Group Member Life & Dental Enrollment Application

Dental / Life / AD&D / Disability

Florida Combined Life

An Independent Licensee of the Blue Cross and Blue Shield Association

We can help

If you, or someone you're helping, has questions about Florida Combined Life Dental, Life, AD&D or Disability plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Florida Combined Life Dental, Life, AD&D or Disability plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Florida Combined Life Dental, Life, AD&D or Disability plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Florida Combined Life Dental, Life, AD&D or Disability plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid 1-800-370-5856 Life, AD&D or Disability.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Florida Combined Life Dental, Life, AD&D or Disability plans, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability.

如果您，或是您正在協助的對象，有關於 插入項目的名稱 Florida Combined Life Dental, Life, AD&D or Disability plans,方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability。

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Florida Combined Life Dental, Life, AD&D or Disability plans,vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Florida Combined Life Dental, Life, AD&D or Disability plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Florida Combined Life Dental, Life, AD&D or Disability plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Florida Combined Life Dental, Life, AD&D or Disability plans، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-888-223-4892 Dental PPO, Dental Prepiad 1-877-325-3979, Life, AD&D or Disability 1-800-370-5856

Se tu o qualcuno che stai aiutando avete domande su Florida Combined Life Dental, Life, AD&D or Disability plans, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Florida Combined Life Dental, Life, AD&D or Disability plans, haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability an.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Florida Combined Life Dental, Life, AD&D or Disability plans, 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability. 로 전화하십시오.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Florida Combined Life Dental, Life, AD&D or Disability plans, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability.

જો તમે કે તમે મદદ કરી રહ્યાં હો તેમને Florida Combined Life Dental, Life, AD&D or Disability plans, વિશે પ્રશ્નો હોય, તો તમને મદદ અને તમારી ભાષામાં માહિતી કોઇ ખર્ચ વગર મેળવવાનો અધિકાર છે. દુભાષિયા માટે આ નંબર પર ફોન કરો, 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability.

หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคาถามเกี่ยวกับ Florida Combined Life Dental, Life, AD&D or Disability
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability.

1557 Non-Discrimination

Florida Combined Life Insurance Company, Inc. (FCL) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. FCL does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

FCL:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact 1-888-223-4892 Dental PPO, 1-877-325-3979 Dental Prepaid, 1-800-370-5856 Life, AD&D or Disability.

If you believe that FCL has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
Email civilrightscoordinator@fclife.com.

You can file a grievance in person or by mail or 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
1–800–368–1019, 800–537–7697 (TDD).

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

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Please write clearly in black or blue ink

Section A: Employer Provided Information

Group Name: 1.	Life Group #: 2.	Dental Group # 3.	Division #: 4.
Coverage Effective Date: 5.	Date of Hire: mm dd yyyy 6.	Occupation: 7.	Class: 8.

Work Status: 9. ☐ Actively at Work ☐ COBRA ☐ Retired	Paid: ☐ Hourly ☐ Salary 10.	Annual Salary: $ 11.	Hours worked per week: 12.	☐ Open Enrollment: *(Dental Only)* 13.

Section B: Employee Information *(Refer to Section D for Dependent Information)*

Last Name: 14.	First Name: 15.	M.I.: 16.	Gender: ☐M ☐F 17.	Date of Birth (DOB): 18.

Social Security No.: 19.	Address: 20.	Apt.#: 21.	City: 22.	State: 23.	Zip: 24.

County: 25.	Home Phone #: ( ) 26.	Business Phone #: ( ) 27.	Marital Status: ☐ Single ☐ Married ☐ Divorced 28.	Email Address: 29.

Section C: Dental Coverage Selection

(If yes, select one of the Plans below.) Employee: ☐ Yes ☐ No, I decline Coverage. Child(ren): ☐ Yes ☐ No, I decline Coverage. 30.
Spouse: ☐ Yes ☐ No, I decline Coverage.

Plan Type Requested: ☐ BlueDental Choice Plus (PPO) _____ ☐ BlueDental Choice (PPO) _____ ☐ BlueDental Choice Copayment (PPO) _____ 31.
☐ BlueDental Care (Prepaid) _____ ☐ BlueDental Freedom (Indemnity) _____

Section D: Employee and Dependent Information

Add additional dependents to the back of this form, sign and date it.

First Name / Middle Initial / Last Name 32.	Social Security No. 33.	Date of Birth mm/dd/yyyy 34.	Relation to You (DP = Domestic Partner) 35.	Gender 36.	BlueDental Care Only Facility ID # To see a list of dentists in the network visit www.bcbsfl.com Check box if a current patient 37.
Employee					☐
			☐ Spouse or ☐ DP	☐ M ☐ F	☐
			☐ Child or ☐ DP Child	☐ M ☐ F	☐
			☐ Child or ☐ DP Child	☐ M ☐ F	☐
			☐ Child or ☐ DP Child	☐ M ☐ F	☐

Section E: Other Dental Insurance Information (This section must be completed for claims processing.)

In addition to this policy, do you or your dependents have any other dental insurance under a group plan? ☐Yes ☐ No If yes, complete below. 38.

Name of Person: 39.	Group Name & #: 40.	Policy #: 41.

Insurance Co./Name and Address: 42.

Section F: Life, AD&D and Disability Coverage Selection

(If yes, select coverages below.) Employee: ☐ Yes ☐ No, I decline Coverage. Child(ren): ☐ Yes ☐ No, I decline Coverage. 43.
Spouse: ☐ Yes ☐ No, I decline Coverage.

Coverage Requested: 44.

☐ Basic Term Life $_____ ☐ Supplemental Life $_____ ☐Supplemental AD&D ☐ Small Group Package 10
☐ Accidental Death & Dismemberment (AD&D) $_____ ☐ Short Term Disability (STD) ☐ STD Buy-Up ☐ Small Group Package 20
☐ Dependent Life $_____ ☐ Long Term Disability (LTD) ☐ LTD Buy-Up ☐ Small Group Package 35

Voluntary Coverages: (If spouse Voluntary Life is selected, spouse information must be provided in Section D above.)
Life ☐ Employee $_____ ☐ Spouse $_____ ☐ Child(ren) $_____ AD&D ☐ Employee $_____ ☐ Spouse_____ ☐ Child(ren)_____
☐ Voluntary Short-Term Disability (VSTD) _____
☐ Voluntary Long-Term Disability (VLTD) _____
Have you or your spouse (if applying for coverage) used tobacco products in the past year? You: ☐Yes ☐No Spouse: ☐Yes ☐No

Group Life Beneficiary Information Add additional beneficiaries to the back of this form, sign and date it. 45.
This will revoke any existing beneficiary designation you may have. Total % must = 100%.

Primary Beneficiary:	DOB:	Relation to You:	% of Share:
Primary Beneficiary:	DOB:	Relation to You:	% of Share:
Secondary (Contingent) Beneficiary:	DOB:	Relation to You:	% of Share:
Secondary (Contingent) Beneficiary:	DOB:	Relation to You:	% of Share:

Section G: Acceptance of Coverage (Please read before signing)	Section H: Refusal of Any/All Coverage (Please read before signing)
I wish to apply for any coverage checked YES under Parts C and F on the front of this form. I have read and understand the Acceptance of Coverage on this form. I certify the statements on this application, including any attachment to it, are true and complete to the best of my knowledge and belief. *(If you checked NO for any coverage under Parts C or F, sign and date Part H also.)* 46.	I do not wish to apply for any coverage checked NO under Parts C and F above. I understand there may be additional requirements if I decide to apply at a later time. 47.
Signature: Date	Signature: Date
FRAUD NOTICE: I understand that 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.	

Section I: Acceptance of Coverage Authorization

I hereby apply for the coverage checked "Yes" on the front of this form. My employer has selected the coverage through Florida Combined Life Insurance Company, Inc. (FCL). I authorize my employer to deduct from my earnings my premium contribution (if any). I understand all of the following: 1. If my coverage is to be issued and continued, I must meet all the group contract's requirements; 2. if my dependents' coverage, if any, is to be issued and continued, my dependents must meet all the group contract's requirements; and (3) if I am not actively at work on my proposed coverage effective date, my effective date for certain coverages may be deferred until the date I return to active work.

I understand a dependent cannot be: (1) covered as both a dependent and an employee, including married employees of the same employer, (2) covered under more than one employee, or (3) full-time military.

I understand that my employer is not an agent of FCL. I also understand that my employer is responsible for notifying all employees of: 1. all effective dates; 2. all termination dates; 3. any Employee Retirement Income Security Act (ERISA) rights or responsibilities; and 4. all other matters pertaining to coverage under the group contract.

If an overpayment is made, I authorize FCL to recover the excess from any person or entity to which payment is made.

I acknowledge that, if I apply for FCL dental coverage later, coverage will not be available until the next open enrollment. I also understand if I apply later for coverages, other than dental, I may be required to furnish evidence of insurability.

I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I hereby certify that the statements on this application, including any attachment to it, are true and complete to the best of my knowledge and belief. I understand and agree that any misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage.

A photocopy of this application shall be as valid as the original. However, the original application is required to evaluate this application. I agree to be bound by the group contract's terms and conditions. I understand that this application is hereby made a part of the group contract. I will attach it to my certificate of coverage, when issued.

Add additional dependents below. Be sure to include your signature and the date.

First Name	Middle Initial	Last Name	Social Security No.	Date of Birth mm/dd/yyyy	Relation to You (DP = Domestic Partner)	Gender	BlueDental Care Only Facility ID # Check box if a current patient
					☐ Child or ☐ DP Child	☐ M ☐ F	☐
					☐ Child or ☐ DP Child	☐ M ☐ F	☐
					☐ Child or ☐ DP Child	☐ M ☐ F	☐

Add additional beneficiaries below. Be sure to include your signature and the date. Total % must = 100%.

Primary Beneficiary:	DOB:	Relation to You:	% of Share:
Primary Beneficiary:	DOB:	Relation to You:	% of Share:
Secondary (Contingent) Beneficiary:	DOB:	Relation to You:	% of Share:
Secondary (Contingent) Beneficiary:	DOB:	Relation to You:	% of Share:

Signature Date