Please type or print in black ink.

DCN

29377275 (4-Tier) Rev. 9-16

BPN ____________________

Dental Application

GROUP ROLL 79118/01

1. APPLICANT'S INFORMATION

Last Name | First | M.I. | Social Security Number – –

Mailing Address | **State in Which You Reside** | Home Phone ( ) –

City | State | Zip Code | Work Phone ( ) –

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed *(Give date if changing Marital Status)* – – | **Sex** ☐ **M** ☐ **F** | **Birth Date** *(mm-dd-yy)* – –

Applicant's Employer | Occupation

Employment Status and Date *(mm-dd-yy)* ☐ Full-time ☐ Part-time – – | **Requested Effective Date** *(mm-dd-yy)* – –

2. SPOUSE/DEPENDENT INFORMATION *(Use extra paper if necessary)*

- List all family members to be covered, other than yourself. Indicate their relationship to you (i.e. child, stepchild, adopted, legal guardian, grandchild).
- Indicate dependent's address below dependent's name if the address is different from yours.
- **If Marital Status is Single and you are applying for coverage for your Eligible Dependent(s), you are required to attach a copy of the state birth certificate for each dependent unless previously submitted.**

☐ Yes ☐ No Are there any children under age 26 eligible to enroll under their own/spouse's employer Dental plan?

First Name	M.I.	Last *(if different)*	Relationship	Sex	Birth Date *(mm-dd-yy)*	Active Military	Married	Court Ordered Coverage	Social Security Number
			SPOUSE	☐ M ☐ F	– –	☐ Yes ☐ No	**N/A**	**N/A**	– –
Address:				☐ M ☐ F	– –	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	– –
Address:				☐ M ☐ F	– –	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	– –
Address:				☐ M ☐ F	– –	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	– –

3. DENTAL COVERAGE

☐ New Coverage
☐ Change in Existing Coverage
☐ I Refuse Coverage*

I am applying for:

☐ Single Coverage = myself only
☐ Single Plus Dependent Coverage = myself and eligible children
If married, is your spouse covered by an employer sponsored group dental benefit plan?
☐ ***Yes*** ☐ ***No*** *If no, must apply for Family Coverage.*
☐ Two-Party Adult Coverage = myself and spouse
☐ Family Coverage° = myself, spouse and eligible children

°*(List all family members to be covered other than yourself in Section 2)*

***Refusal of Coverage**

The group Benefit Plan provided by my employer has been explained to me thoroughly, and I understand it fully. I elect not to participate and understand that I will not be entitled to any benefits provided by the group Benefit Plan. I make this election voluntarily and under no compulsion or duress.

4. SIGNATURES *(This form must be signed and dated)*

I understand that any company(s) with which I am applying for coverage reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the Benefit Plan is issued to me. I have read this application in its entirety (including the back page) and understand and acknowledge that the accuracy and sufficiency of the information I provide (or fail to provide) in each and every numbered section of this application serves as the basis in determining my eligibility (and the eligibility of my dependents) for coverage and receiving a Benefit Plan(s), and by signing this application I certify the information is accurate and complete. I understand and agree that inaccurate, incomplete or omitted information represented in this application may constitute a fraudulent act or intentional misrepresentation of material facts voiding or retroactively cancelling any Benefit Plan(s) issued, as well as any claims for medical benefits and services paid, based on the information I submit through this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

X ______________________________
Applicant's Signature **Date Signed**

X ______________________________
Spouse's Signature (if to be insured) **Date Signed**

Agent Number	**Agent Name**

If you have questions or require assistance when completing this application, please contact one of our offices listed below:

Home Office
4510 13th Ave. S.
Fargo, ND 58121
Phone: (800) 342-4718

Fargo District Office
4510 13th Ave. S.
Fargo, ND 58121
Phone: (701) 277-2232

Grand Forks District Office
American Office Park
2810 19th Ave. S.
Grand Forks, ND 58201
Phone: (701) 795-5340

Dickinson Office
1674 15th St. W., Suite D
Dickinson, ND 58601
Phone: (701) 225-8092

Bismarck District Office
1415 Mapleton Ave.
Bismarck, ND 58503
Phone: (701) 223-6348

Minot District Office
1308 20th Ave. SW
Minot, ND 58701
Phone: (701) 858-5000

Devils Lake Office
425 College Dr. S., Suite 13
Devils Lake, ND 58301-3537
Phone: (701) 662-8613

Jamestown Office
300 2nd Ave. NE., Suite 132
Jamestown, ND 58401
Phone: (701) 251-3180

Williston Office
1137 2nd Ave. W., Suite 105
Williston, ND 58801
Phone: (701) 572-4535

This information is available to individuals with disabilities in alternate formats, free of charge, by calling Member Services at 1-800-342-4718 (toll-free) or through the North Dakota Relay at 1-800-366-6888 or 711.

Member Services Toll-Free
(800) 342-4718

LIMITATIONS AND EXCLUSIONS

I understand Members are subject to limitations and exclusions outlined in the relevant Benefit Plan or policy.

METHOD OF PAYMENT

In the event my employer adopts the method of payroll deduction, I hereby authorize and direct my employer to deduct the current premium from my wages or salary and remit the same to Blue Cross Blue Shield of North Dakota. This authorization is to continue in effect until revoked by me in writing.