



**BlueCross BlueShield  
of Illinois**

www.yourfederaldental.com

# Federal DentalBlue Application

**Mail this Form to:**

Blue Cross and Blue Shield of Illinois  
P.O. Box 23150  
Belleville, IL 62223

To apply for Federal DentalBlue coverage you must be enrolled in the Service Benefit Plan and reside in the service area of Blue Cross and Blue Shield of Illinois. Please check the applicable box below.

**Questions:**

1-866-431-1595

I am a Standard Option Member requesting enrollment in the Federal DentalBlue Standard Option Program.

I am a Basic Option Member requesting enrollment in the Federal DentalBlue Basic Option Program.

## Applicant Information

(Please use black ink, not pencil)

Choose One:  Single  Employee +1  Family

Last Name		First Name		Initial	Date of Birth		Social Security Number					
Street Address				City			State			Zip		
Home Phone Number			Work Phone Number			FEP ID Number					Enrollment Code	
						R						

## Dependent Information

**Please note:** If you would like to buy coverage for your spouse and/or dependent children who are currently enrolled under the Service Benefit Plan, then you must list them below.

Only the dependents enrolled under your Service Benefit Plan coverage are eligible to apply for the Federal DentalBlue Program.

First Name	Initial	Date of Birth	Social Security Number	Sex (M/F)	Last Name (if different)	Relationship

If you need to list more dependents, please attach an additional sheet.

## Payment Information (please select one option below)

**BANK DEBIT OPTION** (Enclose voided check or deposit slip.) Blue Cross and Blue Shield of Illinois is authorized to charge my account for the premiums for Federal DentalBlue.

Bank Name \_\_\_\_\_

Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

SIGNATURE OF ACCOUNT HOLDER

X

**BILLING FREQUENCY OPTIONS** (check one):  MONTHLY  QUARTERLY  SEMI-ANNUALLY  ANNUALLY

**BILL DIRECT OPTION** Do not send payment with your application. You will be billed after your application is processed.

Select your billing frequency:  QUARTERLY  SEMI-ANNUALLY  ANNUALLY

**SEE REVERSE SIDE FOR ADDITIONAL INFORMATION AND SIGNATURE**

# I Understand

These benefits are neither offered nor guaranteed under the FEHB Program, but are made available to all applicants and dependents who are members of the Service Benefit Plan and live in the service area of Blue Cross and Blue Shield of Illinois. The cost of these benefits is not included in the FEHB premium, and charges for these services do not count toward any FEHB deductibles or catastrophic protection benefits. These benefits are not subject to the FEHB disputed claims procedures.

## I acknowledge and agree:

- that coverage shall become effective only after this application is approved by BCBSIL and shall be only as stated in the certificate issued by BCBSIL; and
- I authorize any dentist, dental professional, medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy related services organization, health plan, or other medical or medically related facility, governmental agency or other person or firm, to disclose to BCBSIL or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize BCBSIL to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by BCBSIL for the purpose of evaluating my application for dental insurance. Further, I understand that my authorization is required for BCBSIL

X

Applicant's Signature (Your signature is required) \_\_\_\_\_ Date \_\_\_\_\_

X

Dependent's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(ONLY if 18 or over and ONLY if to be insured)

to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by BCBSIL as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided BCBSIL approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of BCBSIL prior to the date such revocation is received by BCBSIL; and

- that any health care provider having information or records pertaining to me or any covered family member is authorized to furnish such information or records at BCBSIL's request; and
- I have read all statements on this application and represent that they are true and complete to the best of my knowledge and belief. Each response in this application has been entered by me or at my direction and may be used by BCBSIL to determine eligibility of me and any family member for this coverage. Any misstatement or omission of material information in this application can result in claim denial, rescission or reformation retroactive to the original effective date of the policy, solely at the discretion of BCBSIL. I will promptly repay any benefit payments to which persons covered under the policy were not entitled; and
- that I will pay premiums as stated above.

X

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

X

Dependent's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(ONLY if 18 or over and ONLY if to be insured)

**PROXY STATEMENT:** The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

### Primary Applicant's Signature

X \_\_\_\_\_

Print Your Name as You Signed It: \_\_\_\_\_ Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

# Open Season

The period during the year when the United States government allows federal employees to enroll and make changes to their enrollment in the Federal Employee Program.

# Enrollment Period

The Federal DentalBlue benefits are based upon year-long premiums. (For federal employees enrolled during the calendar year, the enrollment period and total premium liability are determined based on the effective date of enrollment.) If you cancel your Federal DentalBlue coverage prior to 12 months of continuous coverage, you will not be able to re-enroll during the next three Open Seasons.