Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

DENTAL APPLICATION AND CHANGE FORM

PLEASE COMPLETE AREAS BELOW – PLEASE PRINT

1. LAST NAME	FIRST NAME	INT.	DATE OF BIRTH	SEX	SOCIAL SECURITY NO.	OFFICE USE ONLY
APPLICANT			MO. DAY YEAR			I.D.No.
ADDRESS OF APPLICANT (Street)			(City)	(State)	(ZIP)	Group No.

2. CURRENT EMPLOYMENT INFORMATION	GROUP#	MARITAL STATUS	Effective Date
EMPLOYER'S NAME		❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED	

DATE OF HIRE	DEPT.	CLOCK NO.	OCCUPATION	3. BENEFIT SELECTION	PLN.	PKG.	CH	RSN	WWP
				❑ Individual ❑ Employee/Spouse ❑ Family – list mbrs below ❑ Employee/Child(ren)					

Comment

4. CURRENT INSURANCE INFORMATION

Arkansas Blue Cross Dental Policy #: _____

Arkansas Blue Cross Health Policy #: _____

Health Advantage Health Member #: _____

OTHER INSURANCE INFORMATION

Do you or any member of your family covered under this application have other dental insurance with another insurance company? ❑ NO

❑ YES – List Name of company and policy number

_____

5. CHANGE COVERAGE AS INDICATED BELOW

❑ CHANGE TO INDIVIDUAL DUE TO:

- ❑ Death – Date: _____
- ❑ Divorce – Date: _____
- ❑ Other: _____

❑ CHANGE TO FAMILY DUE TO:

- ❑ Marriage – Date:
- ❑ Other – Explain: _____

_____

(If dependents are to be covered, list in Section 6)

❑ CHANGE MY NAME TO (AS SHOWN ABOVE) FROM: _____

6. CHANGE IN DEPENDENT STATUS

Add	Delete	LAST NAME FIRST NAME M. INIT.	Birthdate	Relationship	Sex	SSN	Date of Change	Reason (for deletion only)
❑	❑							
❑	❑							
❑	❑							
❑	❑							
❑	❑							
❑	❑							

AUTHORIZATION & SIGNATURE

I understand that no benefits for services of any kind are provided for treatment that was received prior to the effective date of my dental coverage.

I do hereby authorize any dentist, hospital or other provider of medical services or supplies to make available to Arkansas Blue Cross and Blue Shield upon request any and all medical records and facts pertaining to us and our physical condition.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Print Name of Applicant	Signature of Applicant	Date
Print Employer/Group Representative	Signature Employer/Group Representative	Date