PLEASE PRINT CLEARLY

ANTHEM BLUE CROSS AND BLUE SHIELD
DENTAL ADMINISTRATION OFFICE
555 MIDDLE CREEK PARKWAY MS425
COLORADO SPRINGS, COLORADO 80921-3634

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc.

GROUP NAME
GROUP NUMBER
DENTAL PLAN SELECTED (FOR GROUPS OFFERING MORE THAN 1 PLAN)

DENTAL ENROLLMENT APPLICATION

EFFECTIVE DATE
MO. DAY YEAR

I WISH TO: ☐ ENROLL/NEW ☐ ADD DEPENDENTS ☐ REMOVE DEPENDENTS ☐ ADDRESS CHANGE ☐ COBRA

EMPLOYEE INFORMATION

FIRST NAME AND M.I. | LAST NAME | MALE ☐ FEMALE ☐ | SOCIAL SECURITY NUMBER — —

ADDRESS (STREET) | DATE OF BIRTH MO. DAY YEAR

CITY | STATE | ZIP CODE | DAYTIME PHONE NO. ( )

MARITAL STATUS
☐ MARRIED ☐ SINGLE
☐ DIVORCED
☐ SEPARATED
☐ WIDOW (ER)
DATE MO. DAY YEAR

JOB TITLE | DATE OF EMPLOYMENT MO. DAY YEAR | # OF HOURS THAT YOU WORK PER WEEK ____ | TELEPHONE NUMBERS HOME WORK

TYPE OF DENTAL COVERAGE SELECTED

☐ EMPLOYEE ONLY ☐ EMPLOYEE AND ONE CHILD ☐ EMPLOYEE AND CHILDREN ☐ EMPLOYEE AND SPOUSE ☐ EMPLOYEE AND FAMILY

DEPENDENT COVERAGE INFORMATION

SELECT ONE	Name: (First, M.I., Last name if different) List additional children on separate sheet and attach to application.	RELATION (Spouse, son daughter, stepson, etc.)	Social Security Number	Birthdate Mo | Day | Yr	Check below if dependent is over 23: Full time student	Disabled before age 23	(√) Check if included on tax return
☐ ADD / DELETE ☐			— —		Yes ☐ No ☐	Yes ☐ No ☐	
☐ ADD / DELETE ☐			— —		Yes ☐ No ☐	Yes ☐ No ☐	
☐ ADD / DELETE ☐			— —		Yes ☐ No ☐	Yes ☐ No ☐	
☐ ADD / DELETE ☐			— —		Yes ☐ No ☐	Yes ☐ No ☐	
☐ ADD / DELETE ☐			— —		Yes ☐ No ☐	Yes ☐ No ☐	
☐ ADD / DELETE ☐			— —		Yes ☐ No ☐	Yes ☐ No ☐	

OTHER DENTAL INSURANCE INFORMATION

C.O.B.

Are you, your spouse, or dependent child(ren) covered by any other dental plan that will remain in effect? ☐ Yes ☐ No
If yes, please complete the following:

Whom does it cover? You ☐ Your Spouse ☐ Your Children ☐

Name of Insured ____________ Birthdate Mo Day Yr ____ Insurance Company Name and Address ____________

Policy (or Identification) Number ____________ Group Number ____________

CERTIFICATION (THIS SECTION MUST BE READ AND COMPLETED)

I and my agent (if applicable) certify that I have read, or have had read to me, the completed application (including the CERTIFICATION section), and I realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

I understand that Anthem Blue Cross and Blue Shield may deny claims and void my coverage or may increase the premium charged to my employer if it finds that I misrepresented information on my application. When false or misleading information is discovered, Anthem may void my coverage without advance notice and refund my premium back to the effective date shown on this application or may adjust the group's premium retroactively to my effective date shown on this application, if the discovery is made within two years after such effective date. Any claims paid during the periods when the coverage was not in force will be deducted from any premium refund. If the amount of benefits paid by Anthem exceeds the premium paid, I agree to refund any excess amount to Anthem.

Employee Signature ____________ Daytime Phone Number ____________ Date ____________

Agent/Broker Signature ____________ Daytime Phone Number ____________ Date ____________

Your signature is required before coverage can become effective.