Empire BlueCross BlueShield

Empire BlueCross BlueShield
Dental Enrollment Department
PO Box 838
Minneapolis MN 55440-0838

Dental Prime Individual Enrollment Form

Please complete in blue or black ink only. For information or assistance in completing this form, call Customer Service at 1-877-567-1807.

Applicant Information - Applicants must be at least 18 years of age and not currently covered by another Empire BlueCross BlueShield group or individual dental plan.

Last Name	First Name	Middle Initial	Social Security Number

Gender ☐ M ☐ F	Day Phone Number	Evening Phone Number	E-mail Address	Date of Birth / /

Address	City	State	ZIP Code

Have you had dental coverage in the past: ☐Yes ☐No If yes, when did coverage start _____ When did coverage end _____
Previous insurance carrier's name _____ What was your Policy Number_____

Agent Name	Agent ID	Agent Tax ID	Agent License ID	Agent Paid ID
TotalBen LLC	522442832	52-2442832	LA1075305	522442832

Select One Plan Option and Payment Method

Options: ☐ **Plan A** No Deductible/$500 Maximum ☐ **Plan B** $50 Deductible/$1000 Maximum
☒ **Plan C** $50 Deductible/$1250 Maximum ☐ Vision – you must enroll in a dental Plan in order to enroll for Vision

You can submit this application up to three months in advance of when you would like coverage to start. Coverage starts on the first day of the Requested Start Month. If you do not provide a start month, coverage will begin the first of the month after we receive your completed application. **Requested Start Month _____.**

Select Who Is To Be Enrolled: ☐ Applicant Only ☐ Applicant + One Dependent ☐ Family (Three or More Family Members)

Complete this section if you want to enroll family members. Dependent children under age 26 can be enrolled.

Relationship to Applicant	**First Name, Middle Initial, Last Name**	**Gender**		**Date of Birth** (mm/dd/yyyy)
☐Spouse ☐Domestic Partner		M	F	/ /
Dependent Child		M	F	/ /
Dependent Child		M	F	/ /

Select One Payment Option and Billing Frequency The first premium is charged immediately. Future premiums are deducted/charged around the 20th business day of each coverage period.

☐ **A. Direct Withdrawal from Checking/Savings Account:** ☐ **Monthly** ☐ **Quarterly** ☐ **Annual**
Name on Checking Account _____
Bank Name _____
Routing Number _____ Checking Account Number _____

☐ **B. Credit Card or Debit Card**: ☐ **Monthly** ☐ **Quarterly** ☐ **Annual** ☐ MasterCard ® ☐ Visa ®
Credit/Debit Card Number _____ Exp. Date _____/_____ Security Code _____
Name As It Appears On Credit/Debit Card _____

AUTHORIZATION AND VERIFICATION – Sign and date application as verification of your enrollment.

I have read, or have had read to me, the completed application. I authorize Empire to withdraw funds from my bank account or debit my credit card. I understand that if funds/credit balances are not available or payment is not made on time I will no longer be eligible for coverage. If I decide I do not want the contract, I may return it within 10 days after receipt with a written statement requesting termination of the contract. Upon return, the contract will be deemed void, and any money paid will be refunded minus any claims which may have been paid. I understand if I terminate this contract or discontinue enrollment for any reason, I will not be able to re-enroll for a period of 24 months.

Applicant Signature: SIGN HERE **Date:**