

# Dental Plan Application for Individuals and Families

Please be sure to complete ALL information below to avoid delays in processing.  
**Please print clearly using blue or black ink or type in information.**

## Section 1 Applicant Information

Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_ Suffix \_\_\_\_\_

Home address \_\_\_\_\_ City/town \_\_\_\_\_ State \_\_\_\_\_ ZIP code \_\_\_\_\_

Mailing address \_\_\_\_\_

Date of birth (mm/dd/yyyy) \_\_\_ / \_\_\_ / \_\_\_\_\_ Gender  M  F Social security number<sup>1</sup> \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Current BCBSRI ID (if applicable) \_\_\_\_\_ Home phone number \_\_\_\_\_ Cell phone number \_\_\_\_\_

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

What is your primary language spoken? \_\_\_\_\_ E-mail address \_\_\_\_\_

Race (please check one)

- American Indian or Alaska Native  Asian  Black or African American  Hispanic or Latino  
 Multiracial  Native Hawaiian or other Pacific Islander  White

Dentist name, address \_\_\_\_\_

Are you a current patient?  Yes  No

## Section 2 Dental Plan Options

Choose a **dental** contract type:  Individual  Family

Requested dental effective date (mm/dd/yyyy): \_\_\_ / \_\_\_ / \_\_\_\_\_

**Dental coverage** applied for:

- |   |  |
|---|--|
| <input type="checkbox"/> Dental Direct Basic    | <input type="checkbox"/> Dental Direct Plus  |
| <input type="checkbox"/> Dental Direct Standard | <input type="checkbox"/> Dental Direct Elite |

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

**I have a Qualified Dental Plan**

By checking this box, you are attesting that you are either purchasing a Qualified Dental plan from BCBSRI or you have purchased a Qualified Dental Plan certified by HealthSource RI. Based on this attestation, your medical plan will not include pediatric dental essential health benefits and your premium will be slightly lower.

<sup>1</sup>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](http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html)

**Section 3 Spouse or Domestic Partner Information**

Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_ Suffix \_\_\_\_\_

Home address (if different from applicant) \_\_\_\_\_

Date of birth (mm/dd/yyyy) \_\_\_ / \_\_\_ / \_\_\_\_\_ Gender  M  F Social security number<sup>1</sup> \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail address \_\_\_\_\_

**Section 4 Dependent Information**

(If necessary, please attach dependent addendum found on BCBSRI.com under the Plans for Individual and Families section.)

**Dependent #1**

Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_

Relationship  Son  Daughter

Date of birth (mm/dd/yyyy) \_\_\_ / \_\_\_ / \_\_\_\_\_ Social security number<sup>1</sup> \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail address \_\_\_\_\_

**Dependent #2**

Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_

Relationship  Son  Daughter

Date of birth (mm/dd/yyyy) \_\_\_ / \_\_\_ / \_\_\_\_\_ Social security number<sup>1</sup> \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail address \_\_\_\_\_

**Dependent #3**

Last name \_\_\_\_\_ First name \_\_\_\_\_ M.I. \_\_\_\_\_

Relationship  Son  Daughter

Date of birth (mm/dd/yyyy) \_\_\_ / \_\_\_ / \_\_\_\_\_ Social security number<sup>1</sup> \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail address \_\_\_\_\_

Check here if Dependent Addendum form will be attached.

<sup>1</sup>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](http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html)

## Section 5 Eligibility

BCBSRI is able to offer health insurance to individuals and families within the guidelines of federal and state regulations. Please complete the information below to check if we are able to offer you insurance.

### Please answer the following questions so that we may determine your eligibility:

1. Are you a Rhode Island resident?  Yes  No
2. If employed, will your employer (or anyone acting on behalf of your employer) pay or reimburse you (through wage adjustments or otherwise) for any portion of the premium under this policy?  Yes  No
3. If employed, did your employer offer this policy to you as a benefit or otherwise market this policy to you or other individual employees?  Yes  No
4. Do you, your employer, or any individual to be insured under this policy intend to treat this policy as a tax exempt benefit under Section 162, 125, or 106 of the Internal Revenue Code?  Yes  No
5. Are you, your spouse, domestic partner, or any of your dependents presently eligible for or enrolled in the following?

	You	Spouse	Dependent
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Please select the reasons you are applying for insurance [check all that apply]

- Open Enrollment
- You've lost other coverage.
- You've married, had a child, or adopted a child.
- You've been enrolled or not enrolled for coverage because of an error by an employee of HealthSource RI or the U.S. Department of Health and Human Services.
- Your contract with another issuer was not followed.
- You've moved to Rhode Island on a permanent basis.
- You've lost eligibility for other coverage due to the death of the policyholder, loss of employment or reduction of hours of the policyholder's employment, divorce from the policyholder, the policyholder becoming entitled to Medicare, a child no longer eligible for other coverage, and the employer providing other coverage filing for Chapter 11 bankruptcy.
- You've lost eligibility for coverage under Medicaid or CHIP (RiteCare) or gained eligibility for payment assistance under a Medicaid or CHIP (RiteCare).

<sup>1</sup>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](http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html)

## Section 6 Other Insurance and Medicine

What was the name of your current or prior **dental** insurance carrier? \_\_\_\_\_  
Is your dental coverage still in effect?  Yes  No  
If no, what was the date your coverage ended? (mm/dd/yyyy) \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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

#### **This is not Medicare Supplement Insurance**

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named 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 because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.**

**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.
- ✓ 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, insurance division, or the State Senior Insurance Counseling Program.

## Section 7 Dental Direct Disclosure Statement

- A 6-month waiting period applies to simple extractions and denture repairs on some plans.
- A 12-month waiting period applies to root canals, periodontal services, oral surgery, crowns and prosthodontics on some plans.

**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.*

## Section 8 HealthSource RI Notice

If you purchase dental insurance directly from Blue Cross & Blue Shield of Rhode Island, you will not be able to get federal premium credits, including the Advance Premium Tax Credit (APTC) and the Cost Sharing Reduction (CSR) subsidy. You may be eligible for these tax credits if you purchase your health coverage directly from HealthSource RI. To find out if you are eligible, please contact HealthSource RI at (855) 683-6759 or visit [www.healthsourceri.com](http://www.healthsourceri.com).

## Section 9 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.



\_\_\_\_\_  
Signature of Applicant or signature of parent or guardian  
if applicant is under 18 years of age

\_\_\_\_\_  
Date

## Section 10 Contact Information

Please mail this form 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 rec'd \_\_\_\_\_ Sales eff. date \_\_\_\_\_ ID# \_\_\_\_\_ Eligibility A T Q N O Other \_\_\_\_\_

Complete date \_\_\_\_\_ Initial \_\_\_\_\_



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.

03/16 BCD-33239 • 1360