BlueDental Care Prepaid Individual Application

Florida Combined Life

Mail to:
Florida Combined Life
Dental Services Administrator
P.O. Box 769569
Roswell, GA 30076-8223

Last Name	First Name	MI	Social Security No.	Gender ☐ M ☐ F	Date of Birth: MM/DD/YYYY / / Minimum applicant age is 18
Home Address	Suite/Apt No.	City	State	Zip Code	County
Home Phone No. ( )	Business Phone No. ( )		Dental Facility # (Select from provider directory)		

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.

Last Name, First Name, M.I. Social Security Number (Please provide information in the corresponding spaces below.)	Relation to You (DP = Domestic Partner)	Gender (M/F)	Birthdate MM/DD/YYYY	Marital Status: Married	Marital Status: Unmarried No Children	Disabled	Lives With You	You Support Financially	Student FT/PT	Florida Resident	Covered By Medicaid	BlueDental Care Facility ID# (Select from provider directory) Check box if a current patient
- -	☐ Spouse or ☐ DP											☐
- -	☐ Child *or* ☐ DP Child			☐	☐	☐	☐	☐	☐	☐	☐	☐
- -	☐ Child *or* ☐ DP Child			☐	☐	☐	☐	☐	☐	☐	☐	☐
- -	☐ Child *or* ☐ DP Child			☐	☐	☐	☐	☐	☐	☐	☐	☐

I wish to enroll in the FCL prepaid individual plan. I understand that this is a MINIMUM ONE (1) YEAR CONTRACT and that all necessary dental services will be provided as described in the plan. Completed applications with correct payment received by the 15th of the month will take effect on the 1st of the following month. Applications received after the 15th of the month will take effect on the 1st of the following month.

Applicant Signature	Date	Agent Name	Agent Code Number
			8890000

Annual Check Section

Make checks payable to Florida Combined Life

Premium Payment $ _____ Check No. _____

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

Annual Credit Card Section

CHECK ONE ☐ MasterCard ☐ Visa ☐ Discover | Credit Card Number | Exp. Date: MM/YY

Amount Charged **(Annual Premium + one time $35 non-refundable enrollment fee = Annual Amount You Pay)**
$ + $35 = $

I hereby authorize charging by Credit Card: Cardholder's Signature | Date:

Monthly Bank Draft Authorization for Deduction Section

Accountholder's Name

Premium Payment $ _____ Check No. _____ Check Routing No. _____

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

$ _____ +$1.00 = $ _____ from Account # _____
(Monthly premium + $1.00 administrative fee) (Monthly Only)

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.

YOU MUST INCLUDE A VOIDED CHECK AND YOUR 1ST MONTH'S PREMIUM WITH THIS APPLICATION.

Accountholder's Signature: _____ Date: _____
(Signature Required)

PI210 Plan Rates

Policy Type (Select one)	Monthly Premium (Bank Draft Only)	Annual Premium (Check, Money Order or Credit Card)
Individual	$10.65	$127.80
Individual + one dependent	$18.19	$218.28
Individual + two dependents	$24.65	$295.80
Individual + three dependents	$31.00	$372.00
Individual + four or more dependents	$36.88	$442.56
Calculate Your Total Below	**Monthly**	**Annual**
Premium Amount	$	$
One time non-refundable enrollment fee	+ $35.00	+ $35.00
Administrative Fee (Bank Draft Only)	+ $1.00	
Total Amount Due	$	$

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.

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

FOR MORE INFORMATION CALL
1-888-753-4363