Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

DENTAL
APPLICATION AND CHANGE FORM

Group Administrator Use Only
Multi-option: which ____________

Group No.:	Employer:	DEPT.:	DATE OF FULL-TIME EMPLOYMENT:	ID No.:

GROUP EMPLOYEE APPLICATION

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	SEX	SOCIAL SECURITY NO.
APPLICANT			MO. DAY YEAR		

SECTION 1 | POLICY ELIGIBILITY

Check all applicable boxes below that support your eligibility, provide date of qualifying life event and documentation.

	Date		Date
❏ 1-Annual Open Enrollment Period		❏ 6-Marriage	________
❏ 2-New Hire		❏ 7-New Adoption	________
❏ 3-Waiving Coverage		❏ 8-New Guardianship/Legal Custody/Court Order to Add Child	________
❏ 4-Loss of Minimum Essential Coverage	________	❏ 9-Other Reason: Ex. Rehire, ACA (give specific reason) ________	________
❏ 5-Newborn	________		

NOTE: If application is not received during Open Enrollment Period, we must receive appropriate documentation with this application to confirm qualifying life event/special election period (i.e. copy of marriage license, Certificate of Creditable Coverage from previous insurance company, legal guardianship/custody documentation, etc.).

SECTION 2 | WHO IS APPLYING

Coverage Desired: ❏ Employee Only ❏ Employee & Spouse ❏ Employee & Child(ren) ❏ Employee, Spouse & Child(ren)

Please indicate under the relationship column below whether dependent children are natural, step or adopted.

First Name	M.I.	Last Name	Relationship	Sex	Date of Birth	Social Security No.
			Self			

SECTION 3 | MARITAL STATUS

❏ Single (including widowed or divorced) ❏ Married (including separated)

SECTION 4 | CONTACT INFORMATION

Street or P.O. Box ____________ City ____________ State ______ ZIP ________

Primary Phone Number (   ) ____________ Work Phone Number (   ) ____________ Email ____________

SECTION 5 | EMPLOYMENT STATUS

Job Title ____________

❏ Hourly Hours Worked Weekly____________

❏ Salaried ❏ Other

Are you a current, active employee? ❏ Yes ❏ No

FOR OFFICE USE ONLY

C/T	PKG	DATE
EFF DATE	UND	
OTH		

SECTION 6 | CURRENT/PREVIOUS DENTAL INSURANCE INFORMATION

(This section must be completed to process your enrollment application.)

For previous or continuing coverage please complete the following:
(If covered by more than one insurance plan, use additional paper)

Insurance Company	Address	Phone
Policyholder Name	Date of Birth	Member ID#

List the following information for all family members covered by this policy (indicate those not residing in your household with a check ✓ mark)

First Name	Last Name	Relationship	✓	Eff. Date of Coverage	End Date of Coverage

SECTION 7 | CHANGE REQUEST SECTION

Changes may be sent by: **Email:** Groupaccounts@arkbluecross.com
Fax: 501-378-3248

MAIL: Arkansas Blue Cross and Blue Shield
ATTN: Group Accounts, Riverfront Plaza, 9th Floor
P.O. Box 2181
Little Rock, AR, 72203-9974

Change to individual due to:

❏ Death – Date: ______________________

❏ Divorce – Date: ______________________

❏ Other: ______________________

Change coverage as indicated below:

❏ Name Change: ______________________

❏ Other – Explain: ______________________

Current Name: ______________________

New Name: ______________________

CHANGE IN DEPENDENT STATUS

Delete	Last Name	First Name	M.I.	Birthdate	Relationship	Sex	SSN	Date of Change	Reason (for deletion only)

SECTION 8 | AUTHORIZATION & SIGNATURES

I understand that no benefits for services of any kind are provided for treatment that was received prior to the effective date of my dental coverage.

I do hereby authorize any dentist, hospital or other provider of medical services or supplies to make available to Arkansas Blue Cross and Blue Shield upon request any and all medical records and facts pertaining to us and our physical condition.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefits or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

______________________ Print Name of Applicant (Employee)

______________________ Signature of Applicant (Employee)

______________________ Date

______________________ Print Name of Employer/Group Representative*

______________________ Signature of Employer/Group Representative*

______________________ Date

**Required for new hires and additions only.*

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICE

NOTICE: Our Company complies with applicable federal and state civil rights laws and does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex.

We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in various formats (large print, audio, accessible electronic formats, other formats), and language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. **If you need these services, contact our Civil Rights Coordinator.**

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
601 Gaines Street, Little Rock, AR 72201
Phone: 1-844-662-2276; TDD: 1-844-662-2275

You can file a grievance in person, by mail, or by email. If you need help filing a grievance our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201
Phone: 1-800-368-1019; TDD: 1-800-537-7697

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-844-662-2276.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-662-2276.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-844-662-2276.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-662-2276.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-662-2276 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-662-2276.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-662-2276.

ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. إتصل بالرقم 1-844-662-2276.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-844-662-2276.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-662-2276.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-844-662-2276.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-844-662-2276.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-844-662-2276.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-662-2276まで、お電話にてご連絡ください。

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-662-2276.

توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات و کمک‌های زبانی رایگان برای شما موجود است. برای کسب اطلاعات بیشتر، با شماره 1-844-662-2276 تماس بگیرید.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-662-2276.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-662-2276 पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-662-2276.

انتباہ: اگر آپ اردو بولتے ہیں تو، آپ کے لئے زبان کی مدد کی خدمات بلا معاوضہ دستیاب ہیں۔ 1-844-662-2276 پر کال کریں۔

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-662-2276.

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-844-662-2276.