



Life and Health Insurance Company

Independent Licensee of the Blue Cross and Blue Shield Association

100 SW Market Street
P.O. Box 1271 E-3A
Portland, OR 97207-1271
(503) 721-7161 • (800) 794-5390

Home Office Use Only
ID #
Eff. Date
Vis. Rider [] EFT []

Application for Renewable Individual Dental Insurance with Optional Vision Rider

Please complete all information on this page and on Page 2. Incomplete information may result in a delayed Effective Date.

Applicant's Last Name, Applicant's First Name, M.I., Date of Birth, Social Security Number, Married/Divorced/Single, E-mail Address, Mailing Address, Telephone Number

Requested Effective Date

Your requested Effective Date must be following or coinciding with the date We receive your Application, after the date your Application is signed, and within 60 days from the date of your signature, or a new Application will be required.

A new Application may result in a delayed Effective Date. In no event may the Effective Date of this Policy be back-dated

For Dollar-Based and Incentive 10 Dental: [] 1st OR [] 15th of (month) (year)

For Managed Care Dental 1st of (month) (year)

Dependents to be enrolled: Dependent children must be under 26 years of age.

Table with 5 columns: Name (Last, First, M.I.), Social Security Number, Birth Date, Sex, Relationship (Spouse or Child)

Please list names as they should appear on your identification card. If enrolling additional dependents, please attach a separate sheet including the information above. If you are enrolling a non-state registered domestic partner, please complete the attached affidavit.

Other coverage information (This is not a waiver of coverage. This information is required for payment of claims.)

Do you or any family members enrolling have other dental coverage? [] Yes [] No

If yes, provide the information regarding other coverage requested below.

Name of Family Member with other coverage, Relationship, Name of Insurance Carrier, Policy No., ID No., Address of Other Carrier, Carrier Phone No., This plan covers [] Self [] Spouse [] Child(ren) [] Family as listed above [] Other

Is the coverage of any dependent affected by a divorce decree/court order? [] Yes [] No

If yes, please include portion of decree that shows responsibility for health expenses.

