DENTAL

ENROLLMENT / CHANGE OF STATUS

Subscriber SSN (or assigned contract number) ___ - __ - ____ BCBSM Group _____ - Suffix ___

☐ **Plan 2** *(no ortho)*

☐ **Plan 3** *(ortho rider for dep <19)*

SUBSCRIBER INFORMATION

Subscriber Last Name ☐ check if new | Subscriber First Name | M.I. | Marital Status ☐ S ☐ M | Gender ☐ M ☐ F | Subscriber Birth Date __ / __ / ____ | Home Phone ___ - ___ - ____ ☐ check if new

Home Street Address ☐ check if new | City | State | Zip Code | Work Phone ___ - ___ - ____ ☐ check if new

County | Country - if other than USA | Email - optional

List all persons to be enrolled / terminated:

	CHECK ONE	LAST NAME	FIRST NAME	MI	GENDER	DATE OF BIRTH MM/DD/YYYY	SOCIAL SECURITY #	* REL CODE
Spouse	☐ Add ☐ Delete					/ /		
Dep-1	☐ Add ☐ Delete					/ /		
Dep-2	☐ Add ☐ Delete					/ /		
Dep-3	☐ Add ☐ Delete					/ /		

If the permanent address of the spouse or dependent is different from the address above, please complete the information below:

Spouse/Dependent (Full Name)	Street Address	City	State	Zip code

Do you, your spouse or dependent(s) maintain other health coverage? ☐ NO ☐ YES If Yes, complete below: Check here if this applies to all members on the contract: ☐

Person covered (Full Name)	Group Name	Policy Number	Carrier	Location
Person covered (Full Name)	Group Name	Policy Number	Carrier	Location

Are you, your spouse or any dependent(s) listed enrolled in Medicare? ☐ NO ☐ YES If Yes, attach a copy of Medicare card(s). ☐ Actively working ☐ Retired ☐ Under 65 ☐ ESRD (End Stage Renal Disease)

Subscriber Signature	Signature Date	Remarks

☐ Check here if new and have current AFLAC or other Dental Coverage

~ Waiting Periods Will be Waived

NOTE: applicant must attach proof of other coverage