Please Mail This Form To:
DBS, P.O. Box 2400, Winston-Salem, NC 27102

Dental Blue Select℠
Application / Change Form

☐ NEW ENROLLEE (Please Complete A, C, D, E, F and G)
☐ CHANGE REQUEST (For changes, complete Sections A, B and all other applicable sections)

A. EMPLOYEE INFORMATION

Social Security Number:	Date of Birth:	Sex: ☐ Male ☐ Female	
Last Name:	First Name:	MI:	Marital Status: ☐ Single ☐ Married
Mailing Address:	City:	State:	Zip Code:
Date Employed (minimum of 30 hours):	Employee ID Number:	Dental Blue Select ID Number (if applicable):	
Home Phone Number: ( )	Work Phone Number: ( )	E-Mail Address:	

B. IF MAKING A CHANGE FROM PREVIOUS ENROLLMENT

Check All That Apply:
- ☐ Name Change
- ☐ Employee SSN Correction
- ☐ Add/Remove Dependent
- ☐ Address/Telephone Number Change
- ☐ Replace ID Card
- ☐ Date of Birth Correction
- ☐ E-Mail Address
- ☐ Late Enrollee
- ☐ COBRA
- ☐ Other: _____

Add Dependent(s): — **Date of Occurrence**
- ☐ Marriage _____
- ☐ Newborn (up to age 1) _____
- ☐ Adoption _____
- ☐ Court Order _____
- ☐ Other _____ _____

Remove Dependent(s): — **Date of Occurrence**
- ☐ Divorce _____
- ☐ Death _____
- ☐ Obtained full-time employment _____
- ☐ Obtained other coverage _____
- ☐ Other _____ _____

Reinstate Coverage:
Reason: _____

Cancel Coverage:
- ☐ Not Eligible
  Reason: _____
  _____ date
- ☐ Subscriber Request
  _____ date
- ☐ Other _____
  _____ date

C. TO BE COMPLETED BY THE EMPLOYER

Name of Employer:	Dental Blue Select Group No:	Effective Date:	Dept. / Division:

☐ Active Employee (minimum of 30 hours) ☐ Elected Official	☐ COBRA	COBRA Qualifying Event: ☐ Termination of Employment ☐ Divorce ☐ Death of Subscriber ☐ Reduction in Hours ☐ Over Age Dependent

What was the date of the qualifying event?	Date Continuation Started:	Date Continuation Ends:

Visit us at ***bcbsnc.com***

BlueCross BlueShield of North Carolina

D. COVERAGE SELECTION – Complete for BCBSNC Dental Blue Select

Options Selected: ☐ Employee Only ☐ Employee and Child(ren)
☐ Employee/Spouse/Domestic Partner ☐ Employee/Family

Plan Option Selected: ☐ Standard Plan ☐ Complete Plan ☐ Complete Plan with Orthodontia
☐ Enhanced Plan ☐ Enhanced Plan with Orthodontia

Benefit Period Maximum Amount Selected: ☐ $1,000 ☐ $1,500 (available on all plans except Standard Plan)

E. PRIOR DENTAL COVERAGE Dental Blue Select - (Enhanced and Complete Only)

If your Employer elected to offer the Dental Blue Select – Enhanced or Complete Plan, prior creditable dental coverage may apply towards the dental waiting periods. In order to obtain prior credit, you must attach a prior billing or certificate of prior creditable coverage that includes the names and effective dates of each covered person(s).

F. FAMILY INFORMATION – Complete for anyone taking or dropping Dental Blue Select Coverage*

	Name (First, Middle Initial, Last, Suffix)	Social Security Number	Birthdate mm/dd/yyyy	Sex	Child Status (please check if applicable for any dependent under the age 26)
☐ Add / ☐ Delete	☐ Spouse ☐ Domestic Partner			☐ F ☐ M	☐ Foster ☐ Adopted ☐ Handicapped**
☐ Add / ☐ Delete	Child 1			☐ F ☐ M	☐ Foster ☐ Adopted ☐ Handicapped**
☐ Add / ☐ Delete	Child 2			☐ F ☐ M	☐ Foster ☐ Adopted ☐ Handicapped**
☐ Add / ☐ Delete	Child 3			☐ F ☐ M	☐ Foster ☐ Adopted ☐ Handicapped**
☐ Add / ☐ Delete	Child 4			☐ F ☐ M	☐ Foster ☐ Adopted ☐ Handicapped**
☐ Add / ☐ Delete	Child 5			☐ F ☐ M	☐ Foster ☐ Adopted ☐ Handicapped**
☐ Add / ☐ Delete	Child 6***			☐ F ☐ M	☐ Foster ☐ Adopted ☐ Handicapped**

☐ **Additional Dependent form attached.**

* Application does not guarantee enrollment.
** A request for coverage (form P24) is required if your child is 26 years or older and will be reviewed to determine eligibility. Physically Handicapped Certificate Form must accompany this application, if applicable. Form is available at ***www.bcbsnc-dental.com***.
*** If you have more than six children, complete an Additional Dependent form.

G. EMPLOYEE AUTHORIZATION

I understand the benefits for which I (we) will be eligible are those described in the Blue Cross and Blue Shield of North Carolina (BCBSNC) contract (including the benefit booklet) and changes provided for therein. I certify that all statements made herein and on all sections of this application are complete and true to the best of my knowledge. I understand that BCBSNC may, within two years of the date of this application, rescind my policy for any of my acts or practices that constitute fraud or if I make an intentional misrepresentation of material fact. If fraudulent misstatements were made, BCBSNC may take legal action at any time.

Signature of Employee _____ Date _____