BlueCross BlueShield of Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

Website: www.bcbskc.com

Individual Preferred-Care Dental

Office Use Only:
Group #: ____________
Certificate #: ____________
Date Received: ____________
Date Processed: ____________
Processed By: ____________

Requested Effective Date ______________________ (application must be received prior to the effective date)
(**Effective the 1st of each month ONLY**)

I – Application Request

☐ **New Application** (For individuals who currently have dental coverage as a dependent with Blue Cross Blue Shield of Kansas City, have you been continuously covered for at least 6 months? ☐ Yes ☐ No)
If "yes" please provide the certificate number (found on Your Member I.D. card) ______________________

☐ **Change** (If application is to be used as a change form, please specify below):
☐ Address Change ☐ Other Reason For Change (Required): ______________________

II – Applicant/Family Information (List ONLY individuals desiring coverage)

Child rates apply to those age 18 and younger as of January 1 of the current year; adult rates apply to those age 19 and older as of January 1 of the current year.

	Last Name First Name M.I.	Date of Birth	Sex	Social Security #	Relationship To Applicant
Applicant		/ /	☐ Male ☐ Female		
Dependent		/ /	☐ Male ☐ Female		
Dependent		/ /	☐ Male ☐ Female		
Dependent		/ /	☐ Male ☐ Female		
Dependent		/ /	☐ Male ☐ Female		

III – Coverage Selection

Type of Coverage Desired **(You must initially purchase at least three months coverage; see brochure for Premiums)**

☐ Type I and Type II – Diagnostic and Preventive Services; Basic Restorative Services, Endodontics and Extractions

IV – Billing Information

1. Last Name	First Name		M.I.	
2. Home Address	City	State	County	Zip Code
3. Billing Address (if different than above)	City	State	County	Zip Code
4. Daytime Phone ( )	5. Home Phone ( )	6. E-Mail Address		

If You or Your dependent currently have individual or group health coverage through Blue Cross and Blue Shield of Kansas City, please specify Your certificate # (this information can be found on Your Member I.D. card):

______________________ (Please provide all Member I.D. numbers)

Applicant information:

Last Name: First Name: M.I.

V – Payment Option

The membership premium is to be:

☐ Automatically deducted (Tech-No-Check) from my checking account monthly (complete Financial Institution Information; Section VI); **THREE MONTHS PREMIUM DUE WITH APPLICATION**.

☐ Charged to my credit card; initial three months Premium will be charged to my credit card (complete Credit Card Authorization; Section VII); **THREE MONTHS PREMIUM DUE WITH APPLICATION.**

☐ Billed to my home every calendar year Quarter (January, April, July, and October); **THREE MONTHS PREMIUM DUE WITH APPLICATION.**

VI – Financial Institution Information (If you selected Tech-No-Check Option above)

- With Tech-No-Check electronic funds transfer, Your monthly premium is automatically deducted from your checking account. Following Your third month's coverage, Your account will be drafted on the 5th of each month or the next business day.
- You will be notified when Tech-No-Check is in force.
- You must attach a copy of Your voided check.

As a convenience to me, I hereby authorize BCBSKC to initiate debit entries from my account when the payment is due. A copy of my voided check is attached.

NOTE: To cancel your electronic funds transfer authorization, your request must be received 10 days prior to your electronic funds transfer withdrawal date.

Billing Party Name (Please Print):	Billing Party Social Security No.
Billing Party Signature:	Date:

VII – Credit Card Authorization (If you selected the credit card payment option)

We offer the convenience of paying by credit card. With your signed authoriztaion, payment by credit card can be accepted for your initial three month premium. Also, with your signed aurhtorization, we can automatically charge your credit card for your full premium each month. To pay by credit card, select one or both of the following options *(all information must be complete for processing)*:

☐ Please charge my credit card for my initial premium payment in the amount of : $.

☐ Please charge my credit card automatically each month for the full premium amount due. I understand that my credit card will be charged each month on the 5th day of the month.

Choose only one: ☐ Visa ☐ Master Card ☐ American Express ☐ Discover

Account Number: ______________________________ Expiration Date: ____________________

Account Name: ______________________________ Signature: ______________________________

NOTE: To cancel your automatic credit card authorization, your request must be received 10 days prior to your credit card withdrawal date.

Applicant information:

Last Name: First Name: M.I.

VIII – Agreement

I request coverage under the Preferred Care Dental Contract issued by Blue Cross and Blue Shield of Kansas City ("BCBSKC"). I understand services will be available subject to the exclusions, limitations and benefits described in the Contract. I understand that any misstatement on this enrollment application may result in a denial of a claim and/or discontinuation of coverage. I understand that if at any time it is determined by BCBSKC that a person listed on this application did not meet the policy's definition of dependent, or I misrepresented any of the information contained herein; BCBSKC has the right to cancel or rescind coverage for the person or for all persons under the application, and to recover any benefit payments for such ineligible person(s). I understand no statement I make voids my coverage or reduces my benefits after my coverage has been in force for two (2) years from the effective date, unless my statements are material to the risk assumed and contained in my written application. I understand my dental records will be maintained with strict confidentiality by BCBSKC in accordance with applicable federal and state laws. **(Parent or guardian signature required for minors under the age of 18.)**

Applicant's (Parent/Guardian) Signature		Spouse's Signature (if enrolling)	
Printed Name:	Date	Printed Name:	Date

VII – Agent Representation (if applicable)

AGENT USE ONLY	I represent that to the best of my knowledge all statements are complete and accurate.		BCBS 6 Digit Broker No.
	Broker Signature	Date	
	Printed Name	Telephone No. ( )	**REQUIRED**