



# Regence

Life and Health Insurance Company

Independent Licensee of the Blue Cross and Blue Shield Association.

100 SW Market Street  
P.O. Box 1271 E-3A  
Portland, OR 97207-1271  
(503) 721-7161 • (800) 794-5390

Home Office Use Only	
ID #	
Eff. Date	
Vis. Rider <input type="checkbox"/>	EFT <input type="checkbox"/>

## RENEWABLE INDIVIDUAL DENTAL INSURANCE APPLICATION (WITH OPTIONAL VISION RIDER)

Please complete all information on this page and on Page 2. Incomplete information may result in a delayed Effective Date.

Applicant's Last Name		Applicant's First Name		M.I.	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number	
Date of Birth (mm/dd/yyyy)		<input type="checkbox"/> Married / Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Single		Telephone Number ( )		E-mail Address	
Home Address & Apt. No./Mailing Address				City		State	Zip

### Requested Effective Date

Your requested Effective Date must be following or coinciding with the date We receive your Application, after the date your Application is signed, and within 60 days from the date of your signature, or a new Application will be required.

**A new Application may result in a delayed Effective Date. In no event may the Effective Date of this Policy be back-dated**

For **Dollar-Based** and **Incentive 10** Dental:  1<sup>st</sup> OR  15<sup>th</sup> of \_\_\_\_\_ (month) \_\_\_\_\_ (year)

For **Managed Care** Dental: 1<sup>st</sup> of \_\_\_\_\_ (month) \_\_\_\_\_ (year)

**Dependents to be enrolled:** Dependent children must be under 26 years of age.

Last Name	First Name	M	SS#	Birth Date	Sex	Relationship (Spouse or Child)
Same as above			Same as above	Same as above	M / F	Self
					M / F	
					M / F	
					M / F	
					M / F	
					M / F	

**Please list names as they should appear on your identification card.** If enrolling additional dependents, please attach a separate sheet including the information above. **If you are enrolling a non-state certified domestic partner, please complete the attached affidavit.**

**Other coverage information (This is not a waiver of coverage.** This information is required for payment of claims.) Do you or any family members enrolling have other dental coverage?  Yes  No

**If yes, provide the information regarding other coverage requested below.**

Name of Family Member with other coverage				Relationship			
Name of Insurance Carrier		Policy No.		ID No.		Carrier Phone No. ( )	
Address of Other Carrier				City		State	Zip Code
Is the coverage of any dependent affected by a divorce decree/court order? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please include portion of decree that shows responsibility for health expenses.							
This plan covers: <input type="checkbox"/> Self <input type="checkbox"/> Spouse / Domestic Partner <input type="checkbox"/> Child(ren) <input type="checkbox"/> Stepchild(ren) <input type="checkbox"/> Other Please list names:							

**You may enroll for Dental Only Coverage or Dental with Vision Coverage.  
All members must be enrolled for the same coverage and premium payment schedule.**

**I am making application for:**

**DOLLAR-BASED DENTAL INSURANCE**

**NOTE:** This coverage has a **6 MONTH BENEFIT WAITING PERIOD (BWP)\*** for **ALL SERVICES**.

**INCENTIVE 10 DENTAL INSURANCE**

**NOTE:** This coverage has a **6 MONTH BWP\*** for **RESTORATIVE SERVICES** and a **12 MONTH BWP\*** for **MAJOR SERVICES**

**MANAGED CARE DENTAL INSURANCE**

**NOTE:** This coverage has a **6 MONTH BWP\*** for **MAJOR and ORTHO SERVICES**

\*The **BENEFIT WAITING PERIOD** is the continuous length of time the member must be covered under the Policy before becoming eligible for benefits.

**Add Vision Rider**     Yes     No

**Premium Payment Schedule:**     **Monthly**     **Quarterly**

**Premium Calculation for Dollar Based and Incentive 10 Dental**

	Number enrolling for coverage		Enter <u>Monthly</u> or <u>Quarterly</u> <b>Dental Only or Dental with Vision</b> Premium Rate	=	\$ _____
<b>Under Age 18</b>	_____	<b>X</b>	\$ _____	=	\$ _____
<b>Age 18 through age 64</b>	_____	<b>X</b>	\$ _____	=	\$ _____
<b>Age 65 and over</b>	_____	<b>X</b>	\$ _____	=	\$ _____
<b>Total <u>Monthly</u> or <u>Quarterly</u> Dental or Dental with Vision Premium Rate</b>					<b>\$ _____</b>

**Premium Calculation for Managed Care Dental**

**Family Status of Member(s) enrolling:**

**Individual**

**Individual & Spouse**

Enter Monthly or Quarterly **Dental or Dental with Vision**

**Individual & 1 Child**

**Family**

**Premium Rate** \$ \_\_\_\_\_

**Your 1<sup>st</sup> premium payment must be enclosed with this Application.**

**Total Monthly or Quarterly Dental or Dental with Vision**

**Premium Rate** \$ \_\_\_\_\_ **PLUS Policy Fee of \$ 25.00 = Total Due \$ \_\_\_\_\_ (Enclosed)**

I hereby apply for enrollment with Regence Life and Health Insurance Company under the Individual Dental Insurance plan.

I acknowledge and understand Regence Life and Health Insurance Company and the Participating Provider may request or disclose health information about me or my dependents (persons who are listed for benefit coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
- an insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

**DISCLOSURE:** If you have a broker or agent, they may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence Life and Health Insurance Company. Incentives may be based on any of several factors including the products you buy, your broker or agent's volume of business with Regence Life and Health Insurance Company and the other services your agent or broker provides to you. These incentives may have a direct or indirect impact on your rates. For more information, please contact your broker or agent.

**INSURANCE FRAUD WARNING:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all entitlements to benefits are void and the contract may be canceled or modified retroactively to its effective date.

► \_\_\_\_\_  
Insured's Signature

\_\_\_\_\_ Parent's or Guardian's Signature

► \_\_\_\_\_  
Date Signed

\_\_\_\_\_ Agent Number

\_\_\_\_\_ Licensed Agent's Name (Please Print)