Dental Plan Application for Individuals and Families

Please be sure to complete ALL information below, including signing the application, to avoid delays in processing.
Please print clearly using blue or black ink or type in information.
Save time! Apply online at bcbsri.com/individual/shop

Section 1 Applicant Information

First name _____ M.I. _____ Last name _____ Suffix_____

Home address _____

City/town _____ State _____ ZIP code _____

Mailing address (if different from home address) _____

City/town _____ State _____ ZIP code _____

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Sex assigned at birth ☐ M ☐ F

Social Security number[1] _____ Current BCBSRI ID _____

Home phone number _____ Cell phone number _____

Marital status (please check one) ☐ Single ☐ Married ☐ Divorced ☐ Common Law ☐ Civil Union ☐ Domestic Partner ☐ Widow/er

What is your primary language spoken? _____ Email address _____

What is your race and/or ethnicity? (**select all that apply**)
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Portuguese ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White
☐ Other ☐ Prefer not to say

Use your BCBSRI member account to add/update demographic information. Visit bcbsri.com to register or log in.

Section 2 Dental Plan Options

Choose a **dental** contract type: ☐ Individual ☐ Family (Select "Family" if adding spouse and/or dependents)
Requested dental effective date (mm/dd/yyyy): ____ / ____ / _____

Dental coverage applied for:

☐ Dental Direct Basic	☐ Dental Direct Plus
☐ Dental Direct Standard	☐ Dental Direct Elite

These are Qualified Dental Plans, which are certified as providing the pediatric dental essential health benefit.

[1]Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law.
See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html

Please remember to sign this application on page 4.

Section 3 Spouse or Domestic Partner Information (Complete if adding spouse or domestic partner)

First name _____ M.I. _____ Last name _____ Suffix_____

Home address (if different from applicant) _____

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Sex assigned at birth ☐ Male ☐ Female

Email address _____ Social Security number[1] _____

What is your race and/or ethnicity? (**select all that apply**)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino
☐ Portuguese ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White
☐ Other ☐ Prefer not to say

Use your BCBSRI member account to add/update demographic information. Visit **bcbsri.com** to register or log in.

Section 4 Dependent Information

(If necessary, please attach dependent addendum found at **bcbsri.com/individual/member/forms**.)

Dependent #1

First name _____ M.I. _____ Last name _____ Suffix_____

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Sex assigned at birth ☐ M ☐ F

Email address _____ Social Security number[1] _____

Dependent #2

First name _____ M.I. _____ Last name _____ Suffix_____

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Sex assigned at birth ☐ M ☐ F

Email address _____ Social Security number[1] _____

Dependent #3

First name _____ M.I. _____ Last name _____ Suffix_____

Date of birth (mm/dd/yyyy) ___ / ___ / _____ Sex assigned at birth ☐ M ☐ F

Email address _____ Social Security number[1] _____

☐ Check here if Dependent Addendum form will be attached.

Section 5 Eligibility

To determine eligibility please let us know, are you a Rhode Island resident? ☐ Yes ☐ No

[1]Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law.
See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html

Please remember to sign this application on page 4.

Section 6 Medicare

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when any of the services covered by the policy are also covered by Medicare. Medicare pays extensive benefits for medically necessary services regardless of the reason you need them.

These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

✓ Check the coverage in all health insurance policies you already have. You can compare your current policy and the one you have selected by going on our website or by calling our Individual Sales Department.

✓ For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance program (SHIP).

Section 7 Dental Direct Disclosure Statement

- A 12-month waiting period applies to periodontal services, oral surgery, crowns, and prosthodontics on some plans.
- You may be eligible to waive any applicable waiting periods for a dental plan if you've had equal or substantially similar prior coverage for at least 12 months. Proof of equal or substantially similar prior coverage must be provided within 60 days of the effective date of this dental plan. Your previous dental plan must have terminated within 60 days of the effective date of the new dental application with Blue Cross & Blue Shield of Rhode Island Dental.

Please note: *Waiting periods do not apply to members under the age of 19 enrolling in a Qualified Dental Plan. If you terminate coverage and then re-apply, the waiting periods listed above will apply without accounting for your prior coverage.*

[1]Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law.
See www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html

Please remember to sign this application on the next page.

Section 8 Signature

By signing this application, I certify and agree that:

1.) I have read the above statements, or that they have been read to me; and

2.) All responses on this application are the truth, as best I know. If anyone knowingly lied or hid the truth BCBSRI will have the right to:

- Reduce or deny a claim; and
- Cancel the plan, back to the effective date; and
- Recoup any monies paid, back to the effective date.

3.) The applicant is the responsible person for the payment of premiums.

4.) No benefits will apply until the coverage is made effective by BCBSRI.

5.) This application may be signed electronically through Docusign only, and I agree that the electronic signature created by Docusign is the same as a handwritten signature for the purposes of validity, enforceability, and admissibility.

☐ By checking this box, you are consenting for Blue Cross & Blue Shield of Rhode Island to contact you via automatic telephone dialing system, by artificial or prerecorded message, or by text message at the phone number you have provided above. You agree that you give your consent to receive health and benefits updates, product offers and personalized reminders about your health, from Blue Cross & Blue Shield of Rhode Island and its agents that provide mobile communication services. Standard message and data rates may apply. This is an optional service and is not required to enroll in your health plan or purchase goods and services from Blue Cross & Blue Shield of Rhode Island.

SIGN HERE ☞

_____

Signature of applicant or parent/guardian *if applicant is under 18 years of age* Date

APPLICATION CANNOT BE PROCESSED WITHOUT SIGNATURE

Section 9 Contact Information

Please submit your application by using one of the methods below:

- Email to: IndividualEnrollmentIntake@bcbsri.org
- Fax to: (401) 459-5378
- Mail to: Blue Cross & Blue Shield of Rhode Island
  Attn: Individual Sales Department
  500 Exchange Street
  Providence, Rhode Island 02903-2699

For questions, call: Individual Sales Department: 1-855-690-2583 (my0blue) or (401) 459-5550

INTERNAL USE ONLY

Sales eff. date _____ ID# _____ Eligibility _____ Initial _____

Blue Cross Blue Shield of Rhode Island

500 Exchange Street • Providence, RI 02903-2699

Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

8/26 BCD-1569650