BlueDental Care Prepaid

Application/Change Form for Individual Plans

We can help

If you, or someone you're helping, has questions about Prepaid Individual Plan FI315, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-877-325-3979.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Prepaid Individual Plan FI315, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-325-3979.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Prepaid Individual Plan FI315, 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 1-877-325-3979.

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Prepaid Individual Plan FI315, 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 1-877-325-3979.

Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Prepaid Individual Plan FI315, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-877-325-3979.

如果您，或是您正在協助的對象，有關於 插入項目的名稱Prepaid Individual Plan FI315 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 1-877-325-3979。

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Prepaid Individual Plan FI315, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-877-325-3979.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Prepaid Individual Plan FI315, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-325-3979.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Prepaid Individual Plan FI315, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-877-325-3979.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Prepaid Individual Plan FI315، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 1-877-325-3979.

Se tu o qualcuno che stai aiutando avete domande su Prepaid Individual Plan FI315, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-877-325-3979.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Prepaid Individual Plan FI315 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 1-877-325-3979 an.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이Prepaid Individual Plan FI315 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-325-3979로 전화하십시오.

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie Prepaid Individual Plan FI315, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-877-325-3979.

જો તમે કે તમે મદદ કરી રહ્યાં હો તેમને Prepaid Individual Plan FI315 વિશે પ્રશ્નો હોય, તો તમને મદદ અને તમારી ભાષામાં માહિતી કોઇ ખર્ચ વગર મેળવવાનો અધિકાર છે. દુભાષિયા માટે આ નંબર પર ફોન કરો, 1-877-325-3979.

หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคาถามเกี่ยวกับ Prepaid Individual Plan FI315
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-877-325-3979

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 1-877-325-3979

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.*

BlueDental Care Prepaid

Application/Change Form for Individual Plans

Mail to:
Florida Combined Life
Dental Service Administrator
P.O. Box 769569
Roswell, GA 30076-8223

☐ **New Applicant (Complete Sections 2 through 6)**

☐ **Making a Change (Start with Section 1)**

SECTION 1 – CHANGE INFORMATION

(Check all those that apply and complete sections indicated)

☐ Name	Complete Sections 2 and 6	From: ________________ To: ______________
☐ Social Security Number Correction	Complete Sections 2 and 6	From: ________________ To: ______________
☐ Other Personal Information Changes	Complete Sections 2 and 6	
☐ Add/Delete Dependents	Complete Sections 2, 3 and 6	
☐ Delete All Coverage	Complete Sections 2 and 6	
☐ Provider Change	Complete Sections 2, 3 and 6	
☐ Change Bank Draft	Complete Sections 2, 4 (#3) and 6	
☐ Change Credit Card	Complete Sections 2, 4 (#2) and 6	
☐ Other: ____________________		

Change Information Required:
Requested Effective Date of Change: ________________
Contract No. ________________
(Located on your ID Card)
Remarks: ________________

Reason for Change:
☐ Marriage ☐ Age Limit ☐ Moved Out of Service Area ☐ Divorce
☐ Other (Explain):____________________

SECTION 2 – APPLICANT INFORMATION

Last Name	First Name	MI	Social Security No.	Gender ☐ M ☐ F	Date of Birth mm/dd/yyyy / / Minimum applicant age is 18

Address	Suite/Apt. No.	City	State	Zip Code	County

Home Phone No. ( )	Business Phone No. ( )	Dental Facility # (Select from Provider Directory)

SECTION 3 – DEPENDENT INFORMATION

List all Eligible Dependents to be covered. Eligible Dependents include your spouse/domestic partner and/or children to age 30. Children of a domestic partner may be covered when the domestic partner is also covered. If necessary, attach additional sheet(s) of paper that are signed and dated.

Add	Delete	Last Name	First Name	MI	Social Security No.	Birth Date mm/dd/yyyy	Relation to You	Gender	BlueDental Care Facility ID# (Select from Provider Directory) Check box if a current patient
☐	☐						☐Spouse *or* ☐DP	☐ M ☐ F	☐
☐	☐						☐Child *or* ☐DP Child	☐ M ☐ F	☐
☐	☐						☐Child *or* ☐DP Child	☐ M ☐ F	☐
☐	☐						☐Child *or* ☐DP Child	☐ M ☐ F	☐

If you have questions about completing this application, contact your agent or call 888-753-4363.

Payment Information on Page Two Must be Completed.

Last Name	First Name	Social Security No.

SECTION 4 – PREMIUM PAYMENT

1. Annual Check Selection
(Make checks payable to Florida Combined Life)
Premium Payment $ ___________
Check No. ___________

2. Annual Credit Card Section
Check One: ☐ MasterCard ☐ Visa ☐ Discover
Credit Card No. _________________________
Exp. Date mm/yy ______

Amount Charged (annual premium + one-time $35 non-refundable enrollment fee = Annual Amount You Pay) $ _____________ + $35 = $ ___________

I hereby authorize charging by credit card:

Cardholder's Signature: ________________________________

Date: ____________________

FI315 PLAN RATES

Policy type (Select One)	Monthly Premium (Bank Draft Only)	Annual Premium (Check, Money Order or Credit Card)
Individual	$11.99	$143.88
Individual + one dependent	$22.78	$273.36
Individual + two dependents	$32.37	$388.44
Individual + three dependents	$41.97	$503.64
Individual + four or more Dependents	$50.36	$604.32

Calculate Your Total Below	Monthly	Annual
Premium Amount	$	$
One time non-refundable enrollment fee	+ $35.00	+ $35.00
Administrative Fee (Bank Draft Only)	+ $1.00	
Total Amount Due	$	$

3. Monthly Bank Draft Authorization for Deduction Section

Accountholder's Name ____ Premium Payment $ ____________________

Bank Routing No. ____________ Check No. ______________ I authorize ______________________________________
(Financial Institution/Bank Name)

to make a bank draft of $ ______________ + $1.00 = $ ______________ from Bank Account # ____________________
(*Monthly premium + $1.00 administrative fee)* *(Monthly Only)*

and to remit the amounts deducted to FCL, upon instructions from FCL. The amount of deduction indicated above is approximate and may be corrected as instructed by FCL. This authorization will remain in effect until: (a) I/we cancel it in writing; (b) the above account is closed; (c) the deduction and remittance arrangements between the above financial institution and FCL are discontinued; or (d) the policy is cancelled. I understand that this authorization does not waive or change any of the payment provisions of the policy issued to me by FCL, and if this authorization terminates for any reason, any further payments required under the policy will be made as provided in the policy. I agree that the above financial institution is acting gratuitously and for my sole accommodation and not as an agent for FCL.

YOU MUST INCLUDE A VOIDED CHECK AND YOUR 1ST MONTH'S PREMIUM WITH THIS APPLICATION.

Accountholder's Signature (Required): **X** ______________________________________ **Date:**_____________________

SECTION 5 – AGENT INFORMATION

Agent Name	Agent Code Number:

SECTION 6

I wish to enroll in the FCL prepaid individual plan. I understand that this is a MINIMUM ONE (1) YEAR CONTRACT and that all necessary dental services will be provided as described in the plan. Completed applications with correct payment received by the 15th of the month will take effect on the 1st of the following month. Applications received after the 15th of the month will take effect on the 1st of the month following the subsequent month.

CHANGE AUTHORIZATION

Membership changes granted to persons herein shall be subject to all provisions and limitations of the individual policy. I am aware that a change in dependents may affect the amount of premium due to FCL for the individual Prepaid Dental Plan coverage. I understand the changes requested will not become effective until FCL has issued approval of the policy. I certify that I have the authorization to request any change to the policy.

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.**

X ____ ____________________________________

APPLICANT SIGNATURE (Required): **DATE** (Required)