an unmarried child who is age 19-25 this year, please complete below. Provide last name if different from yours. (Please use an additional sheet of paper for more than one child.)

Last name (Child/Dependent)	First name	Initial	Birth Date MM/DD/YYYY	Gender	Social Security Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>

- I live in Michigan six or more months each year: Yes No
- Are you or any family members applying for coverage currently active under a Blue Cross Blue Shield of Michigan group health plan? Yes No

If yes, please provide your:

Contract Number	Group Number	Policy End Date
<input type="text"/>	<input type="text"/>	<input type="text"/>

3. Are you covered under another health insurance carrier?

Check all that apply:

<input type="checkbox"/> Carrier	Contract Number
<input type="checkbox"/> Medicare/Medicare Advantage	<input type="text"/>
<input type="checkbox"/> Medicaid	

4. Are you currently enrolled in another dental program? Yes No Termination Date

I am applying for BCBSM Personal Blue Dental or Personal Blue Dental Plus subject to the terms and conditions of this application and I agree that I and my covered dependents will be bound by all of the BCBSM Personal Blue Dental or Personal Blue Dental Plus benefit requirements. Approval of this application and coverage effective date will be determined by BCBSM and shall be subject to requirements by BCBSM for additional information and payment of bills. I certify that the requirements of eligibility are met and that the information I have given on this application is true and correct to the best of my knowledge. I authorize BCBSM to obtain from providers of service any and all records relating to me and my covered dependents and acknowledge that BCBSM has the right to use and disclose these records and other confidential member information for valid business purpose.

Area below for BCBSM Use Only

Signature of Applicant

Date

Agent Code	MA/GA Code	Assoc./Chamber Code	Agent's Signature	Date
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Group Number	Service Code	Eff.Date: MMDDYYYY	U/W:	DEID
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please read the following information before completing the other side of this application.

The information on this form and the following conditions are part of your contract with Blue Cross Blue Shield of Michigan. Personal Blue Dental and Personal Blue Dental Plus coverage begins on the date determined by BCBSM. When BCBSM accepts your application, you and your family are bound by the terms of the policy and this application. A subscriber and any dependents must remain enrolled in Personal Blue Dental or Personal Blue Dental Plus coverage for a minimum of 12 months. If you terminate coverage for any reason you are not eligible to reapply for 12 months from the date of termination.

Medical coverage

You must have medical coverage to purchase Personal Blue Dental or Personal Blue Dental Plus.

Authorization

You are responsible for giving notice to BCBSM of changes in your status and your family's status that affect coverage, such as marriage, births or death of someone covered under the policy. Please send notice in writing to:

Personal Blue Dental or Personal Blue Dental Plus
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd. – Mail Code BP202
Detroit, MI 48226

You authorize BCBSM to obtain hospital, medical and dental records about you and your family from health care providers; and you authorize the release of any information needed to process or review a claim.

Proof of eligibility

You agree to provide proof of your eligibility for coverage in addition to that of your dependents when requested by BCBSM.

Confidentiality

We keep your personal health information confidential and do not release it without your consent or as permitted by state and federal privacy laws.

Approval

Approval of this application for dental care coverage will be indicated by your receipt of a billing notice. **Please do not submit payment until you receive a bill.**

Family Continuation

Family Continuation provides continuance of coverage for a dependent child of the subscriber if the child meets all of the following requirements:

- The child is between the ages of 19 and 25
- The child is unmarried
- The child is a member of the subscriber's household (unless he or she temporarily resides elsewhere, such as college students living away at school)
- The subscriber provides more than half of the child's support
- The child is related to the subscriber by blood, marriage, legal adoption or legal guardianship
- The child is a full-time student for a minimum of five months of the year **OR** has gross income of less than four times the personal exemption amount identified in the IRS Gross Income Test

Disabled dependent coverage

You may be eligible to obtain coverage for an unmarried child who is incapable of self-sustaining employment because of a disability that occurred before age 19. You must supply proof of the disability from a physician licensed in Michigan.

Enrollment

If you want to enroll, please submit your completed application to:

Blue Cross Blue Shield of Michigan - MC BP202
600 E. Lafayette Blvd.
Detroit, Michigan 48226-9942