



BlueCross BlueShield of North Carolina

P.O. Box 30016
Durham, NC 27702-3016

APPLICATION Dental Blue for Individuals

FOR OFFICE USE ONLY		
Application Receipt Date	Group Number	Effective Date*
*If application is received before the 20th of the month, policy is effective the first of the next month; if application is received after the 20th, the policy is effective the first of the following month		

NEW PID# CHANGE

Section 1: Applicant Information

Last Name: _____ First Name: _____ Middle Initial: _____
 Home Address (if billing address is different, please enter home address here and billing address in Section 5 below): _____

 City: _____ County of Residence: _____ State: _____ Zip Code: _____
 Date of Birth: _____ / _____ / _____ Business Phone Number: _____ Area Code: _____ Home Phone Number: _____
 Social Security Number: _____ - _____ - _____ Sex: Male Female Marital Status: Single Married Separated Divorced Widowed

Section 2: Spouse Information - Complete ONLY if Spouse is to be Covered

Name of Spouse (first, middle initial, last - ONLY if different): _____ Date of Birth: _____ / _____ / _____ Sex: Male Female

Section 3: Unmarried Dependent Children Under Age 26 or Handicapped - List ONLY Those Children to be Covered

Name (first, middle initial, last - ONLY if different)	Date of Birth Month Day Year	Relationship	Sex
			<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Male <input type="checkbox"/> Female
			<input type="checkbox"/> Male <input type="checkbox"/> Female

Section 4: For New Applications

Has anyone applying for coverage on this application had Dental Blue for Individuals coverage within the last twelve (12) months? Yes No
 If yes, please remove them from the application. You may NOT re-enroll within twelve (12) months of terminating coverage, unless you are enrolling an adopted child or providing court-ordered coverage for a dependent.

Section 5: Payment Information

Billing Frequency: Monthly Method: Bank Draft Bill Me Directly
 Billing Address (if different from home address): _____ City: _____ State: _____ Zip Code: _____

Section 6: Banking / Payment Authorization

Type of Account: Checking Savings Bank Account Number: _____ Bank Routing Transit Number: _____
 Name of Bank: _____ Name(s) of Bank Account Holder: _____
 By signing below, I am an authorized user of this credit card and/or bank account. I understand that the bank account/credit card account listed cannot be my employer's account. As a convenience to me, I hereby request and authorize Blue Cross and Blue Shield of North Carolina (BCBSNC) to initiate the charge to my credit card and/or bank account payable to the order of BCBSNC. I agree that BCBSNC's rights in respect to each credit card charge and/or bank draft shall be the same as if it were a credit card charge made by me and/or a check drawn on my bank account, and signed by me personally. I also authorize the financial institution to apply the credit card charge to my credit card and/or reduce the balance of my bank account by the amount of the bank draft. This authorization will remain in effect until I revoke it in writing at least 10 days prior to the date the account is scheduled to be charged. I agree that if such charges be dishonored, whether with or without cause and whether intentionally or inadvertently, BCBSNC shall have no liability whatsoever even though dishonor results in forfeiture of insurance. The total premium will be charged upon this application's acceptance.
 AUTHORIZED SIGNATURE(S) (as it/they appear(s) on the bank's records, all authorized persons must sign):
 Name: X _____ Date: _____ Name: X _____ Date: _____

Section 7: Signature Authorization

I understand that this application, along with the benefit booklet and the "Summary of Benefits", is the legal contract between BCBSNC and myself. I further understand that any coverage provided according to this application will be subject to the provisions of the benefit booklet, issued to me by BCBSNC. I hereby certify that the information provided is accurate to the best of my knowledge.
 Signature of Applicant or Parent/Guardian (if applicant is under age 18): X _____ Date: _____

Section 8: BCBSNC/Producer Internal Use Only

I hereby certify that I have truly and accurately recorded the information supplied by the applicant. Signature of Representative: X _____ Representative's Name (please print): _____ Rep. No. _____

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