DENTAL

Enrollment Application – The Auburn University Dental Plan – Blue Cross and Blue Shield of Alabama*

PLEASEPRINT:USEBLACKBALLPOINTPEN –PRESS FIRMLY

EMPLOYEENAME(LAST) (FIRST) (INITIAL)				EMPLOYEE'S DATE OF BIRTH
STREET ADDRESS CITY STATE ZIP		PHONENUMBER		GROUPNUMBER
CHECKONE: ☐ MALE ☐ FEMALE	CHECK ONE: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ SPONSOR ☐ WIDOWED	CHECK ONE: ☐ Dr. ☐ Miss ☐ Mrs. ☐ Ms. ☐ Mr.	SOCIAL SECURITY NUMBER	TYPE OF COVERAGE ☐ BASIC ☐ EXPANDED

TYPE OF DENTAL COVERAGE SELECTED: ☐ INDIVIDUAL ☐ EMPLOYEE & SPOUSE (OR SPONSORED ADULT) ☐ EMPLOYEE & CHILD(REN) ☐ FAMILY

LIST ALL DEPENDENTS ELIGIBLE UNDER THIS CONTRACT AND PROVIDE SOCIAL SECURITY NUMBERS.
NOTE: The Social Security Number for the employee and all dependents must be provided in order for this application to be processed.

	LAST NAME	FIRST NAME	INITIAL	RELATIONSHIP	GENDER	SOCIAL SECURITY NUMBER	DATE OF BIRTH MONTH	DAY	YEAR
1.				☐ SPOUSE ☐ SPONSOREDADULT	☐ MALE ☐ FEMALE				
2.				☐ CHILD ☐ SPONSOREDCHILD	☐ MALE ☐ FEMALE				
3.				☐ CHILD ☐ SPONSOREDCHILD	☐ MALE ☐ FEMALE				
4.				☐ CHILD ☐ SPONSOREDCHILD	☐ MALE ☐ FEMALE				
5.				☐ CHILD ☐ SPONSOREDCHILD	☐ MALE ☐ FEMALE				

NATURE OF APPLICATION —

CONTRACT APPLICATION
☐ New Coverage

CANCEL CONTRACT
☐ Dental Coverage

CHANGE CONTRACT
☐ Name Change
☐ Address Change
☐ Type of Coverage Change
☐ Change COB Information

ADD DEPENDENT
☐ Add Spouse
☐ Add Dependent Child
☐ Add Sponsored Adult Dependent
☐ Add Sponsored Child Dependent

REMOVE DEPENDENT
☐ Remove Spouse
☐ Remove Child
☐ Remove Sponsored Adult
☐ Remove Sponsored Child

DATE EVENT OCCURRED: (Example: Date of marriage, birthdate of child, etc.) **01/01/2018**

STUDENT EXTENSION CERTIFICATION – List any dependent child applying for student extension:

NAME OF CHILD NAME OF SCHOOL

COORDINATION OF BENEFITS INFORMATION — If you, your spouse, or your dependents are covered by any other group dental insurance please give the following information.

NAME OF CONTRACT HOLDER _____

POLICY, ID, CONTRACT OR CERTIFICATE NUMBER _____ TYPE COVERAGE ☐ INDIVIDUAL ☐ FAMILY

NAME OF INSURANCE COMPANY _____

ADDRESS _____

EMPLOYER'S NAME CITY _____ GROUP# _____

☐ I am requesting cancellation of my existing benefits as checked above.

☐ I apply for the Group Dental Benefits certificate or Group Agreement for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (my employer or other organization through which I am applying for coverage) and you (Blue Cross and Blue Shield of Alabama). If you accept this application, you will send me an ID card. My Group's contract with you is made up of 1) my Group's application to you, 2) The Group Health Benefits Certificate or Group Agreement, and 3) any written amendments to the Certificate or Group Agreement. My contact with you is made up of these three items and this and any later application by me to you. My coverage will be through this contract. I name my Group as my Group Agent or Remitting Agent. I ask my Group to pay you direct and I give my Group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application. You may take back any monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by law including any compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until you accept this application in writing.

If you do not accept my application, the only thing you have to do is to return my fees I paid. You may pay providers directly for service to me. I ask my dentist, doctor, hospital or anyone else to give all dental or medical records of me or my family to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as you need to decide about this application and process of any of our claims.

I will cooperate with you. If you need information about other dental policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or my family member) or be reimbursed, I will give it to you.

By signing this application, I certify that all dependents are eligible for coverage under the terms of the Group Plan for which I am applying.

SIGNATURE OF EMPLOYEE DATE SIGNED DATE EMPLOYED

SIGNATURE AND TITLE OF EMPLOYER REPRESENTATIVE (Employer's Verification of Applicant Employment) DATE SIGNED EMPLOYERPHONENUMBER

EMPLOYER'S NAME	EMPLOYER'S ADDRESS
AUBURN UNIVERSITY	**PAYROLL AND EMPLOYEE BENEFITS** **212 INGRAM HALL, AUBURN, ALABAMA 36849**