BlueDental Care Prepaid

Application/Change Form for Individual Plans

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

Mail to:
Florida Combined Life
Dental Service Administrator
P.O. Box 769569
Roswell, GA 30076-8223

☐ **New Applicant (Complete #1 through 3 and complete Premium Payment Form)**
☐ **Making a Change (Start with #1)**

Change Information (Check all those that apply and complete numbers indicated)

☐ Name	Complete #1 and #3	From: _____ To: _____
☐ Social Security Number Correction	Complete #1 and #3	From: _____ To: _____
☐ Other Personal Information Changes	Complete #1 and #3	
☐ Add/Delete Dependents	Complete #1, #2 and #3	
☐ Delete All Coverage	Complete #1 and #3	
☐ Provider Change	Complete #1, 2 and #3	
☐ Change Bank Draft	Complete Premium Payment Form (#3)	
☐ Change Credit Card	Complete Premium Payment Form (#2)	
☐ Other: _____		

Change Information Required:
Requested Effective Date of Change: _____
Contract No. _____
(Located on your ID Card)
Remarks: _____

Reason for Change: ☐ Marriage ☐ Age Limit ☐ Moved out of Service Area ☐ Divorce
☐ Other (Explain): _____

Personal Details

Please answer the following questions accurately and completely to the best of your knowledge and belief. A Florida Combined Life Insurance Company, Inc. (FCL) representative, or someone acting on our behalf, may contact you for more details.

We rely on you to tell us the truth about all applicants' health and medical histories (if applicable). Please note any misrepresentation, omission, concealment of facts, or incorrect statement may result in modification, termination, or rescission of your contract. Under Florida law, it is a crime to provide any false, incomplete or misleading information in order to get insurance coverage.

1. Applicant Information

First Name	M.I.	Last Name	Suffix	Social Security Number/ITIN	Gender
					☐ M ☐ F

Date of Birth MM/DD/YYYY (Minimum applicant age is 18)	Birth State, Province, or County	Dental Facility Number (Select from Provider Directory)
/ /		

Home Address _____ City _____ State _____ Zip Code _____ County _____

Is your billing address the same as your home address? ☐ Yes ☐ No

I would like to receive correspondence at: ☐ Home Address ☐ Billing Address

Billing Address _____ City _____ State _____ Zip Code _____ County _____

Contact Information
By providing your phone number(s), you agree that Florida Combined Life and those acting on their behalf can contact you about your application, enrollment, coverage and benefits at the number(s) provided. Mobile call rates may apply based on your plan with your mobile phone carrier.
Primary Phone Number: ( ) Secondary Pone Number: ( ) Best time to call: _____

Applicant Email Address: _____

Other Information - Are you a Florida resident? ☐ Yes ☐ No

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

Applicant First Name	M.I.	Last Name	Social Security Number

2. Applicant Information List all Eligible Dependents to be covered. Eligible Dependents include your spouse/domestic partner and/or children to age 30. Children of a domestic partner may be covered when the domestic partner is also covered. A Primary Care Dentist must be selected from the BlueDental Care Provider Directory for each applicant. If necessary, attach additional sheet(s) of paper that are signed and dated.

Each person on the application can select a different Facility Number

Add/Delete	**First, M.I. Last**	**Social Security Number**	**Date of Birth** mm/dd/yyyy	**Relationship to Applicant**	**Gender**	**Facility #** Check box if a current patient
☐ ☐				☐ Spouse *or* ☐ DP	☐ M ☐ F	☐
☐ ☐				☐ Child *or* ☐ DP Child	☐ M ☐ F	☐
☐ ☐				☐ Child *or* ☐ DP Child	☐ M ☐ F	☐
☐ ☐				☐ Child *or* ☐ DP Child	☐ M ☐ F	☐

Agent Acknowledgement

Agent Name: _____ Florida License Number:_____

3. CONSUMER ACKNOWLEDGEMET

I wish to enroll in the FCL prepaid individual plan. I understand that this is a MINIMUM ONE (1) YEAR CONTRACT and that all necessary dental services will be provided as described in the plan. Completed applications with correct payment received by the 15th of the month will take effect on the 1st of the following month. Applications received after the 15th of the month will take effect on the 1st of the month following the subsequent month.

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

CHANGE AUTHORIZATION:
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 Prepaid Dental Plan coverage. I understand the changes requested will not become effective until FCL has issued approval of the policy. I certify that I have the authorization to request any change to the policy.

Fraud Notice:
Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree**.**

SIGNATURE:

X _____ _____
APPLICANT SIGNATURE (Required): DATE (Required)

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Applicant First Name	M.I.	Last Name	Social Security Number

Premium Payment

1. Annual Check Selection
(Make checks payable to Florida Combined Life)
Premium Payment $ _____
Check No. _____

2. Annual Credit Card Section
Check One: ☐ MasterCard ☐ Visa ☐ Discover
Credit Card No. _____
Exp. Date mm/yy _____

Amount Charged (annual premium + one-time $35 non-refundable enrollment fee = Annual Amount You Pay) $ _____ + $35 = $ _____
I hereby authorize charging by credit card:

Cardholder's Signature: _____

Date: _____

FI315 PLAN RATES

Policy type (Select One)	Monthly Premium (Bank Draft Only)	Annual Premium (Check, Money Order or Credit Card)
Individual	$11.99	$143.88
Individual + one dependent	$22.78	$273.36
Individual + two dependents	$32.37	$388.44
Individual + three dependents	$41.97	$503.64
Individual + four or more Dependents	$50.36	$604.32
Calculate Your Total Below	**Monthly**	**Annual**
Premium Amount	$	$
One time non-refundable enrollment fee	+ $35.00	+ $35.00
Administrative Fee (Bank Draft Only)	+ $1.00	
Total Amount Due	$	$

3. Monthly Bank Draft Authorization for Deduction Section

Accountholder's Name _____ Premium Payment $ _____
Bank Routing No. _____ Check No. _____ I authorize _____
(Financial Institution/Bank Name)

to make a bank draft of $ _____ + $1.00 = $ _____ from Bank Account # _____
(Monthly premium + $1.00 administrative fee) *(Monthly Only)*

and to remit the amounts deducted to 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 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.

YOU MUST INCLUDE A VOIDED CHECK AND YOUR 1ST MONTH'S PREMIUM WITH THIS APPLICATION.

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

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We can help

If you, or someone you're helping, has questions about Prepaid Individual Plan FI315, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-325-3979.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Prepaid Individual Plan FI315, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-325-3979.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Prepaid Individual Plan FI315, 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 1-877-325-3979.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Prepaid Individual Plan FI315, 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 1-877-325-3979.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Prepaid Individual Plan FI315, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-325-3979.

如果您，或是您正在協助的對象，有關於 插入項目的名稱Prepaid Individual Plan FI315 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 1-877-325-3979。

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Prepaid Individual Plan FI315, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-325-3979.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Prepaid Individual Plan FI315, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-325-3979.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Prepaid Individual Plan FI315, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-325-3979.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Prepaid Individual Plan FI315، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-325-3979.

Se tu o qualcuno che stai aiutando avete domande su Prepaid Individual Plan FI315, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-877-325-3979.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Prepaid Individual Plan FI315 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 1-877-325-3979 an.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Prepaid Individual Plan FI315 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-325-3979로 전화하십시오.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Prepaid Individual Plan FI315, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-877-325-3979.

જો તમે કે તમે મદદ કરી રહ્યાં હો તેમને Prepaid Individual Plan FI315 વિશે પ્રશ્નો હોય, તો તમને મદદ અને તમારી ભાષામાં માહિતી કોઇ ખર્ચ વગર મેળવવાનો અધિકાર છે. દુભાષિયા માટે આ નંબર પર ફોન કરો, 1-877-325-3979.

หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคาถามเกี่ยวกับ Prepaid Individual Plan FI315
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-877-325-3979

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 1-877-325-3979

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.*