

INSTRUCTIONS FOR INDIVIDUAL APPLICATION

Please take the time to fill out this application form completely so that you and your family will receive proper and timely coverage. Completed application should be submitted to your employer.

This application is a legal document, so it is important that you fill it out completely and correctly. The following instructions will help you complete the form. (Do not fill out the shaded areas of the form; they will be completed by your employer.)

1. EMPLOYEE INFORMATION

Complete all blank spaces in this section. Do not use such titles as Mr., Mrs., Dr., etc. Use only the full legal name, such as "Mary A. Smith," instead of "Mrs. John Smith."

2. COVERAGE INFORMATION (AS APPLICABLE TO PLAN CHOSEN)

- Check the box for Single or Family coverage.
- Indicate your Dentacare Center selection.*
- List the number of your Dentacare Center selected.*
- If the Dual Choice Option is selected by your employer, please mark the plan chosen.

*If Dentacare product is selected.

3. ENROLLMENT INFORMATION

In the boxes provided, print the name, relationship of dependent, student status, sex and birth date for each person to be covered.

In the relationship column, please enter one of the following:

N = Natural Child	S = Stepchild	O = Other (Please attach written explanation
A = Adopted Child	G = Grandchild	to application. We will notify you whether or not
	(If Legal Guardian)	this dependent qualifies for coverage under your contract.)

4. INSURANCE INFORMATION

Complete this section if anyone named in this application has other insurance coverage, including Blue Cross Blue Shield of Wisconsin or Compcare. (Completion of this does not preclude you from being investigated for other coverage.)

5. SIGNATURE

The application must be signed and dated.

Thank you for taking the time to complete this application correctly.

We appreciate your assistance and look forward to serving you.

Individual Application

Please Print (Shaded areas to be completed by the employer)

Group Number	Section Number	Package Code
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1. EMPLOYER INFORMATION

Employer Name		Employer Phone			
Social Security Number	Employee Last Name	First Name	Initial		
Street Address		City	State	Zip	
Home Phone	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widow or Widower		
First Day Worked Full Time	Date of Re-Call or Return from Leave	Dept. Code	Employee No.	Scheduled Hours per Week _____	Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No
Job Title					<input type="checkbox"/> Active <input type="checkbox"/> Retiree
Are you or any dependent now disabled or unable to perform normal activities?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Person	Reason	

2. COVERAGE INFORMATION – COMPLETE TYPE OF COVERAGE AND CENTER SELECTED

<input type="checkbox"/> Single <input type="checkbox"/> Family	Dentacare Center Selected	Dentacare Center Number
Dual Choice – Please select the appropriate box only if your employer provides you with the selection of more than one plan. <input type="checkbox"/> Dentacare <input type="checkbox"/> Choice <input type="checkbox"/> Preferred		

3. ENROLLMENT INFORMATION – COMPLETE THE FOLLOWING FOR ALL FAMILY MEMBERS FOR WHOM YOU ARE REQUESTING COVERAGE

Last Name	First Name	Init	Relationship	Student	Sex	Birth Date
Spouse						
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No		
Dependent				<input type="checkbox"/> Yes <input type="checkbox"/> No		

4. INSURANCE INFORMATION – COMPLETE IF YOU HAVE OTHER INSURANCE OR HAVE EXISTING BCBSWI OR COMPCARE COVERAGE. (THIS DOES NOT PRECLUDE YOU FROM BEING INVESTIGATED FOR OTHER COVERAGE.)

1) Does anyone named in this application have other group insurance coverage, or have existing Blue Cross Blue Shield of Wisconsin or CompCare coverage? <input type="checkbox"/> Yes (Complete the following) <input type="checkbox"/> No		1a) Type of Coverage <input type="checkbox"/> Medical <input type="checkbox"/> Dental		
1b) Individual's Employer		Employer Phone		
1c) Name under which policy is listed	1d) Social Security Number	1e) <input type="checkbox"/> Single Plan <input type="checkbox"/> Family Plan	1f) Effective Date	
1g) Name of Insurance Company	City (mailing address for claims)	State	1h) Policy I.D. Number	1i) Group Number
2) Do you or your spouse have dependent children from a previous marriage? <input type="checkbox"/> Yes <input type="checkbox"/> No				

5. SIGNATURE: I HAVE READ AND UNDERSTAND THE TERMS & CONDITIONS ON THE REVERSE, AND HEREBY APPLY TO ENROLL

X _____	Date Signed: _____
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Terms and Conditions

A. INSURED GROUPS

With respect to coverages which are insured:

1. The availability of any coverage to the Applicant is determined by the Group's inclusion of that coverage in the Group's plan of insurance. The coverages, if so included, are provided by Blue Cross Blue Shield of Wisconsin or Compcare Health Services; hereinafter referred to as "Insurer."
2. No person except an officer of the Insurer is authorized to vary or modify a contract.
3. Subject to the acceptance of this Application by the Insurer, the Applicant authorizes the Employer to deduct from the Applicant's wage or salary his/her portion, if any, of the premium for the coverages applied for, and to timely remit such portion to the party designated by the Insurer. The money submitted with this Application is accepted by the Insurer as a refundable deposit. The Applicant understands that such acceptance is not an indication of coverage. If the Insurer approved this Application, such money shall be applied to the first month's premium. If not, such money will be refunded to the Applicant.
4. If this Application is accepted by the Insurer, and any covered person subsequently ceases to be eligible for coverage under the contract(s) then in effect for such person, then the coverage(s) for such person shall terminate in accordance with the terms of such contract(s). Should such person wish to continue his/her coverage(s) after such termination, the Employer shall furnish him/her the appropriate applications for the policies then being offered to such persons. It is such person's responsibility to make timely application for such policies.

B. SELF-FUNDED GROUPS

With respect to coverages which are self-funded by the Group:

1. In completing the Application, the Applicant understands that DentalBlue, hereinafter called "Company," is not the insurer of the benefit plan. The Company provides only administrative services, and has no obligation to fund claims.
2. No person except an officer of the Group is authorized to vary or modify a contract.

C. ALL GROUPS

With respect to all coverages, whether insured or self-funded:

1. All statements and answers in this Application are representations made by the Applicant on behalf of himself/herself and the dependents, if any, named in this Application to induce the issuance of the contract(s) applied for. The contents of this Application are to be solely relied upon by the Insurer/Company, exclusive of the knowledge of an agent or employee of the Insurer/Company.
2. The Applicant on behalf of himself/herself and the dependents, if any, named in this application, agrees to cooperate in providing the Insurer/Company with information needed to process this Application.
3. The contract(s) applied for will become effective only upon the Applicant's completion of the probationary period, if any, and acceptance of this Application by the Insurer/Company. The Insurer/Company will notify the Applicant of his/her effective date and issue an identification card; however, with respect to medical coverage only, this Application may be used as a temporary identification card.
4. This Application, when approved, and any endorsement, amendment or rider hereto will be made part of the contract(s) applied for.

www.bluecrosswisconsin.com

*DentalBlue products are insured by Blue Cross Blue Shield of Wisconsin and CompCare Health Services Insurance Corporation, independent licensees of the Blue Cross Blue Shield Association.
® Registered mark of the Blue Cross Blue Shield Association.*

