BlueDental Care℠
Prepaid Individual Application
Completion & Submission Guide for
Form #50551-0910

A fully-completed application will prevent unnecessary delays. **Failure to complete this application may have an adverse effect on the desired effective date.** If you have questions about how to complete this application, please contact your area manager.

SECTION 1 – CHANGE INFORMATION
Only use this section if you are requesting a change to your existing membership. Check box(es) indicating reason(s) for your change request. Complete the "**Change Information Required**" section and indicate **your** requested effective date, member ID number (*located on your ID Card*) and any special remarks.
Name change – Provide your current name in the (From) section and your new name in the (To) section. Complete all information in Section 2. Read Section 6 and sign and date the application.
Social Security Number Correction – Provide your incorrect Social Security number in the (From) section and your correct Social Security number in the (To) section. Complete all information in Section 2. Read Section 6 and sign and date the application.
Other Personal Information Changes – Check this box if your address, phone number or date of birth requires a correction. Complete all information in Section 2. Read Section 6 and sign and date the application.
Add or Delete Dependents – Complete all information in Section 2 and 3. In Section 3, indicate if your change is to add or delete a dependent. Provide the dependent's last name, first name, middle initial, SS#, birth date, relationship to you, and his or her gender. Read Section 6 and sign and date the application.
Delete all Coverage – Check this if all coverage is being terminated including yourself and all dependents. Complete all information in Section 2. Read Section 6 and sign and date the application.
Change Bank Draft – Complete all information in Sections 2 and 4 (#3). Include the bank name, the amount of the bank draft and the bank account and routing numbers. The accountholder must sign and date for bank draft authorization. Read section 6 and sign and date the application. You must include a voided check.
Change Credit Card – Complete all information in Sections 2 and 4 (#2). Check the correct box to determine the type of credit card. Provide the credit card number, the expiration date and the amount charged. The cardholder must sign and date authorization for credit card. Read Section 6 and sign and date the application.
Other – Use this box to include other changes not listed on the form. Provide reason for change.
Reason for Change – Indicate the reason for the change by checking the appropriate box(es).

SECTION 2 – APPLICANT INFORMATION

Field	Required Field?	Comments
Last Name, First Name and MI	Yes	Indicate your Last Name, First Name and Middle Initial. **Failure to provide your name will result in the application being returned and may have an adverse effect on your desired effective date.**
Social Security No. (SS#)	Yes	Indicate your Social Security number. If you are not comfortable with providing us with your SS#, you may leave the field blank. A generic number will be generated in place of the SS#. This number will be known as the Certificate number.
Gender	Yes	Indicate your gender. If left blank, one or the other will be checked based solely on your first name.
Date of Birth	Yes	Indicate your Date of Birth. If left blank, there will be an attempt to contact you to obtain your DOB. If contact is not made within 3 days, a letter will be sent to you requesting your DOB. **This will cause a delay and may have an adverse effect on your desired effective date.**

Address	Yes	Indicate your, street number, the name of the street, the suite/apt. no. if applicable, and your city, state and zip code. **Failure to provide the address will result in the application being returned and may have an adverse effect on your desired effective date.**
Phone #'s	No	This is helpful information but not critical to processing the application.
Dental Facility #	Yes	Provide a Dental Facility ID#. To see a list of dentists in the network visit www.bcbsfl.com. If not completed, a generic number will be assigned (the number will not be associated with any dentist). This will cause the member to experience problems, as the dentist will not be able to verify coverage. Also, if an invalid facility number (office is closed, dentist is not accepting new patients) is shown, it will be replaced with a generic number and could delay processing.

SECTION 3 – DEPENDENT INFORMATION

Field	Required Field?	Comments
Add or Delete	Yes	**Check the "Add" box when adding a dependent** **Check the "Delete" box when removing a dependent**
Last Name, First Name and MI	Yes	Indicate the Last Name, First Name and Middle Initial of each dependent. **Failure to provide the name will result in the application being returned and may have an adverse effect on your desired effective date.**
Social Security No.	No	The dependent's Social Security number is preferred but not required. If you are not comfortable with providing your dependent's SS#, you may leave the field blank. A generic number will not be generated.
Birth Date	Yes	Indicate the date of birth for all dependents. If left blank, there will be an attempt to contact you to obtain the DOB. If contact is not made within 3 days, a letter will be sent to you requesting the DOB. **This will cause a delay and may have an adverse effect on your desired effective date.**
Relation to You	Yes	Provide the type of relationship the dependent has to you (e.g., spouse or domestic partner, child or child of a domestic partner).
Gender	Yes	Indicate the gender for all dependents shown. If left blank, one or the other will be checked based solely on your dependent's first name.
Dental Facility ID #	No	Indicate the Dental Facility ID# for each dependent. If the field is not completed, the application will be returned. Check the box if you are currently a patient.

Page 2 of the Application

Field Name	Required Field	Comments
Last Name, First Name & SS#	Yes	Indicate your First and Last name as well as your Social Security number. This will allow us to match page 1 and page 2 should they become separated.

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SECTION 4 – PREMIUM PAYMENT

Field	Required Field?	Comments
1. Annual Check Selection	Yes	Complete only if you are making a payment by check for full annual premium**.** **Make checks payable to Florida Combined Life**.
Premium Payment	Yes	Indicate the amount of the premium payment. The amount must be for the full annual premium.
Check No.	Yes	Indicate the check number

Field	Required Field?	Comments
2. Annual Credit Card Section	Yes	Indicate the type of credit card to be used (MasterCard, Visa, or Discover). Failure to provide the type of card will not result in the application being returned. It will cause a delay in the application processing.
Credit Card No.	Yes	Indicate the credit card number. The credit card number must contain sixteen (16) numbers.
Expiration Date	Yes	Indicate the credit card expiration date (required format: mm/yy). Ex. – 05/11 Failure to provide the card number and expiration date will result in the application being returned and may have an adverse effect on your desired effective date.
Amount Charged	Yes	List the initial amount and the final amount after adding in the $35 enrollment fee.
Cardholder's Signature and Date	Yes	The actual cardholder is the only person who can sign and date the Annual Credit Card Section of the application. **Failure to have the cardholder sign the application will result in the application being returned and may have an adverse effect on your desired effective date.**

Field	Required Field?	Comments
3. Monthly Bank Draft	Yes	Complete this section if your payment will be made by bank draft. You must submit a voided check with this application.
Accountholder's Name	Yes	Indicate the name of the accountholder. If someone other than you is authorizing a bank draft, the accountholder's name must match the name on the voided check & the account number.
Premium Payment	Yes	Indicate the exact amount of the premium payment
Bank Routing No.	Yes	This field must match the routing number on the voided check. The routing number must contain nine (9) numbers.
Check No.	Yes	Indicate the check number of the voided check.
Financial Institution/Bank Name	Yes	Indicate the name of the bank that the draft will be drawn from. **If this section is left blank, the information will be pulled from the voided check (which is required).**
Bank Draft Amount	Yes	List the initial amount and the final amount after adding in the $1 administrative fee.
Bank Account #	Yes	This field **must** match the account number on the **voided** check.
Accountholder's signature and Date	Yes	The actual accountholder for the bank draft must sign and date this section. **Failure to do so will result in the application being returned and may have an adverse effect on your desired effective date.**
NOTE: A **voided check** and the first month's premium **must be included** with the application.		

PI210 Plan Rates		
Field	**Required Field?**	**Comments**
Total Amount Due	Yes	Show the total monthly or annual amount due. Remember: A payment check is required *with* the application. **Failure to submit the premium with the application will result in the application being returned and may have an adverse effect on your desired effective date.**

SECTION 5 – AGENT INFORMATION		
Field	**Required Field?**	**Comments**
Agent's Name	Yes	This information has already been filled in on your application. There is nothing for you to do in this section.
Agent Code Number	Yes	This information has already been filled in on your application. There is nothing for you to do in this section.

SECTION 6		
Field	**Required Field?**	**Comments**
Applicant's Signature	Yes	The applicant must sign and date the application. **Failure to sign the application will result in the application being returned and may have an adverse effect on your desired effective date.**

Submission Guidelines

The completed application and payment (if paying via check or money order) should be mailed to:

Florida Combined Life Ins. Co.
Dental Service Administrator
P.O. Box 769569
Roswell, GA 30076

If the application needs to be **overnighted**, send to:

Florida Combined Life Ins. Co.
Dental Service Administrator
100 Mansell Court East
Roswell, GA 30076

If faxing the application, payment can only be via credit card. The original application should be retained in the agent's office. The fax number is: (**770) 518-3102.**

Note: If sold in conjunction with a Blue Cross and Blue Shield of Florida health policy, two (2) checks (if paying via check) are required, one for the health policy and one for the PI210 policy.