



BlueCross BlueShield of Oklahoma

A Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.
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www.bcbsok.com

BlueSelect Voluntary Group Dental Application

OFFICE USE ONLY	MEMBER IDENTIFICATION NUMBER	GROUP NUMBER	EFFECTIVE DATE	APPROVED BY	
	DATE PROCESSED		BROKER NUMBER	TM NUMBER	AE NUMBER

1. TELL US WHO YOU WANT TO ENROLL (CHECK ONE BOX ONLY)

EMPLOYEE ONLY
COMPLETE ITEMS 1 THROUGH 6, AND 9
 EMPLOYEE AND CHILDREN
COMPLETE ITEMS 1 THROUGH 6, AND 8 AND 9
 EMPLOYEE, SPOUSE AND CHILDREN
COMPLETE ITEMS 1 THROUGH 9
 EMPLOYEE AND SPOUSE
COMPLETE ITEMS 1 THROUGH 7, AND 9

TELL US ABOUT THE EMPLOYEE

2. NAME OF APPLICANT (EMPLOYEE) (LAST, FIRST, MIDDLE) RESIDENCE TELEPHONE NUMBER A/C

3. ADDRESS (STREET OR BOX NO.) (CITY) (STATE) 9-DIGIT ZIP CODE

4. SOCIAL SECURITY NUMBER MO. DATE OF BIRTH DAY YR. SEX M F BUSINESS PHONE NUMBER A/C

5. I AM EMPLOYED BY (NAME OF COMPANY) ADDRESS (STREET OR BOX NO., CITY, STATE, ZIP) HOW MANY HOURS PER WEEK DO YOU WORK? DATE EMPLOYED FULL-TIME MO. DAY YR. EMPLOYER GROUP NO. (TO BE COMPLETED BY EMPLOYER FOR SUBSEQUENT HIRES)

6. DOES ANYONE LISTED ON THIS APPLICATION HAVE DENTAL INSURANCE? IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION: INSURANCE COMPANY NAME

INSURED'S NAME MEMBER ID/SUBSCRIBER NO./ CASE NO. GROUP NO./POLICY NO. PERSONS COVERED: APPLICANT SPOUSE DEPENDENTS LISTED ON APPLICATION OTHER

HAS COVERAGE TERMINATED? IF NO, WILL YOUR CURRENT COVERAGE BE TERMINATED IF THIS COVERAGE IS APPROVED? YES, ON / / NO, I WILL KEEP BOTH COVERAGES

TELL US ABOUT THE APPLICANT(S), OTHER THAN THE EMPLOYEE, APPLYING FOR COVERAGE

7. NAME OF SPOUSE (FIRST, MIDDLE, LAST) MONTH DATE OF BIRTH DAY YR. SOCIAL SECURITY NUMBER

8. DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST) RELATIONSHIP TO APPLICANT MONTH DATE OF BIRTH DAY YR. SOCIAL SECURITY NUMBER

IS THE DEPENDENT UNMARRIED AND LIVING WITH YOU IN A PARENT-CHILD RELATIONSHIP? IS IT STATED IN A COURT DECREE THAT YOU ARE TO PROVIDE HEALTH COVERAGE FOR DEPENDENT? IS DEPENDENT A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL, COLLEGE, OR UNIVERSITY?

NAME OF INSTITUTION LOCATION HOURS ENROLLED

DEPENDENT'S FULL NAME (FIRST, MIDDLE, LAST) RELATIONSHIP TO APPLICANT MONTH DATE OF BIRTH DAY YR. SOCIAL SECURITY NUMBER

IS THE DEPENDENT UNMARRIED AND LIVING WITH YOU IN A PARENT-CHILD RELATIONSHIP? IS IT STATED IN A COURT DECREE THAT YOU ARE TO PROVIDE HEALTH COVERAGE FOR DEPENDENT? IS DEPENDENT A FULL-TIME STUDENT AT AN ACCREDITED SCHOOL, COLLEGE, OR UNIVERSITY?

NAME OF INSTITUTION LOCATION HOURS ENROLLED

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NAME OF INSTITUTION LOCATION HOURS ENROLLED

IF MORE SPACE IS NEEDED FOR DEPENDENTS, USE ANOTHER APPLICATION FORM.
FOR OFFICE USE ONLY

GROUP NUMBER	F/C AGREEMENT NUMBER	F/C CODE	WVR CODE	WVR CODE EXP DATE	DIV. CODE	CROSS REFERENCE AGREEMENT NO.	BRK IND	BRK NO.	
			00	00-00-0000					
COB CODE	INVOICE NUMBER	MSC CODE	EFFECTIVE DATE	CHAR. CODE DATE	SUB CHAR.	DEP. CHAR.	MINOR CHAR.	SUB DENT. CHAR.	DEP DENT. CHAR.
10									
10									
10									
10									

NOTE: Please complete reverse side

9. DENTAL APPLICATION AGREEMENT

I and any other persons whose names appear on this application hereby apply for coverage from Blue Cross and Blue Shield of Oklahoma as indicated in this application.

I understand and agree to the items listed below:

- This is an application only, and I should not cancel any existing dental coverage unless and until I am notified in writing by Blue Cross and Blue Shield of Oklahoma of my acceptance.
- I have read all the statements on this application and represent that they are true and complete. I understand that any false or incomplete information can result in retroactive cancellation of coverage for all persons under the membership, and I will repay promptly any benefit payments to which persons covered under this membership were not entitled.
- Any insurance agent, dentist, or other person who knowingly and willfully makes a false or fraudulent statement or representation relative to any application for insurance, or who makes any such statement to obtain a fee, commission, money or benefit shall be guilty of a misdemeanor (TITLE 36, SECTION 1204 of the Oklahoma State Statutes).
- I authorize any dentist, physician, practitioner, hospital or other institution to release, disclose and furnish Blue Cross and Blue Shield of Oklahoma for its review and retention in connection with any application for dental coverage and future claims, all information, records, or copies of records relating to medical history and conditions, including but not limited to diagnosis, treatment, care, surgery, and the dates thereof.
- I appoint the Board of Directors of Blue Cross and Blue Shield of Oklahoma my true and lawful attorney to represent me at any and all meetings of the members of Blue Cross and Blue Shield of Oklahoma, and to vote in my name upon any matters arising at said meetings. However, I retain the right to attend and vote at any and all meetings of the members.
- I authorize my employer, as my agent, to deduct the amount of charges from my wages or salary for the purpose of paying my membership charges to the Plan.

Please read and review the terms of this application before signing.

SIGNATURE OF APPLICANT (EMPLOYEE)-I AGREE TO ALL THE TERMS OF THIS APPLICATION

X

MO . DATE SIGNED DAY YR.

SIGNATURE OF SPOUSE-I AGREE TO ALL THE TERMS OF THIS APPLICATION

X

MO . DATE SIGNED DAY YR.