



Application for Personal Dental — Individual Dental Coverage

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Section A: Subscriber Information Please print or type

Social Security Number		Home Telephone Number		Daytime Telephone Number	
Name (Last)	(First)	(Initial)	Birth Date / /	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Street Address/PO Box		City	State	Zip Code	County of Residence

Section B: List members who are applying for coverage (Spouse and unmarried children who are under 19, or who have their 19th birthday this year; or Family Continuation members as defined by our underwriting guidelines.)

First Name	Last Name (if different)	Social Security Number	Sex	Birth Date
Spouse				/ /
Dependent-1				/ /
Dependent-2				/ /
Dependent-3				/ /
Dependent-4				/ /

Section C: Health Insurance Information Please provide current medical coverage information below. You must have medical coverage to purchase Personal Dental.

Medical Coverage Carrier	Full Name of Subscriber	Contract Number	Group Number	Contract Type <input type="checkbox"/> Single <input type="checkbox"/> Family

If you are currently enrolled in Flexible Blue or IC Blue medical coverage you are not eligible for this product. We do offer a different dental product for individuals enrolled in those products. Please call 888-MI-BCBSM (888-642-2276) from 8 a.m. to 8 p.m. Monday through Friday for more information.

Section D: Medicare Information

Are you and anyone named on this application entitled to Medicare? No Yes If yes, complete the following:

Full Name	Medicare Number	Part A Effective Date	Part B Effective Date
		/ /	/ /
		/ /	/ /

I certify that I carefully read the important information on the reverse side, and the statements and answers given are complete and correct to the best of my knowledge and belief. No information required to be given, either expressly or by implication, has been knowingly withheld. I understand that Blue Cross Blue Shield of Michigan will rely upon the completeness and truthfulness of the information given and the statements made, and that if I have made false statements or misrepresentations, or have failed to disclose any material fact, BCBSM will be entitled to declare the dental care contract void and refuse all allowance of the benefits to any person under the contract.

Subscriber's Signature (Do not print)	Date Signed / /
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For office use only

Group Number	Plan Code	Effective Date / /
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Please read the following information before completing the other side of this application.

The information on this form and the following conditions are part of your contract with Blue Cross Blue Shield of Michigan. Personal Dental coverage begins on the date determined by BCBSM. When BCBSM accepts your application, you and your family are bound by the terms of the policy and this application. A subscriber and any dependents must remain enrolled in Personal Dental coverage for a minimum of 12 months. If you terminate coverage for any reason you are not eligible to reapply for 12 months from the date of termination.

Medical coverage

You must have medical coverage to purchase Personal Dental.

Authorization

You are responsible for giving notice to BCBSM of changes in your status and your family's status that affect coverage, such as marriage, births or death of someone covered under the policy. Please send notice in writing to:

Personal Dental
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd. – Mail Code BP202
Detroit, MI 48226

You authorize BCBSM to obtain hospital, medical and dental records about you and your family from health care providers; and you authorize the release of any information needed to process or review a claim.

Proof of eligibility

You agree to provide proof of your eligibility for coverage in addition to that of your dependents when requested by BCBSM.

Confidentiality

We keep your personal health information confidential and do not release it without your consent or as permitted by state and federal privacy laws.

Approval

Approval of this application for dental care coverage will be indicated by your receipt of a billing notice. **Please do not submit payment until you receive a bill.**

Family Continuation

Family Continuation provides continuance of coverage for a dependent child of the subscriber if the child meets all of the following requirements:

- The child is between the ages of 19 and 25
- The child is unmarried
- The child is a member of the subscriber's household (unless he or she temporarily resides elsewhere, such as college students living away at school)
- The subscriber provides more than half of the child's support
- The child is related to the subscriber by blood, marriage, legal adoption or legal guardianship
- The child is a full-time student for a minimum of five months of the year **OR** has gross income of less than four times the personal exemption amount identified in the IRS Gross Income Test

Disabled dependent coverage

You may be eligible to obtain coverage for an unmarried child who is incapable of self-sustaining employment because of a disability that occurred before age 19. You must supply proof of the disability from a physician licensed in Michigan.

Enrollment

If you want to enroll, please submit your completed application to:

Blue Cross Blue Shield of Michigan - MC B576
600 E. Lafayette Blvd.
Detroit, Michigan 48226-9942