Florida Combined Life

An Independent Licensee of the Blue Cross and Blue Shield Association

Group Member Life & Dental Enrollment Application

Dental / Life / AD&D / Disability

Please type or write clearly in black or blue ink

Section A: Employer Provided Information

Group Name: 1.	Life Group #: 2.	Dental Group # 3.	Division #: 4.
Coverage Effective Date: 5.	Date of Hire: 6.	Occupation: 7.	Class: 8.

Work Status: ☐ Actively at Work ☐ Cobra ☐ Retired 9.	Retirement Date: 10.	Paid: ☐ Hourly ☐ Salary 11.	Annual Salary: $ 12.	Hours worked per week: 13.	☐ Open Enrollment: *(Dental Only)* 14.

Section B: Employee Information *(Refer to Section E. for Additional Employee Information)*

Last Name: 15.	First Name: 16.	M.I.: 17.	Gender: ☐M ☐F 18.	Date of Birth (DOB): 19.
Address: 20.	Apt.#: 21.	City: 22.	State: 23. Zip: 24.	Social Security #: 25.
County: 26.	Home Phone #: ( ) 27.	Business Phone #: ( ) 28.	Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed 29.	

Section C: Dental Coverage Selection 30.

*(If **yes**, select one of the Plans below.)* Employee: ☐ Yes ☐ No, I decline Coverage. Child(ren): ☐ Yes ☐ No, I decline Coverage.
Spouse: ☐ Yes ☐ No, I decline Coverage. *(If **child** selected, all children must be enrolled.)*

Plan Type Requested: ☐ BlueDental Choice (PPO)__________ ☐ BlueDental Choice Plus (PPO) ________ ☐ BlueDental Freedom (Indemnity) _______ 31.
☐ BlueDental Choice Copayment (PPO) ________ ☐ BlueDental Care (Prepaid) __________ ☐ Other_____________________

Section D: Life and Disability Coverage Selection 32.

*(If **yes**, select coverages below.)* Employee: ☐ Yes ☐ No, I decline Coverage. Child(ren): ☐ Yes ☐ No, I decline Coverage.
Spouse: ☐ Yes ☐ No, I decline Coverage. *(If **child** selected, all children must be enrolled.)*

Coverage Requested:
☐ Basic Term Life $__________
☐ Accidental Death & Dismemberment (AD&D) $________
☐ Dependent Life
☐ Short Term Disability (STD)
☐ Supplemental Life $________ ☐ Supplemental AD&D
☐ Hospital Indemnity (***Select Only One)*** ☐Employee Only ☐Emp/Spouse ☐Emp/Child(ren) ☐Emp/Family
☐ Long Term Disability (LTD) ☐ LTD Buy-Up

Voluntary Coverages: *(If **spouse** Voluntary Life or AD&D is selected, spouse information **must** be provided in Section E).* 33.
Life: ☐ Employee $_______ ☐ Spouse $_________ ☐ Child(ren) $_______
AD&D: ☐ Employee $_______ ☐ Spouse ☐ Child(ren)
☐ Voluntary Short Term Disability (VSTD)
☐ Voluntary Long Term Disability (VLTD)

Your Group Life Beneficiary Information

Attach separate sheet, if needed, with additional beneficiaries, sign and date. 34.
This will revoke any existing beneficiary designation you may have. **Total % must = 100%.**

Beneficiary	DOB:	Relation to You:	% of Share:
Primary Beneficiary:			
Secondary (Contingent) Beneficiary:			
Secondary (Contingent) Beneficiary:			

Section E: Employee and Dependent Information

Attach separate sheet, if needed, sign and date — #37 – #47 Check all that apply

35. First Name, M.I., Last Name *(Please provide information in the corresponding numbered spaces below.)* / 36. Social Security Number (Please provide in spaces below.)	37. Relation to You (DP = Domestic partner)	38. Marital Status: Married	Unmarried No Children	39. Gender (M/F)	40. Date of Birth (mm/dd/yyyy)	41. Disabled	42. Lives with You	43. You Support Financially	44. Student FT/PT	45. BlueDental Care Facility ID # (Select from provider directory)	Check box if a current patient	46. Florida Resident	47. Covered by Medicaid
Employee											☐		
35. / ___-__-____	☐Spouse or ☐ DP					☐	☐	☐			☐		
35. / ___-__-____	☐Child or ☐ DP Child	☐	☐			☐	☐	☐	☐		☐	☐	☐
35. / ___-__-____	☐Child or ☐ DP Child	☐	☐			☐	☐	☐	☐		☐	☐	☐
35. / ___-__-____	☐Child or ☐ DP Child	☐	☐			☐	☐	☐	☐		☐	☐	☐

Section F: Other Dental Insurance Information (This section must be completed for claims processing)

In addition to this policy, do you or your dependents have any other Dental insurance under a group plan? ☐Yes ☐ No If yes, complete below. 48.

Name of Person: 49.	Group Name & #: 50.	Policy #: 51.
Insurance Co./Name and Address: 52.		

Section G: Acceptance of Coverage (Please read before signing)	Section H: Refusal of Any/All Coverage (Please read before signing)
I wish to apply for any coverage checked **YES** under Parts C and D above. I have read and understand the Acceptance of Coverage on the reverse side of this form. I certify the statements on this application, including any attachment to it, are true and complete to the best of my knowledge and belief. *(If you checked NO for any coverage under Parts C or D, sign and date Part H also.)* **53.**	I do not wish to apply for any coverage checked **NO** under Parts C and D above. I understand there may be additional requirements if I decide to apply at a later time. **54.**
Signature: Date	Signature: Date

FRAUD NOTICE: I understand that 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.

Section I: Acceptance of Coverage Authorization

I hereby apply for the coverage checked "Yes" on the front of this form. My employer has selected the coverage through Florida Combined Life Insurance Company, Inc. (FCL). I authorize my employer to deduct from my earnings my premium contribution (if any). I understand all of the following: 1. If my coverage is to be issued and continued, I must meet all the group contract's requirements; 2. if my dependents' coverage, if any, is to be issued and continued, my dependents must meet all the group contract's requirements; and (3) if I am not actively at work on my proposed coverage effective date, my effective date for certain coverages **may** be deferred until the date I return to active work.

I understand a dependent cannot be: (1) covered as both a dependent and an employee, including married employees of the same employer, (2) covered under more than one employee, or (3) full-time military.

I understand that my employer is not an agent of FCL. I also understand that my employer is responsible for notifying all employees of: 1. all effective dates; 2. all termination dates; 3. any Employee Retirement Income Security Act (ERISA) rights or responsibilities; and 4. all other matters pertaining to coverage under the group contract.

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, if I apply for FCL dental coverage later, coverage will not be available until the next open enrollment. I also understand if I apply later for coverages, other than dental, I **may** be required to furnish evidence of insurability.

I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I hereby certify that the statements on this application, including any attachment to it, are true and complete. I understand and agree that any misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage.

A photocopy of this application shall be as valid as the original. However, the original application is required to evaluate this application. I agree to be bound by the group contract's terms and conditions. I understand that this application is hereby made a part of the group contract. I will attach it to my certificate of coverage, when issued.