Blue Cross Blue Shield of Rhode Island

Blue Cross Dental Direct
2016 Plan Option Change Form

EXISTING MEMBERS MAY USE THIS FORM TO REQUEST A DENTAL PLAN CHANGE.
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 ______________

Date of birth (mm/dd/yyyy) ___ / ___ / ____ Gender ☐ M ☐ F Social security number[1] _____-_____-___

Home phone number _____-_____-______________

Cell phone number _____-_____-________________

Current BCBSRI ID ____________________________

Address____

What is your primary language spoken? _________________________________

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

Section 2 Dental Plan Options

Dental coverage applied for: (*please choose one*)

☐ Dental Direct Basic
☐ Dental Direct Standard
☐ Dental Direct Plus
☐ 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**

Do you have dental coverage through another dental insurance carrier? ☐ Yes or ☐ No

If yes, what is the name of your dental insurance carrier? ____

[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

Section 3 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.
- 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.

Please note, when switching plans:

- If you have satisfied your waiting period on your current plan, the waiting period will not apply to your new plan. If you are switching plans and still in your waiting period, the waiting period will carry over and continue on your new plan.
- This will be your only opportunity to switch plans for Dental Direct coverage. Once you switch, you will not be able to change plans until the next open enrollment period, or during a special enrollment period.

Section 4 Terms, Conditions, and Signatures

By signing this application, I certify and agree that:

- I understand the dental plan benefits being chosen, including the deductible (if any) and benefit maximums.
- This change will not apply until the coverage is made effective by BCBSRI.
- Upon BCBSRI's approval, BCBSRI will send me new dental plan information.
- This dental plan change shall apply to me and all enrolled dependents.
- I am responsible for sharing benefit information with my enrolled family members covered under this policy.
- I certify that I have read the above statements or that they have been read to me and that the statements herein are true and complete to the best of my knowledge and belief.

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 or fax: (401) 831-7300 or 1-800-831-2400 Representatives are available
Monday through Friday,from 8:00 a.m. to 8:00 p.m.

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www.bcbsri.com

500 Exchange Street • Providence, RI 02903-2699

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