Employee Application for Group Dental Insurance

Florida Combined Life

SECTION 1: To be completed by Group Insurance Administrator or Employer

FCL Group No. 1	Group Name 2	Business Phone No. 3
	Bay County Employees	( )
Division No. 4	Class 5	Effective Date MM DD YYYY 6
		/ /

SECTION 2: To be completed by Employee (Please print.)

Part A: Complete the following part with information on **yourself.**

Full legal name of employee (Last, First, MI) 7	Social Security No. 8	Birthdate MM DD YYYY 9
		/ /

Street Address 10	City 11	County 12	State 13	Zip Code 14

Home Phone No. 15	Business Phone No. 16	Occupation/Job Title 17	Gender 18	Marital Status 19
( )	( )		☐M ☐F	☐Single ☐Divorced ☐Legally ☐Married ☐Widowed Separated

Full-time Hire date MM DD YYYY 20	Are you 21	How Paid? 22	Hours worked per week 23
/ /	☐Actively at work ☐Retired ☐COBRA	☐Hourly ☐Salary	

Part B: Coverage Selection *(Note: Consult your group insurance administrator for benefits available to you.)*

A Dependent cannot be covered as both a dependent and an employee, covered under more than one employee, in full-time military service, or enrolled for coverages declined by the employee. Married employees of the same employer may not be covered as both an employee and a dependent.

Employee 24	Spouse 25	Child(ren)	If selected, all children must be enrolled. 26
☐Yes ☐No, I **decline** coverage	☐Yes ☐No, I **decline** coverage	☐Yes ☐No, I **decline** coverage	

If you checked **YES** in the Employee Coverage selection box, select one of these plans. 27

☐ **Low Option**	☐ **Mid Option**	☐ **High Option**

Part C: Identify each individual to be covered below. **Attach additional sheet of paper, if necessary. Sign and date it.**

28 First Name, M.I., Last Name (Please provide information in the corresponding numbered spaces below.) 29 Social Security Number (Please provide in spaces below)	30 Relation to You (DP = Domestic Partner)	31 Gender (M/F)	32 Birthdate mm/dd/yyyy	Check If: 33 Marital Status – Married	33 Marital Status – Unmarried No Children	34 Disabled	35 Lives With You	36 You Support Financially	37 Student FT/PT	38 Florida Resident	39 Covered By Medicaid	40 BlueDental Care Facility ID# Check box if a current patient (Select from provider directory)
Employee												☐
28 ___-___-____	☐Spouse or ☐DP											☐
28 ___-___-____	☐Child *or* ☐DP Child			☐	☐	☐	☐	☐	☐	☐	☐	☐
28 ___-___-____	☐Child *or* ☐DP Child			☐	☐	☐	☐	☐	☐	☐	☐	☐
28 ___-___-____	☐Child *or* ☐DP Child			☐	☐	☐	☐	☐	☐	☐	☐	☐

Do any dependents listed above reside at a different address than indicated above? ☐ Yes ☐ No 41
If **yes**, list name(s):

Do you or any of your dependents listed above have Dental insurance under another group plan? ☐ Yes ☐ No 42
If you answered **yes** to other group dental insurance, complete 43 through 47 below. If more than one dependent, attach a separate sheet of paper with the additional information.

Dependent Name 43	Other Group Plan Name & Plan No. 44	Insured/Member Name Birthdate 45
		/ /

Insurance Co. Name & Address	Phone No. 46	Policy No. 47
	( )	

Part D: Coverage Acceptance of ANY Coverage (Please read before signing.)	**Part E:** Coverage Refusal of ANY/ALL Coverage (Please read before signing.)
I wish to apply for any coverage checked **YES** under Part B Coverage Selection. I have read and accept the "Acceptance of Coverage" on the reverse side of this form. I hereby certify that the statements on this application, including any attachment to it, are true and complete. (If you checked NO for any dependent coverage under Part B, sign and date Part E also.) 48	I do not wish to apply for any coverage checked NO under Part B Coverage Selection. I understand that if I decide to apply at a later time, coverage will not be available until the next open enrollment. 49
Employee Signature Date	Employee Signature Date

Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

FRAUD NOTICE: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Acceptance of Coverage

Please Read Before Signing the Front Side of this Form

I hereby apply for the coverage checked “Yes” on the front of this form. My employer has selected the coverage through Florida Combined Life Insurance Company, Inc. (FCL). I authorize my employer to deduct from my earnings my premium contribution (if any). I understand all of the following: 1. if my coverage is to be issued and continued, I must meet all the group contract’s requirements; 2. if my dependents’ coverage, if any, is to be issued and continued, my dependents must meet all the group contract’s requirements.

I understand that my employer is not an agent of FCL. I also understand that my employer is responsible for notifying all employees of: 1. all effective dates; 2. all termination dates; 3. any COBRA or ERISA rights or responsibilities; and 4. all other matters pertaining to coverage under the group contract.

If coordination of benefits applies for me and my dependents and an overpayment is made, I authorize FCL to recover the excess from any person or entity to which payment is made.

I acknowledge that, if I apply for FCL coverage later, coverage will not be available until the next open enrollment.

I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I hereby certify that the statements on this application, including any attachment to it, are true and complete. I understand and agree that any misstatements may result in denial of benefits and/or termination of coverage.

A photocopy of this application shall be as valid as the original. However, the original application, labeled “White copy – FCL,” is required to evaluate this application. I agree to be bound by the group contract’s terms and conditions. I understand that this application is hereby made a part of the group contract. I will attach it to my certificate of coverage, when issued.