Application/Change Form for Individual Insurance for BlueDental Choice/Copayment PPO

We can help

If you, or someone you're helping, has questions about BlueDental Choice Q, QF/BlueDental Copayment Q, QF, 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.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de BlueDental Choice Q, QF/BlueDental Copayment Q, QF, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-223-4892.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan BlueDental Choice Q, QF/BlueDental Copayment Q, QF, 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.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về BlueDental Choice Q, QF/BlueDental Copayment Q, QF, 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.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o BlueDental Choice Q, QF/BlueDental Copayment Q, QF, 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.

如果您，或是您正在協助的對象，有關於 插入SBM項目的名稱 BlueDental Choice Q, QF/BlueDental Copayment Q, QF 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。

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de BlueDental Choice Q, QF/BlueDental Copayment Q, QF, 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.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa BlueDental Choice Q, QF/BlueDental Copayment Q, QF, 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.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу BlueDental Choice Q, QF/BlueDental Copayment Q, QF, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-888-223-4892.

صوصخب ةلئسأ هدعاست صخش ىدل وأ كيدل ناك نإ BlueDental Choice Q, QF/BlueDental Copayment Q, QF ، ينف قحلا كيدلف ب لصئا مجرتم عم ثدحتلل .ةفلكت ةنيا نود نم كتغلب ةيرورضلا تامولعملاو ةدعاسملا ىلع لوصحلا 1-888-223-4892.

Se tu o qualcuno che stai aiutando avete domande su BlueDental Choice Q, QF/BlueDental Copayment Q, QF, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-888-223-4892.

Falls Sie oder jemand, dem Sie helfen, Fragen zum BlueDental Choice Q, QF/BlueDental Copayment Q, QF 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 an.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 BlueDental Choice Q, QF/BlueDental Copayment Q, QF 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 로 전화하십시오.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie BlueDental Choice Q, QF/BlueDental Copayment Q, QF, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-888-223-4892.

જો તમે કે તમે મદદ કરી રહ્યાં હો તેમને BlueDental Choice Q, QF/BlueDental Copayment Q, QF 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.

หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคาถามเกี่ยวกับ BlueDental Choice Q, QF/BlueDental Copayment Q, QF
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-888-223-4892

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, sex, gender identity or sexual orientation. FCL does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

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.

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, sex, gender identity or sexual orientation, 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*.

Application/Change Form for Individual Insurance for BlueDental Choice/Copayment PPO

Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

☐ **Making a Change** (Start with Section 1)
☐ **New Applicant** (Complete Sections 2 through 9)

Mail to: P.O. Box 44236
Jacksonville, FL 32231-4236

I wish to purchase this coverage for:

☐ Myself ☐ Myself and my Spouse/Domestic Partner ☐ My Dependent Child(ren) under the age of 19 (Child Only Plan) ☐ My Family

SECTION 1 - CHANGE INFORMATION

(**For <u>all changes</u> complete sections 2, 9 and 10. To add or delete a dependent, complete Section 4, for premium payment changes, complete Section 6.**)

☐ Add/Delete Dependents ☐ Name Change from: _____ to: _____
☐ Terminate All Coverage ☐ Social Security No. Correction from: _____ to: _____
☐ Change Bank Draft ☐ Other Personal Information Changes
☐ Other: _____ ☐ Reinstatement – Premiums must be paid to a current status. Submit premium payable by Money order or cashier's check within 60 days of termination process date.
_____

REQUIRED: Member Number (located on your ID card) _____

Remarks:

SECTION 2 - APPLICANT INFORMATION

Last Name	First Name	MI	Social Security No.

Home Address	City	State	Zip Code

Birth Date: (mm/dd/yyyy)	Gender: ☐ M ☐ F	Telephone No. ( )	E-mail:

SECTION 3 – POLICY SELECTION

☐ BlueDental Choice QF Policy (Adult only or Family ☐ BlueDental Copayment QF Policy (Adult only or Family)
☐ BlueDental Choice Q Policy (Child Only) ☐ BlueDental Copayment Q Policy (Child Only)

SECTION 4 – DEPENDENT INFORMATION

List all Eligible Dependents to be covered. Eligible Dependents for a Child Only (Q) plan include Dependent Children who are 18 years of age or under on the coverage effective date. Coverage in the Q plan will end on the last day of the Calendar Year the Child turns age 19. Eligible Dependents for an Adult or Family (QF) plan include your spouse/ domestic partner and/or children ages newborn to 30. A child may be insured as a dependent until attaining age 26. However a child up to age 30 may be eligible for coverage if the child is (1) unmarried and does not have a dependent; (2) a resident of Florida or a full-time student; and (3) not provided coverage under another dental insurance policy or eligible for benefits under Title XVIII of the Social Security Act. Attach additional sheet of paper, if necessary. Sign and date it.

Add	Delete	Last Name First Name MI	Social Security No.	Birth Date mm/dd/yyyy	Relation to You	Gender
☐	☐				☐Spouse *or* ☐DP	☐ M ☐ F
☐	☐				☐Child *or* ☐DP Child	☐ M ☐ F
☐	☐				☐Child *or* ☐DP Child	☐ M ☐ F
☐	☐				☐Child *or* ☐DP Child	☐ M ☐ F

Do you or any of your dependents have Dental insurance under another Policy? ☐ Yes ☐ No If "Yes" complete the following the time of application:

Person's Name: Policy No.:

Insurance Co. Name/Address:

SECTION 5 - SUPPLEMENTAL INFORMATION

You must be a Florida resident and a United States citizen or have a permanent Visa (6 months) at the time of application to be eligible for coverage.

1. Is the person named in Section 2 a permanent Florida resident?.....	☐ Yes ☐ No
2. Are all persons listed in Sections 2 and 4 United States citizens? ……	☐ Yes ☐ No
If "No," do all persons listed in Section 2 and 4 have a permanent Visa (with at least 6 months remaining? We may ask for documentation to confirm legal status of all applicants.	☐ Yes ☐ No

Member Name	Type of VISA	VISA Expiration Date

SECTION 6 – PREMIUM PAYMENT METHOD

1. Check: Monthly Premium Payment: $_____
   (Make checks payable to Florida Combined Life)
2. Bank Draft: (Automatic Monthly Withdrawal) ☐ I understand that if I choose automatic withdrawal by bank draft, my invoices will only be sent electronically.

REQUIRED email address: _____ (enter a valid email address as it will be used to communicate important information about your bank draft or application).

You Must Include A Voided Check With This Application For Bank Draft and Complete the Section Below. We will deduct your 1st and future premiums from your account. Policy premiums will be drafted three days in advance of the 1st of the month.

I authorize _____ to make a bank draft of $_____
(Financial Institution/Bank Name)

From Account No. _____ Bank Routing No. _____

and to remit the amounts deducted to Florida Combined Life Insurance Company, Inc. (FCL), upon instructions from FCL. The amount of deduction indicated above is approximate and may be corrected as instructed by FCL. This authorization will remain in effect until: (a) I/we cancel it in writing; (b) the above account is closed; (c) the deduction and remittance arrangements between the above financial institution and FCL are discontinued; or (d) the insurance policy is cancelled. I understand that this authorization does not waive or change any of the payment provisions of the policy issued to me by FCL, and if this authorization terminates for any reason, any further payments required under the policy will be made as provided in the policy. I agree that the above financial institution is acting gratuitously and for my sole accommodation and not as an agent for FCL.

Accountholder's Signature (Required): X _____ Date:_____

SECTION 7 – AGENT INFORMATION (Agent Use Only)
(All Information must be completed to process application)

Agent Printed Name**:**	**Signature** X:	Date:
Agent Phone Number: ( )	Agent Fax Number: ( )	
Florida State License Number:	BCBSF Agent Code:	

SECTION 8 – REPLACEMENT OF COVERAGE

1. Is this insurance intended to replace ANY dental insurance currently "in force?" ☐ Yes ☐ No
   If "Yes", complete the following:
   Insurance Company Name: Policy No.:
   Effective Date: Termination Date:
   (Also, complete the Replacement of Insurance notice and submit it with your application.)
2. During the last 90 days, have you had 12 consecutive months of dental insurance (including individual or group) coverage? ☐ Yes ☐ No If "Yes" complete the following:
   Insurance Company Name: Policy No.:
   Effective Date: Termination Date:

SECTION 9 – ACCEPTANCE OF COVERAGE

I am a Florida resident, and I wish to enroll in the policy selected in Section 3. I understand the insurance applied for will not become effective until FCL has approved my application. I understand that waiting periods may apply for certain services.

I understand that this is a minimum one (1) year contract and all necessary dental services will be provided as described in the plan.

I authorize FCL to exchange benefit information with any insurance company, organization, or individual to determine if coordination of benefits applies for me and my dependents. 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 FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I 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 misstatements may result in denial of benefits and/or termination of coverage.

I understand that this application is hereby made a part of the policy. A photocopy of this application shall be as valid as the original.

I understand that FCL may terminate this insurance, with proper notice, at the end of any period for which the premium has been paid.

☐ I understand that the BlueDental Choice Q and the BlueDental Copayment Q policies only provide pediatric benefits to covered persons who have not attained the age of 19.

Do you agree to receive and accept communications from FCL about your application or other notices by email?
☐ Agree ☐ Disagree

Applicant/Guardian Signature (Required): **X** _____ **Date:** _____

(Guardian signature required if applicant is under age 18) Guardian Relationship to Child_____

SECTION 10 – CHANGE AUTHORIZATION

I acknowledge that FCL coverage may be terminated by giving FCL written notice.

Membership changes granted to persons herein shall be subject to all provisions and limitations of the individual policy. I am aware that a change in dependents may affect the amount of premium due to FCL for the individual dental coverage. I understand the change requested will not become effective until FCL has issued approval of the change. I certify that I have the authorization to request any change to the policy.

If I enrolled in my current qualified dental policy on the Federal Marketplace and want to switch to an Off-Marketplace policy, I understand that I am responsible for cancelling from my current dental policy on the Marketplace (www.healthcare.gov).

I attest that I am the primary policyholder or such individual's legally authorized representative with the appropriate authority to make the aforementioned changes.

Applicant/Guardian Signature (Required): **X** _____ **Date:** _____

(Guardian signature required if applicant is under age 18) Guardian Relationship to Child_____

If you have any questions about completing this application, contact your agent or call 888-753-4363.

Fraud Notice: 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.