Employee Application for Group Dental Insurance

Florida Combined Life

We can help

If you, or someone you're helping, has questions about Florida Combined Life dental plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Florida Combined Life dental plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Florida Combined Life dental plans, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Florida Combined Life dental plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Florida Combined Life dental plans, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid.

如果您，或是您正在協助的對象，有關於 插入項目的名稱 Florida Combined Life dental plans 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid。

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Florida Combined Life dental plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Florida Combined Life dental plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Florida Combined Life dental plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid.

إذا كان لديك أو لدى شخص أنت تساعده أسئلة بخصوص Florida Combined Life dental plans، فلديك الحق في الحصول على مساعدة والمعلومات إن الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-888-223-4892 or Blue Dental Choice PPO BlueDental Care Prepaid 1-877-325-3979

Se tu o qualcuno che stai aiutando avete domande su Florida Combined Life dental plans, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Florida Combined Life dental plans, haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care prepaid an.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Florida Combined Life dental plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid 로 전화하십시오.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Florida Combined Life dental plans, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid.

જો તમે કે તમે મદદ કરી રહ્યાં હો તેમને Florida Combined Life dental plans વિશે પ્રશ્નો હોય, તો તમને મદદ અને તમારી ભાષામાં માહિતી કોઇ ખર્ચ વગર મેળવવાનો અધિકાર છે. દુભાષિયા માટે આ નંબર પર ફોન કરો, 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid.

หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคาถามเกี่ยวกับ Florida Combined Life dental plans
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid.

1557 Non-Discrimination

Florida Combined Life Insurance Company, Inc. (FCL) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. FCL does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

FCL.:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact 1-888-223-4892 BlueDental Choice PPO or 1-877-325-3979 BlueDental Care Prepaid.

If you believe that FCL has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
17500 Chenal Parkway
Little Rock, AR 72223
1-800-260-0331
Email civilrightscoordinator@fclife.com.

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human
Services, 200 Independence Avenue SW.,
Room 509F, HHH Building, Washington, DC 20201
1–800–368–1019, 800–537–7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Employee Application for Group Dental Insurance

Florida Combined Life

SECTION 1: To be completed by Group Insurance Administrator or Employer

FCL Group No. 1	Group Name 2	Business Phone No. 3 ( )
Division No. 4	Class 5	Effective Date MM DD YYYY 6 / /

SECTION 2: To be completed by Employee (Please print.)

Part A: Complete the following part with information on **yourself.**

Full legal name of employee (Last, First, MI) 7	Social Security No. 8	Birthdate MM DD YYYY 9 / /

Street Address 10	City 11	County 12	State 13	Zip Code 14

Home Phone No. 15 ( )	Business Phone No. 16 ( )	Occupation/Job Title 17	Gender 18 ☐M ☐F	Marital Status 19 ☐Single ☐Divorced ☐Legally ☐Married ☐ Widowed Separated

Full-time Hire date MM DD YYYY 20 / /	Are you 21 ☐Actively at work ☐Retired ☐COBRA	How Paid? 22 ☐Hourly ☐Salary	Hours worked per week 23

Part B: Coverage Selection *(Note: Consult your group insurance administrator for benefits available to you.)*

A Dependent cannot be covered as both a dependent and an employee, covered under more than one employee, in full-time military service, or enrolled for coverages declined by the employee. Married employees of the same employer may not be covered as both an employee and a dependent.

Employee 24 ☐Yes ☐No, I **decline** coverage	Spouse 25 ☐Yes ☐No, I **decline** coverage	Child(ren) ☐Yes ☐No, I **decline** coverage	If selected, all children must be enrolled. 26

If you checked **YES** in the Employee Coverage selection box, select one of these plans. 27

☐**BlueDental Freedom (Indemnity)**_____ **BlueDental Choice (PPO)**

☐**BlueDental Care (Prepaid)** _____ ☐**Choice** _____ ☐**Copayment** _____ ☐**Plus** _____

Part C: Identify each individual to be covered below. **Attach additional sheet of paper, if necessary. Sign and date it.**

28 First Name, M.I., Last Name (Please provide information in the corresponding numbered spaces below.) / 29 Social Security Number (Please provide in spaces below)	30 Relation to You (DP = Domestic Partner)	31 Gender (M/F)	32 Birthdate mm/dd/yyyy	Check If: 33 Marital Status Married	33 Marital Status Unmarried No Children	34 Disabled	35 Lives With You	36 You Support Financially	37 Student FT/PT	38 Florida Resident	39 Covered By Medicaid	40 BlueDental Care Facility ID# / Check box if a current patient (Select from provider directory)
Employee												☐
28 - -	☐Spouse or ☐DP											☐
28 - -	☐Child *or* ☐DP Child			☐	☐	☐	☐	☐	☐	☐	☐	☐
28 - -	☐Child *or* ☐DP Child			☐	☐	☐	☐	☐	☐	☐	☐	☐
28 - -	☐Child *or* ☐DP Child			☐	☐	☐	☐	☐	☐	☐	☐	☐

Do any dependents listed above reside at a different address than indicated above? ☐ Yes ☐ No 41

If **yes**, list name(s):

Do you or any of your dependents listed above have Dental insurance under another group plan? ☐ Yes ☐ No 42

If you answered **yes** to other group dental insurance, complete 43 through 47 below. If more than one dependent, attach a separate sheet of paper with the additional information.

Dependent Name 43	Other Group Plan Name & Plan No. 44	Insured/Member Name Birthdate / / 45

Insurance Co. Name & Address	Phone No. ( ) 46	Policy No. 47

Part D: Coverage Acceptance of ANY Coverage (Please read before signing.)	**Part E:** Coverage Refusal of ANY/ALL Coverage (Please read before signing.)
I wish to apply for any coverage checked **YES** under Part B Coverage Selection. I have read and accept the "Acceptance of Coverage" on the reverse side of this form. I hereby certify that the statements on this application, including any attachment to it, are true and complete. (If you checked NO for any dependent coverage under Part B, sign and date Part E also.) 48	I do not wish to apply for any coverage checked NO under Part B Coverage Selection. I understand that if I decide to apply at a later time, coverage will not be available until the next open enrollment. 49
Employee Signature Date	Employee Signature Date

Florida Combined Life
An Independent Licensee of the Blue Cross and Blue Shield Association

FRAUD NOTICE: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Acceptance of Coverage

Please Read Before Signing the Front Side of this Form

I hereby apply for the coverage checked “Yes” on the front of this form. My employer has selected the coverage through Florida Combined Life Insurance Company, Inc. (FCL). I authorize my employer to deduct from my earnings my premium contribution (if any). I understand all of the following: 1. if my coverage is to be issued and continued, I must meet all the group contract’s requirements; 2. if my dependents’ coverage, if any, is to be issued and continued, my dependents must meet all the group contract’s requirements.

I understand that my employer is not an agent of FCL. I also understand that my employer is responsible for notifying all employees of: 1. all effective dates; 2. all termination dates; 3. any COBRA or ERISA rights or responsibilities; and 4. all other matters pertaining to coverage under the group contract.

If coordination of benefits applies for me and my dependents and an overpayment is made, I authorize FCL to recover the excess from any person or entity to which payment is made.

I acknowledge that, if I apply for FCL coverage later, coverage will not be available until the next open enrollment.

I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I hereby certify that the statements on this application, including any attachment to it, are true and complete. I understand and agree that any misstatements may result in denial of benefits and/or termination of coverage.

A photocopy of this application shall be as valid as the original. However, the original application, labeled “White copy – FCL,” is required to evaluate this application. I agree to be bound by the group contract’s terms and conditions. I understand that this application is hereby made a part of the group contract. I will attach it to my certificate of coverage, when issued.