Direct Dental Application

Blue Cross Blue Shield of Rhode Island

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	Suffix	First name	M.I.

Home address (street/apartment number)	City/town	State	ZIP code

Mailing address (if different) (street/apartment number)	City/town	State	ZIP code

Date of birth (mm/dd/yyyy)	Gender	Social security number	Current BCBSRI ID (if applicable)
	☐ M ☐ F	_____ - ____ - _____*	

Home phone number	Cell phone number	Marital status (please check one)
( ) _____ - _____	( ) _____ - _____	☐ Single ☐ Married ☐ Domestic partner ☐ Common law ☐ Civil Union ☐ Divorced ☐ Other _____

Section 2 Dental Plan Options

Dental coverage applied for: ☐ Dental Direct Basic ☐ Dental Direct Essential ☐ Dental Direct Plus

Choose a dental contract type: ☐ Individual ☐ Individual and spouse ☐ Individual and children ☐ Family

Please note: Dental dependents, listed in Section 4 of this application, will be removed from your plan on the first of the month following their 19th birthday.

Requested dental effective date (mm/dd/yyyy): ____ / ____ / _____

What is the name of your current or prior dental insurance carrier? _____

Is your dental coverage still in effect? ☐ Yes or ☐ no?

If no, what was the date of termination (mm/dd/yyyy)? _____

Section 3 Spouse, Domestic Partner, or Civil Union Information

Last name	Suffix	First name	M.I.

Home address (if different from applicant)(street/apartment number)	City/town	State	ZIP code

Date of birth (mm/dd/yyyy)	Gender	Social security number
	☐ M ☐ F	_____ - ____ - _____*

Home phone number	Cell phone number
( ) _____ - _____	( ) _____ - _____

*Social Security number is required in order to comply with the reporting requirements of the Mandatory Insurance Reporting Law. See www.cms.hhs.gov/MandatoryInsRep/

Section 4 Dependent Information

Dependent #1 Last name	First name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social security number _____ - ____ - _____*		
Dependent #2 Last name	First name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social security number _____ - ____ - _____*		
Dependent #3 Last name	First name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social security number _____ - ____ - _____*		
Dependent #4 Last name	First name	M.I.	Relationship ☐ Son ☐ Daughter
Date of birth (mm/dd/yyyy)	Social security number _____ - ____ - _____*		

☐ Check here if a Dependent Addendum form is attached. (If you have more than 4 dependents, please attach a completed Dependent Addendum found on BCBSRI.com under the Plans for Individuals and Families section.)

Section 5 Other Insurance Notice

Please read before you buy this insurance.

Check the coverage in all 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.

Important notice to persons on Medicare Advantage Plan, such as BlueCHiP for Medicare
THIS IS NOT A MEDICARE SUPPLEMENT INSURANCE PLAN

This insurance provides limited benefits if you meet the conditions listed in this policy. It does not pay your Medicare Advantage deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

THIS INSURANCE MAY DUPLICATE YOUR MEDICARE ADVANTAGE BENEFITS: The benefits stated in this policy and the coverage provided under your Medicare Advantage plan may pay for some or all of these expenses.

Section 6 Dental Direct Disclosure Statement

- A 12-month waiting period applies to major restorative services and surgical periodontics. If you decide to cancel or change your coverage, you must wait 12 months to re-apply.
- If you re-apply, you must wait an additional 12 months for major restorative coverage and surgical periodontics.

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Section 7 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;
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;
   - Cancel the plan, back to the effective date;
   - 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.

SIGN HERE ☞

Signature of Applicant or signature of parent or guardian *if Applicant is under 18 years of age* — Date

Signature of Spouse — Date

Section 8 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
(401) 351-BLUE (2583) or 1-800-505-BLUE (2583)

INTERNAL USE ONLY

Sales rec'd _____ Sales eff. date _____ ID# _____ Eligibility A T Q N O Other _____

MU rec'd _____ Send out _____ Send back in _____ Results _____ Determination _____

Complete date _____ Initials _____ AB Lev 1 Lev 2 Memb. rec'd _____

500 Exchange Street • Providence, RI 02903-2699

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