

**Instructions for completing and printing Form #50400  
Employee Application for Group Dental Insurance**

This form is 8 ½ X 14 (legal-sized) and you must set your printer so it will print on legal-sized paper in order to comply with State Regulations.

Thank you.

# Employee Application for Group Dental Insurance

## Florida Combined Life

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

FCL Group No.	<b>1</b> Group Name	<b>2</b> Business Phone No. ( )	<b>3</b>
Division No.	<b>4</b> Class	<b>5</b> Effective Date MM DD YYYY / /	<b>6</b>

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

<b>Part A: Complete the following part with information on yourself.</b>									
Full legal name of employee (Last, First, MI) <b>7</b>				Social Security No. <b>8</b>			Birthdate MM DD YYYY <b>9</b> / /		
Street Address <b>10</b>			City <b>11</b>		County <b>12</b>	State <b>13</b>	Zip Code <b>14</b>		
Home Phone No. <b>15</b> ( )		Business Phone No. <b>16</b> ( )		Occupation/Job Title <b>17</b>		Sex <b>18</b> <input type="checkbox"/> M <input type="checkbox"/> F	Marital Status <b>19</b> <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Legally <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated		
Full-time hire date MM DD YYYY <b>20</b> / /		Are you <b>21</b> <input type="checkbox"/> Actively at work <input type="checkbox"/> Retired <input type="checkbox"/> COBRA			How paid? <b>22</b> <input type="checkbox"/> Hourly <input type="checkbox"/> Salary		Hours worked per week <b>23</b>		

**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.

<b>Employee</b> <b>24</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline coverage	<b>Spouse</b> <b>25</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline coverage	<b>Child(ren)</b> <b>26</b> <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline coverage	<i>If selected, all children must be enrolled. Coverage may continue until the end of the calendar year in which the dependent child reaches age 25.</i>
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If you checked **YES** in the Employee Coverage selection box, select one of these plans. **27**

**BlueDental Freedom (Indemnity)** \_\_\_\_\_ **BlueDental Choice (PPO)** \_\_\_\_\_

**BlueDental Care (Prepaid)** \_\_\_\_\_  **Choice** \_\_\_\_\_  **Copayment** \_\_\_\_\_  **Plus** \_\_\_\_\_

<b>Part C: Identify each individual to be covered below. Attach additional sheet of paper, if necessary. Sign and date it.</b>					<b>CHECK IF</b>			<b>BlueDental Care PREPAID ONLY</b>	
<b>28</b>	<b>29</b>	<b>30</b>	<b>31</b>	<b>32</b>	<b>33</b>	<b>34</b>	<b>35</b>	<b>36</b>	<b>37</b>
Name (Last, First, MI)	Social Security Number	Birthdate MM/DD/YYYY	Sex	Supported by You	Living With You	FT/PT Student	Disabled	Dental Facility No. (Select from provider list)	Current Patient
Employee	N/A	N/A	N/A	N/A	N/A	N/A	N/A		<input type="checkbox"/> Y <input type="checkbox"/> N
Spouse		/ /	<input type="checkbox"/> M <input type="checkbox"/> F	N/A	N/A	N/A	N/A		<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
Child		/ /	<input type="checkbox"/> M <input type="checkbox"/> F						<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

Do any dependents listed above reside at a different address than indicated above? Yes No **38**  
 If **yes**, list name(s):

Do you or any of your dependents listed above have Dental insurance under another group plan? Yes No **39**  
 If you answered **yes** to other group dental insurance, complete 40 through 44 below. If more than one dependent, attach a separate sheet of paper with the additional information.

Dependent Name <b>40</b>	Other Group Plan Name & Plan No. <b>41</b>	Insured/Member Name	Birthdate <b>42</b> / /
Insurance Co. Name & Address		Phone No. <b>43</b> ( )	Policy No. <b>44</b>

<b>Part D: Coverage Acceptance of ANY Coverage</b> (Please read before signing.)	<b>Part E: Coverage Refusal of ANY/ALL Coverage</b> (Please read before signing.)
I wish to apply for any coverage checked <b>YES</b> 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.)	I do <b>not</b> wish to apply for any coverage checked <b>NO</b> 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.
Employee Signature _____ Date _____	Employee Signature _____ Date _____

Issued by

## Florida Combined Life

a subsidiary of



**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.

Florida Combined Life and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

www.bcbsfl.com

50400-0105R SR

White Copy - FCL    Canary Copy - Dental Administrator    Pink Copy - Employer    Goldenrod Copy - Employee

## **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.