



Dental Enrollment Form

Effective Date

Group No.

Please read carefully and provide all applicable information.

PERSONAL INFORMATION

Last Name (Print)		First Name (Print)		M.I.	<input type="checkbox"/> Male <input type="checkbox"/> Female
Street Address		City		State	ZIP Code
Home Telephone No. () - () -		Business Telephone No. () - () -		Employer	Job Title
Date of Hire	Part-time to Full-time Effective Date	Class	Dept. No.	E-mail Address	

EMPLOYEE AND DEPENDENT INFORMATION – Each family member may select their own dental office.

	Last Name	First	M.I.	Sex	Birthdate	Social Security	Age	If children are age 19 or over, you must check the appropriate boxes below	
Self	Same as above								
<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner				<input type="checkbox"/> M <input type="checkbox"/> F				Full-time Student	Qualifies as IRS Dependent
Child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Child				<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

To be eligible as a Domestic Partner, the Subscriber and Domestic Partner must have properly filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to the California Family Code, or have properly filed an equivalent document in accordance with the laws of another jurisdiction recognizing the creation of domestic partnerships.

COBRA INFORMATION – To be completed by employer

Company Name	Check correct box indicating "Qualifying Event" causing loss of coverage.		
Date of Qualifying Event	Employee: <input type="checkbox"/> Termination of employment <input type="checkbox"/> Reduction of employee's work hours <input type="checkbox"/> Benefits terminated or reduced within one year before or after retired employee's employer filing for bankruptcy under Chapter 11, if plan provides benefits for retirees		
Date of Loss of Coverage	Family Member: <input type="checkbox"/> Death of the employee <input type="checkbox"/> Loss of dependent child eligibility <input type="checkbox"/> Divorce or legal separation from employee <input type="checkbox"/> Employee's entitlement to Medicare <input type="checkbox"/> Benefits terminated or reduced within one year before or after retired employee's employer filing for bankruptcy under Chapter 11, if the plan provides benefit for retirees <input type="checkbox"/> Other: If enrolling in COBRA coverage, please indicate the qualifying event date and coverage date		
Date When Continued Coverage Ends			
Date Notice Given	Group Policyholder Representative's Signature X	Telephone No.	Applicant's Initials

SELECTED COVERAGE

Type of Coverage: New Enrollment Re-hire Part-time to Full-time Open Enrollment COBRA

You must select one of the plan choices below:

Dental Blue (select one of the following)
 100 200 300 Complete

PPO Dental National Dental PPO Voluntary PPO National Voluntary PPO

Dental Net* Choice Dental (select one of the following)
 Dental Net* PPO Dental

Other _____

* Indicate Dental Office No. in the Employee and Dependent section

LANGUAGE PREFERENCE

When information is sent to you, we may be able to send it to you in a language other than English. What language would you prefer? (Optional)

English Spanish Chinese Korean Japanese Tagalog Vietnamese Khmer Hmong Farsi
 Arabic Armenian Russian Other _____

Totally Disabled	Has other dental coverage	Dental Office No. (if enrolling in Dental Net plan)	Prior Coverage Information: Please fill out the following information to receive proper credit for previous coverage, if immediately prior to becoming eligible for this plan, you or your eligible members were covered under any public or private health care coverage (including MediCal or individual coverage). According to Federal Law, your employer or former carrier must provide you with a certificate that shows evidence of your prior coverage. We reserve the right to request a copy of this certificate.			
			Coverage Begin Date	Coverage End Date	Carrier Name	Reason for Ending Coverage
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					
<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N					

PLEASE READ CAREFULLY – SIGNATURE REQUIRED

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions or misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required dues.

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

HIV TESTING PROHIBITED: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance.

EFFECTIVE DATE: The effective date of coverage is subject to Anthem Blue Cross approval.

REQUIREMENT FOR BINDING ARBITRATION

The following provision does not apply to class actions:

IF YOU ARE APPLYING FOR COVERAGE, PLEASE NOTE THAT ANTHEM BLUE CROSS AND ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY REQUIRE BINDING ARBITRATION TO SETTLE ALL DISPUTES INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT. California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: *"It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."* THIS MEANS THAT YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY ARE WAIVING THE RIGHT TO A JURY TRIAL FOR BOTH MEDICAL MALPRACTICE CLAIMS, AND ANY OTHER DISPUTES INCLUDING DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN OR ANY OTHER ISSUES RELATED TO THE PLAN.

Signature (Required)

Employee Signature	Date
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