Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

Mail to:
P.O. Box 37859
Jacksonville, FL 32236

BlueDental Choice PPO Application for Individual Insurance

All Fields Are Required

Applicant First Name 1	Applicant Last Name 2	Home Phone No. 3 ( )	Social Security No. 4
Home Address 5	Suite/Apt No. 6	Business Phone No. 7 ( )	Birth Date: (mm/dd/yyyy) 8 (Min. applicant age 18)
City 9	State 10 / Zip Code 11	Gender 12 ☐M ☐F	Requested Effective Date (within 90 days) 13

Coverage Type Requested ***(check all that apply)*****:** ☐ Policyholder < 65 ☐ Policyholder Age 65+ ☐ Child(ren) 14
☐ Spouse < 65 ☐ Spouse Age 65+ ☐ Domestic Partner (DP) < 65 ☐ Domestic Partner (DP) Age 65+

Plan Selection Choice: ☐ **Individual BlueDental Choice Plus** ☐ **Individual BlueDental Choice Copayment** 15

List All Eligible Dependents To Be Covered. Children of a domestic partner may be covered when the domestic partner is also covered. Attach additional sheet of paper, if necessary. Sign and date it. 18 – 27, Check all that apply.

16 **First Name, M.I., Last Name** *(Please provide information in the corresponding numbered spaces below.)* / 17 **Social Security Number** (Please provide in spaces below.)	18 **Relation to You** (DP = Domestic Partner)	19 **Marital Status** Married	19 **Marital Status** Unmarried No Children	20 Gender (M/F)	21 **Birthdate** (mm/dd/yyyy)	22 Disabled	23 Lives with You	24 You Support Financially	25 **Student** FT/PT	26 Florida Resident	27 Covered by Medicaid
16 ___-___-___	☐ Spouse *Or* ☐ DP			☐		☐	☐	☐			
16 ___-___-___	☐ Child *or* ☐ DP Child	☐	☐	☐		☐	☐	☐	☐	☐	☐
16 ___-___-___	☐ Child *or* ☐ DP Child	☐	☐	☐		☐	☐	☐	☐	☐	☐
16 ___-___-___	☐ Child *or* ☐ DP Child	☐	☐	☐		☐	☐	☐	☐	☐	☐

Do you or any of your dependents have Dental insurance under another plan? ☐ Yes ☐ No. 28
If "YES" complete the following: **Person's Name:** **Policy No.:**
Insurance Co. Name/Address:

Replacement of Coverage. Is this insurance intended to replace **ANY** dental insurance currently "in-force"? 29
☐ Yes ☐ No If "YES" complete the following:
Insurance Company Name: **Policy No.:**
Effective Date: **Termination Date:**
(Also, complete the Replacement of Insurance notice and submit it with your application.)

Have you been insured by a Florida Combined Life group or individual dental insurance policy within the last 90 days? ☐ Yes ☐ No 30

Are you also applying for Blue Cross and Blue Shield of Florida health insurance coverage? ☐ Yes ☐ No 31

Acceptance of Coverage

I am a Florida resident, and I wish to enroll in the above selected plan. I understand the insurance applied for will not become effective until FCL has approved my application. I understand that waiting periods may apply for certain services.

I authorize FCL to exchange benefit information with any insurance company; organization; or individual to determine if coordination of benefits applies for me and my dependents. If an overpayment is made, I authorize FCL to recover the excess from any person or entity to which payment is made.

I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I certify that the statements on this application, including any attachment to it, are true and complete to the best of my knowledge and belief. I understand and agree that any misstatements may result in denial of benefits and/or termination of coverage.

I understand that this application is hereby made a part of the policy. A photocopy of this application shall be as valid as the original.

Fraud Notice: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Applicant Signature **(Required)**: X 32	Date **(Required)**: 33

I understand that FCL may terminate this insurance at the end of any period for which the premium has been paid.

Applicant Signature **(Required)**: X 34	Date **(Required)**: 35

Payment Information on Page Two Must be Completed.

Please Complete this Page and Sign (if applicable).

First Name 36	Last Name 37	Social Security No. 38

Agent Information: ALL INFORMATION MUST BE COMPLETED TO PROCESS APPLICATION

Agent Printed Name: 39	Signature: 40	Date: 41
Agent Phone Number: 42	Agent Fax Number: 43	
Florida State License Number: 44	BCBSF Agent Code: 45	

Premium Payment Mode: ☐ Monthly *Only payable by Bank Draft* 46
(see rate sheet) ☐ Quarterly* ☐ Semi-Annual* ☐ Annual* **Payable by Bank Draft, Check or Credit Card*

Payment Method: *(Choose One)*

1. Bank Draft: ☐ *For Monthly, Quarterly, Semi-Annual, and Annual Premium Payment Modes* 47

You Must Include A Voided Check With This Application For Bank Draft and Complete the Section Below. We will Deduct your 1st and future premiums from your account.

Policies effective on the 1st of the month will be drafted on the 28th of the previous month; policies effective on the 15th of the month will be drafted on the 12th of the month.

I authorize _____ to make a bank draft of $_____
(Financial Institution/Bank Name)

From Account No. _____ Bank Routing No. _____
and to remit the amounts deducted to FCL, upon instructions from FCL. The amount of deduction indicated above is approximate and may be corrected as instructed by FCL. This authorization will remain in effect until: (a) I/we cancel it in writing; (b) the above account is closed; (c) the deduction and remittance arrangements between the above financial institution and FCL are discontinued; or (d) the insurance policy is cancelled. I understand that this authorization does not waive or change any of the payment provisions of the policy issued to me by FCL, and if this authorization terminates for any reason, any further payments required under the policy will be made as provided in the policy. I agree that the above financial institution is acting gratuitously and for my sole accommodation and not as an agent for FCL.

Accountholder's Signature (Required): X Date:

2. Check: ☐ *For Quarterly, Semi-Annual, and Annual Premium Payment Modes* 48 **Payable to Florida Combined Life (FCL)**	Premium Payment: 49 $	Check No.: 50

3. Credit Card: 51 *For Quarterly, Semi-Annual, and Annual Premium Payment Modes* ☐ MasterCard ☐ Visa	Credit Card No.: 52	Exp. Date: (mm/yy) 53
I hereby authorize charging by Credit Card: 54 **Cardholder's Signature:** X	Amount Charged: 55 $	Date: 56

Please attach your voided check here.

Did You Remember To:

- ❑ **Answer the question about replacement of insurance (Box 29)**
- ❑ **Sign and date the application in both places on page 1 (Boxes 32 - 35)**
- ❑ **Calculate your premium carefully, using the rate sheet**
- ❑ **For Bank Draft, send a voided check that includes the bank routing & account numbers, and sign/date authorization (Box 47). We will deduct your 1st and future premiums from your account.**
- ❑ **For Credit Card payment, complete all requested information, and sign/date authorization (Boxes 51- 56)**

For Internal Use Only

PSR No.	Date Processed	Group & Division No.	Policy Effective Date

If you have any questions about completing this application, please call 800-267-3156.