Empire BlueCross
An Anthem Company

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

Dental Membership Enrollment Form

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru D and return form to benefit administrator.

Employee's Name:	Last		First			Middle Initial	**Social Security Number** / /	
Gender:	Male ☐	Female ☐	**Marital Status:**	Single ☐	Married ☐	Widowed ☐	Divorced ☐	Legally Separated ☐	**Date of Birth (Month-Day-Year)** / /
Employee's Address:	Address					Home Phone Number		Work Phone Number
	City			State		Zip Code		

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):		**Complete If Multiple Plan Options Are Offered**
☐ Employee Only*	☐ No Coverage*	I elect to participate in the following Plan:
☐ Employee and Spouse	* **If waiving coverage for employee and/or any eligible family members, you must complete Part D.**	☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D
☐ Employee and Dependent Child(ren)		
☐ Family		

PART C – DEPENDENT INFORMATION

Relationship To Employee	**First Name, Middle Initial, Last Name** (Include Last Name Only if Different From Employee's)	**Gender**	**Date of Birth** Month/Day/Year	**Full Time Student?**		**Unmarried?**	
Spouse		☐M ☐F	/ /				
Dependent Child		☐M ☐F	/ /	☐Y	☐N	☐Y	☐N
Dependent Child		☐M ☐F	/ /	☐Y	☐N	☐Y	☐N
Dependent Child		☐M ☐F	/ /	☐Y	☐N	☐Y	☐N

PART D – EMPLOYEE SIGNATURE – Select One

Do you (the employee) have other dental coverage? ☐ Yes ☐ No Do your dependents have other dental coverage? ☐ Yes ☐ No

Name of Carrier: _____ Policy/Identification Number _____

☐ I wave coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Empire BlueCross reserves the right to decline any further dental enrollment changes.

Employee Signature: **Date:**

☐ I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. I have read, or have had read to me, the completed application and I realize any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation

Employee Signature: **Date:**

PART E – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

☐ **New Group**
Hire Date: _____/_____/_____
Prior Coverage Start Date (if applicable): _____/_____/_____
Coverage Effective Date: _____/_____/_____

☐ **Existing Dental Group**
Hire Date: _____/_____/_____
Prior Coverage Start Date (if applicable): _____/_____/_____
Coverage Effective Date: _____/_____/_____

☐ **New Hire** – Apply Probationary Period (if applicable) to determine Effective Date
Hire Date: _____/_____/_____
Effective Date: _____/_____/_____

☐ **Open Enrollment**
Effective Date:
_____/_____/_____

☐ **Rehire** Date Lay Off Began: _____/_____/_____
Date Rehired: _____/_____/_____

☐ **Return from Leave of Absence**
Date Leave Began: _____/_____/_____
Date Returned to Work: _____/_____/_____

☐ **Employee Change Part Time to Full Time**
Date of Status Change: _____/_____/_____
Effective Date: _____/_____/_____

☐ **Previously Waived Coverage or Loss of Coverage**
Qualifying Event Reason: _____
Hire Date: _____/_____/_____
Event Date: _____/_____/_____
Effective Date: _____/_____/_____

Group Name: **Group & Subgroup Numbers**:

Group Representative's Signature: **Date:** **Phone Number:** ( )

Services provided by Empire HealthChoice Assurance, Inc. a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Employer Instructions

- Review Parts A, B, C, and D to be sure all information is complete, accurate and legible.
- When reporting effective dates use contractual start and stop guidelines as defined in your contract (i.e., first of month, end of month, or actual dates).

Employer Complete Part: E - Group Enrollment Information

- Check one reason for enrollment and provide requested information including coverage effective dates.
- **New Group** – New customer initial employee enrollment. Complete the Prior Coverage Start Date if your plan benefits include waiting periods and credit for prior creditable coverage applies.
- **Existing Dental Group** – Enrolling additional employees from an acquisition/merger who were not previously offered/enrolled in your dental plan. Complete the Prior Coverage Start Date only if your plan benefits include waiting periods and credit for prior creditable coverage applies.
- **New Hire** – Enroll newly hired employee. If a probationary period applies, the coverage effective date is after the probationary period.
- **Open Enrollment** – An employee is enrolling during group's open enrollment period.
- **Rehire** – A former employee was rehired.
- **Return From Leave of Absence** – An employee is returning from leave of absence.
- **Employee Status Change** – The employee's employment status changed and the employee is now eligible for dental benefits.
- **Previously Waived Coverage or Loss of Coverage** – If an employee waives coverage; he/she can only enroll at a later date if the group contract includes an Open Enrollment period or if the individual has a loss of other insurance coverage. If an employee or dependent involuntarily losses coverage and are now eligible to enroll, complete this section.
- **Group Name** – Provide group name as listed in your contract.
- **Group and Subgroup Number** – Provide applicable numbers for individual employee.
- **Group Representative** – Sign, date, and provide your phone number.

Send Completed Forms To:
Empire BlueCross
Attn: Dental Enrollment Department
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