



# DentalPlus Individual Application

Thank you for selecting DentalPlus. Please print or type.

An Independent Licensee of the Blue Cross and Blue Shield Association

Last name (Contract holder)		First name		Initial	
Date of birth (Month/Day/Year)		Social Security Number			
c/o (if applicable)					
Street address					
City	State	County	Zip	Telephone number	

Coverage Options		
Prepaid: <input type="checkbox"/> One adult – \$273.00	<input type="checkbox"/> One adult, plus a dependent* – \$535.00	<input type="checkbox"/> Family** – Three or more persons – \$757.00
EFT: <input type="checkbox"/> One adult – \$22.75 monthly	<input type="checkbox"/> One adult, plus a dependent* – \$44.58 monthly	<input type="checkbox"/> Family** – Three or more persons – \$63.08 monthly
Amount enclosed \$ _____ *Dependents include spouse or dependent children up to 30 years of age.		
**Family coverage - for children to be covered, at least one parent must be covered on the contract as well.		

This section must be completed:	
Please indicate the name of the DentalPlus dentist and location number you have selected from the enclosed provider list.	
Name of dentist: _____	Location number: _____

If you are applying for coverage for more than one person, list your spouse and/or dependent unmarried children to age 30 to be covered.

### Spouse:

Spouse's last name		First name		Initial	
Date of birth (Month/Day/Year)		Social Security Number			

### Dependent unmarried children under age 30:

Last name	First name	Initial	Sex	Date of birth	Relationship
1					
2					
3					
4					

I make this application to Blue Cross Blue Shield of Arizona (hereafter referred to as BCBSAZ) for DentalPlus coverage. I acknowledge and agree:

- That coverage shall become effective only after this application is approved by BCBSAZ and shall be only as provided in the contract then issued by BCBSAZ; and
- That each response in this application has been entered by me or at my direction and may be used by BCBSAZ to determine acceptability of me and any family member for a contract and that, if I have misstated or omitted any material information, BCBSAZ may declare such coverage null and void from its issuance.

I (we) hereby apply for DentalPlus coverage subject to the above agreement. All persons age 18 or older named on this application must sign and date (unless unavailable because attending school out of town).

Signatures required			
Signature _____	Date _____	Signature _____	Date _____
Signature _____	Date _____	Signature _____	Date _____

Your completed application and payment must be received by the 25th of the month to be effective on the 1st of the following month. Premium notices will be mailed to you each year before your annual due date.

**Make check for annual premium payable to: Blue Cross Blue Shield of Arizona**

**Return check & application to: DentalPlus Administrator, Attn: BCBSAZ DentalPlus, 9054 North Deerbrook Trail, Milwaukee, WI 53223-2474.**

Broker Information	
Broker/agent name _____	Broker code _____
Broker address _____	Phone _____



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## DentalPlus Individual Application

Thank you for choosing the DentalPlus plan from Blue Cross Blue Shield of Arizona (BCBSAZ).

- Please complete the entire application.
- Be sure to select your Primary Dentist from the list included in your enrollment packet. If you have any questions about choosing your dentist, please call BCBSAZ at 1-877-864-4899. **Please Note:** One Primary Dentist per contract (contract includes all applicants).
- All persons named on this application over the age of 18 must sign and date the application.
- Be sure to attach a check or money order for the annual premium. Applications received without payment are returned to the sender.
- Monthly payments available only when using EFT.
- EFT option – Please see the Electronic Fund Transfer form for further information.
- If your application is received by the 25th of the month and all the information is complete, your effective date will be first day of the following month. Applications received after the 25th of the month will be processed for the first day of the second month after receipt of a completed application.
- You will receive a letter from the DentalPlus plan administrator letting you know your effective date and confirming your Primary Dentist within 2-3 weeks of mailing the application.
- If you have any questions or need help completing this application, please call your broker or BCBSAZ at 1-877-864-4899.
- Mail your completed application and payment to:

DentalPlus Administrator  
BCBSAZ DentalPlus Plan  
9054 North Deerbrook Trail  
Milwaukee, WI 53223-2474

We look forward to helping you with your dental care needs.