PLEASE PRINT CLEARLY

ANTHEM BLUE CROSS AND BLUE SHIELD
DENTAL ADMINISTRATION OFFICE
555 MIDDLE CREEK PARKWAY MS425
COLORADO SPRINGS, COLORADO 80921-3634

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc.

GROUP NAME

GROUP NUMBER

DENTAL PLAN SELECTED (FOR GROUPS OFFERING MORE THAN 1 PLAN)

DENTAL ENROLLMENT APPLICATION

EFFECTIVE DATE
MO. | DAY | YEAR

I WISH TO: ☐ ENROLL/NEW ☐ ADD DEPENDENTS ☐ REMOVE DEPENDENTS ☐ ADDRESS CHANGE ☐ COBRA

EMPLOYEE INFORMATION

FIRST NAME AND M.I. | LAST NAME | MALE ☐ | FEMALE ☐ | SOCIAL SECURITY NUMBER — —

ADDRESS (STREET) | DATE OF BIRTH MO. | DAY | YEAR

CITY | STATE | ZIP CODE | DAYTIME PHONE NO. ( )

MARITAL STATUS
☐ MARRIED ☐ SINGLE
☐ DIVORCED
☐ SEPARATED
☐ WIDOW (ER)
DATE MO. | DAY | YEAR

JOB TITLE | DATE OF EMPLOYMENT MO. | DAY | YEAR | # OF HOURS THAT YOU WORK PER WEEK ____ | TELEPHONE NUMBERS HOME | WORK

TYPE OF DENTAL COVERAGE SELECTED

☐ EMPLOYEE ONLY ☐ EMPLOYEE AND ONE CHILD ☐ EMPLOYEE AND CHILDREN ☐ EMPLOYEE AND SPOUSE ☐ EMPLOYEE AND FAMILY

DEPENDENT COVERAGE INFORMATION

SELECT ONE	Name: (First, M.I., Last name if different) List additional children on separate sheet and attach to application.	RELATION (Spouse, son daughter, stepson, etc.)	Social Security Number	Birthdate Mo | Day | Yr	Check below if dependent is over 23: Full time student	Check below if dependent is over 23: Disabled before age 23	(√) Check if included on tax return
☐ ADD / DELETE ☐			— —		Yes ☐ No ☐	Yes ☐ No ☐	
☐ ADD / DELETE ☐			— —		Yes ☐ No ☐	Yes ☐ No ☐	
☐ ADD / DELETE ☐			— —		Yes ☐ No ☐	Yes ☐ No ☐	
☐ ADD / DELETE ☐			— —		Yes ☐ No ☐	Yes ☐ No ☐	
☐ ADD / DELETE ☐			— —		Yes ☐ No ☐	Yes ☐ No ☐	
☐ ADD / DELETE ☐			— —		Yes ☐ No ☐	Yes ☐ No ☐	

OTHER DENTAL INSURANCE INFORMATION

C.O.B.

Are you, your spouse, or dependent child(ren) covered by any other dental plan that will remain in effect? ☐ Yes ☐ No
If yes, please complete the following:

Whom does it cover? You ☐ Your Spouse ☐ Your Children ☐

Name of Insured ____ Birthdate Mo | Day | Yr ____ Insurance Company Name and Address ____

Policy (or Identification) Number ____ Group Number ____

CERTIFICATION (THIS SECTION MUST BE READ AND COMPLETED)

I and my agent (if applicable) certify that I have read, or have had read to me, the completed application (including the CERTIFICATION section), and I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

I understand that Anthem Blue Cross and Blue Shield may deny claims and void my coverage or may increase the premium charged to my employer if it finds that I misrepresented information on my application. When false or misleading information is discovered, Anthem may void my coverage without advance notice and refund my premium back to the effective date shown on this application or may adjust the group's premium retroactively to my effective date shown on this application, if the discovery is made within two years after such effective date. Any claims paid during the periods when the coverage was not in force will be deducted from any premium refund. If the amount of benefits paid by Anthem exceeds the premium paid, I agree to refund any excess amount to Anthem.

Employee Signature ____ Daytime Phone Number ____ Date ____

Agent/Broker Signature ____ Daytime Phone Number ____ Date ____

Your signature is required before coverage can become effective.

TO THE ENROLLED EMPLOYEE:

Verification of application for coverage

You are enrolling in an **Anthem Dental** plan. If dental care services are needed before you receive your Anthem Dental ID card, take this copy of your enrollment application to the dentist or any other provider who may treat you.

The information shown on the front serves as verification that you and your family members (if applicable) have applied for dental coverage through your group dental plan.

This is not a guarantee of coverage. The coverage applied for is only available if the application is accepted by the insurer and the appropriate premium is paid. Coverage afforded is subject to the terms and limitations of the benefit plan or policy under which the applicant becomes enrolled.

If you receive dental services before you get your ID card

If you are required to pay out-of-pocket for covered services, be sure to file a claim for payment **after you have received your dental ID card.** That way you can be sure that your claim will be processed based on the information submitted on your dental care enrollment application.

QUESTIONS?

- Contact your company's group administrator or
- Call the Dental Administration Office at:

  1-800-453-3622

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