Authorized Broker

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Individual & Family Dental Plans
Application for Enrollment

How to apply for dental insurance with Blue Cross Blue Shield of Arizona

- Fill in all information on the application even if you have insurance now with Blue Cross Blue Shield of Arizona (BCBSAZ).
- Print your answers in black or blue ink. Do not use red ink, pencil or highlighters. Fill in all boxes completely; do not just mark with an "x". Do not print in any shaded areas.
- All people listed on this application who are age 18 or older MUST sign and date the signature page of the application. BCBSAZ must receive your application within 30 days from the earliest signature date.
- When you are finished filling out the application, send the application to:

  Applicants must be Arizona residents.

1 Tell us how you'd like to hear from us (optional)

How would you like to receive information from us? ☐ Electronically (e-mail) ☐ Paper (U.S. Postal Mail)

What is your preferred language? ☐ English ☐ Spanish ☐ Other_____

How did you hear about us? Select all that apply:

☐ Personal recommendation ☐ Radio ☐ Internet ☐ Broker ☐ Mail ☐ Facebook
☐ Twitter ☐ Newspaper ☐ TV ☐ Billboard ☐ E-mail ☐ Event
☐ LinkedIn

2 Choose your dental plan

Your dental plan's first day of coverage depends on when BCBSAZ receives your application. If we get your application between the 1st and 15th days of a month, we will start your coverage on the 1st day of the next month. If we get your application between the 16th and last day of a month, we will start your coverage on the 1st day of the second following month.

	Dental Plan	Rates Under 19[1]	Rates 19 and Older[1]
☐	BluePreferred 1i	$14.87	$18.13
☐	BluePreferred 5i	$26.50	$32.32
☐	BluePreferred 6i	$28.79	$35.11

[1] Rates are subject to change on notice to the contract holder

3 Tell us about anyone who needs insurance

Contract Holder

This is the adult in your family who will be the main contact person for your application, your coverage and your bills. If you are applying just for minor children, fill in their information in a "dependent" box and skip to the section on "Guardianships and Child-Only Coverage."

Last Name	Suffix	First Name	
Social Security Number		Date of Birth (MM/DD/YYYY)	Gender ☐ Male ☐ Female
Mailing Address (Number and Street)	Apt	City	
State	Zip Code	County	
Primary Phone	Mobile Phone	E-mail Address	

Spouse *(if applicable)*

Last Name	Suffix	First Name	
Social Security Number		Date of Birth (MM/DD/YYYY)	Gender ☐ Male ☐ Female

Dependent #1 (if applicable)

Last Name	Suffix	First Name	
Social Security Number		Date of Birth (MM/DD/YYYY)	Gender ☐ Male ☐ Female

Dependent #2 (if applicable)

Last Name	Suffix	First Name	
Social Security Number		Date of Birth (MM/DD/YYYY)	Gender ☐ Male ☐ Female

Dependent #3 (if applicable)

Last Name	Suffix	First Name	
Social Security Number		Date of Birth (MM/DD/YYYY)	Gender ☐ Male ☐ Female

Do you have more than three dependents who need dental insurance? ☐ Yes ☐ No If yes, on a separate piece of paper, list these other dependents. For each one, give us the same information you gave us for dependents #1-3 above. Send that paper with this application.

4 Guardianships and Child-Only Coverage

Are you a guardian applying for any child who is your ward under a legal guardianship? ☐ Yes ☐ No If yes, you must send a copy of the guardianship papers with this application.

Are you applying for insurance **only** for a child or children? ☐ Yes ☐ No If yes, we'll need to know the **parent, guardian, or responsible party** for any covered children.

Parent or Guardian

Last Name	Suffix	First Name	Relationship to Covered Child/Children

Mailing Address (Number and Street)	Apt

City	State	Zip Code

Primary Phone	Mobile Phone	E-mail Address

Space Below: For Broker Use Only

Broker Name, Mailing Address and Phone	Broker #
Benefit Logic, Inc. 2321 N. 4th St. Flagstaff, AZ 86004 (928) 526-5691	05673

5 Tell us how you would like to receive your bill

How would you like to receive your monthly bill for your dental insurance premium?

- ☐ Monthly paper bill
- ☐ Automatic monthly deduction from your bank account (Checking or Savings Account) – No bill will be sent

If you selected monthly paper bill:

Send monthly paper bill to: ☐ **Contact Holder's address** ☐ **Different address *(list below)***				
Last Name	Suffix	First Name		
Mailing Address (Number and Street)	Apt	City	State	Zip Code

If you selected automatic bank deduction:

Enter your account information.		
Account Type ☐ Checking ☐ Savings	Bank Routing Number (nine digits)	Account Number (up to 17 digits)

I authorize Blue Cross Blue Shield of Arizona (BCBSAZ) to start an automatic monthly charge to my checking or savings account in the amount of my monthly insurance premium.

I also authorize my bank to reduce my account balance each month by the amount of that charge, just as if I wrote a check or withdrawal slip. Each withdrawal will appear on my account statement.

I want this charge to continue automatically until I write BCBSAZ telling them to stop the automatic deduction.

I agree to allow BCBSAZ and my bank reasonable time to stop the automatic withdrawals. I understand BCBSAZ will refund premium BCBSAZ may owe me if BCBSAZ and my bank can't stop the automatic withdrawals by the date that I ask. I understand and agree that BCBSAZ will not release any refund until 30 days after the last withdrawal date.

I understand BCBSAZ and my bank have the right to stop the automatic withdrawal service at any time. I also agree that if my account has insufficient funds to cover the premium bill at the time of withdrawal, the bank may try to debit my account again that same month, or twice the amount the next month. I understand that BCBSAZ will terminate my coverage back to my original premium due date if there are insufficient funds in two consecutive months, and I do not make my payments through some other way.

I have read and promise to follow the above terms for automatic bank withdrawals.

Signature on account X_____

Date: (MM/DD/YYYY) _____/_____/_____

6 Acknowledgments and Signatures

Please read this application carefully. Once your application is accepted, this application and the acknowledgments below become part of your dental contract with Blue Cross Blue Shield of Arizona (BCBSAZ).

1. I have carefully read this application form and the information I provided. I understand and agree that it will be part of the contract with BCBSAZ for any applicant accepted for dental coverage.

2. I understand and agree that:

   - The information I've provided is important to BCBSAZ's decision to offer dental coverage.
   - BCBSAZ will rely on the information I provided to decide each applicant's eligibility for coverage and the amount of premium to charge us.
   - BCBSAZ may rescind the contract and declare it null and void as of the effective date of coverage, if an applicant doesn't tell the truth about, or leaves out, information that was important to BCBSAZ's decision to issue coverage.

3. I authorize any dentist, physician, practitioner, hospital, clinic or other health related provider or facility to give BCBSAZ and its representatives my health information, including information about any drug use, alcoholism, mental illness, HIV and AIDS, but excluding information about genetic testing and family history when allowed by law. I agree to be responsible for any costs associated with obtaining medical records. BCBSAZ may use this information, and any of my information already in its possession, to process claims. If the law allows it, BCBSAZ may sometimes disclose my information to third parties without my permission.

4. I understand that:

   - BCBSAZ sells dental coverage products either directly or through independent licensed insurance brokers
   - BCBSAZ includes commission payments to brokers as part of the premiums it charges for insurance, but does not vary premiums based on whether I use a broker or buy directly.
   - If I do use a broker and have a broker of record, BCBSAZ generally pays a commission to my broker of record (or the broker's permitted assignee) until one of the following happens: (a) my dental insurance coverage ends; (b) I, as the contract holder, end my relationship with the broker and tell BCBSAZ about it; or (c) the broker becomes ineligible to receive commissions.

5. I apply for enrollment:

   - For myself and on behalf of any spouse and child(ren) named on this application (and in a separate paper sent with this application). I understand that if BCBSAZ accepts this application, I will be the contract holder on behalf of the named spouse and child(ren);

   Or, if this is a child-only policy:

   - On behalf of minor child(ren) named on this application (and in any separate paper sent with this application), I understand that if BCBSAZ accepts this application for the minor child(ren), I will be the responsible party on behalf of the named child(ren).

6. I understand that both parents have equal rights to get the medical, dental, and other records of a child directly from the custodian of the records, unless a court order or law prohibits it. If the other parent of my dependent child is not allowed equal access, I have enclosed a copy of the court order or law that proves it.

7. I understand and agree that BCBSAZ and its authorized representatives may call me at the phone number(s) I gave in this application (including any mobile phone number) about: this application, any insurance coverage I may obtain, any insurance claims, and health and wellness programs and information.

8. If I gave an email address in this application, I agree to receive email from BCBSAZ at that email address.

9. I understand and agree that when BCBSAZ sends me information by mail or email at the addresses and in the manner I have asked, it will be presumed that I have gotten the information: (1) on delivery, if hand-delivered; (2) if mailed, on the earlier of the day I actually receive the mail, or five days after BCBSAZ deposits the information in the U.S. mail, postage prepaid; or (3) if transmitted by email, on the earlier of the day I actually receive the email or 24 hours after BCBSAZ emails it to my email address of record.

6 Acknowledgments and Signatures *(cont.)*

10. I understand that health plans offered by BCBSAZ and in some cases, other insurers, may cover pediatric dental benefits for members under age 19. I also understand that the dental coverage I'm buying under this policy could duplicate coverage provided under such health policies for any member who is under age 19.

All persons named on this application age 18 and older must sign and date this form, to show that they understand and agree to the terms listed above. Please keep a copy of this application. A duplicate copy of this application is available to you or your authorized representative upon request.

Signature **Today's Date (MM/DD/YYYY)**

X _____ _____/_____/_____

X _____ _____/_____/_____

X _____ _____/_____/_____

X _____ _____/_____/_____

If you are the legal guardian, please attach a copy of the guardianship papers.

If you would like Blue Cross Blue Shield of Arizona (BCBSAZ) to share personal information with other people please complete a Confidential Information Release form which was provided with this application.

Please return all pages of this application to:

Benefit Logic, Inc
2321 N. 4th St
Flagstaff, AZ 86004

For questions about this application form and how to fill it out, please call your insurance broker.

For questions about the status of your filed application or enrollment, please call (602) 864-4115 or toll-free at (800) 232-2345, ext. 4115.

To authorize someone else to have access to your personal information, you must complete the Confidential Information Release form which was provided with this application.

Additional forms are available from your broker, the BCBSAZ website at azblue.com in the forms section, or by calling (602) 864-4899 or toll-free at (877) 864-4899.

Notes:

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