BlueCross BlueShield of Georgia

Dental Prime Individual Enrollment Form

Blue Cross and Blue Shield of Georgia
Dental Enrollment Department
PO Box 1193
Minneapolis MN 55440-1193

Please complete in blue or black ink only. For information or assistance in completing this form, call Customer Service at 1-877-567-1807.

Applicant Information - Applicants must be at least 18 years of age and not currently covered by another Blue Cross Blue Shield of Georgia (BCBSGa) group or individual dental plan.

Last Name	First Name	Middle Initial	Social Security Number

Gender ☐ M ☐ F	Day Phone Number	Evening Phone Number	E-mail Address	Date of Birth / /

Address	City	State	ZIP Code

Have you had dental coverage in the past: ☐Yes ☐No If yes, when did coverage start _____ When did coverage end _____
Previous insurance carrier's name _____ What was your Policy Number_____

Agent Name	Agent ID	Agent Tax ID	Agent License ID	Agent Paid ID

Select One Plan Option

Dental Prime: ☐ Plan A No Deductible/$500 Maximum ☐ Plan B $50 Deductible/$1000 Maximum ☐ Plan C $50 Deductible/$1250 Maximum
☐ Vision – you must enroll in a dental Plan in order to enroll for Vision

You can submit this application up to three months in advance of when you would like coverage to start. Coverage starts on the first day of the Requested Start Month. If you do not provide a start month, coverage will begin the first of the month after we receive your completed application.
Requested Start Month _____.

Select Who Is To Be Enrolled: ☐ Applicant Only ☐ Applicant + One Dependent ☐ Family (Three or More Family Members)

Complete this section if you want to enroll family members. Dependent children under age 26 can be enrolled.

Relationship to Applicant	First Name, Middle Initial, Last Name	Gender		Date of Birth (mm/dd/yyyy)
☐Spouse ☐Domestic Partner		M	F	/ /
Dependent Child		M	F	/ /
Dependent Child		M	F	/ /

Select One Payment Option and Billing Frequency The first premium is charged immediately. Future premiums are deducted/charged around the 20th business day of each coverage period.

☐ A. Direct Withdrawal from Checking/Savings Account: ☐ Monthly ☐ Quarterly ☐ Annual
Name on Checking Account _____ Bank Name _____
Routing Number _____ Checking Account Number _____

☐ B. Credit Card or Debit Card: ☐ Monthly ☐ Quarterly ☐ Annual ☐ MasterCard ® ☐ Visa ®
Credit/Debit Card Number _____ Exp. Date _____/_____ Security Code _____ (3 or 4 digits on back of card)
Name As It Appears On Credit/Debit Card _____

AUTHORIZATION AND VERIFICATION – Sign and date application as verification of your enrollment.

I have read the information contained in the application and choose to enroll. I understand the benefits and restrictions of this plan as stated in the material provided with the application. I certify the information contained in this application is true and complete. Any intentional omission or misrepresentation may constitute insurance fraud which could result in possible criminal penalties and/or a claim for civil damages. I understand my enrollment is subject to approval and receipt of payment and verification of funds. The start and cancellation dates of my insurance coverage will be determined by BCBSGa. I authorize BCBSGa to withdraw funds from my bank account or debit my credit card. I understand that if funds/credit balances are not available or payment is not made on time I will no longer be eligible for coverage. If I decide I do not want the contract, I may return it within 10 days after receipt with a written statement requesting termination of the contract. Upon return, the contract will be deemed void, and any money paid will be refunded minus any claims which may have been paid. I understand if I terminate this contract or discontinue enrollment for any reason, I will not be able to re-enroll for a period of 24 months.

Applicant Signature: Date:

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES PRIVACY ACT. Georgia state law establishes standards for the collection use and disclosure of information gathered in connection with insurance transactions. The application attached to this notice contains specific personal questions about you and your dependents. We are required to advise you that personal information may be collected from persons other than you or other individuals proposed for coverage. An investigative consumer report may be made to help us obtain additional medical data from physicians or hospitals. ALL DATA CONFIDENTIAL. O.C.G.A. section 33-39-5,subsection (c) (1 through 4) requires that: 1. Personal information may be collected from persons other than the individual or individuals proposed for coverage; 2. Such information as well as other personal or privileged information subsequently collected by the insurance institution or agent may in certain circumstances be discussed to third parties without authorizations; 3. A right of access and correction exists with respect to all personal information collected; 4. The notice prescribed in subsection (b) of the above referenced Code section will be furnished to the applicant or policyholder upon request.