Regence

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

DENTAL APPLICATION

FOR MEMBERSHIP

☐ New Enrollment
☐ Open Enrollment

(Please Print)

(Do not write in shaded areas)

MEMBER INFORMATION

Name: (Last) (First) (Middle Initial)		Social Security Number	Home Phone	Group Number **10007250**
Mailing Address:		Employer **U of U Retiree**	Cell Phone	
City State Zip Code		Applying for: ☐ Self ☐ Self + Dependent(s)		
Date of Hire	Date of Retirement	Effective Date		

ENROLLED MEMBER(S)

Relationship to Member	Legal Name(s) of members(s) to be covered (include last name if different from Member)	Birthdate MM/DD/YYYY	Social Security Number for each covered dependent	Carrier Name If covered by another dental insurance plan. (Complete for each member)
Self ☐ Male ☐ Female				
Spouse ☐ Male ☐ Female				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				

I authorize any source to release to Regence BlueCross BlueShield of Utah, and/or Regence ValueCare (hereinafter referred to as "the Plan") any dental, employment and/or insurance information requested on any enrolled member. I agree to abide by the Plan's enrollment provisions. I understand that coverage cannot start until after I have served the waiting period agreed to by the employer as recorded on the Plan's records. I authorize my employer to act as my agent in all matters of administration of the group program and acknowledge that my employer is in no way acting as agent for the Plan.

I understand there may not be participating dentists available in all specialty fields.

Any matter in dispute between you and the Plan may be subject to arbitration as an alternative to court action pursuant to the rules of the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration, including, but not limited to: attorney fees, expenses of discovery, witnesses, stenographer, translators, and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both you and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

I further certify that all information completed on this form is true and correct and acknowledge my coverage is subject to cancellation if any completed information is found to be false or incorrect.

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Member Signature Date Signed

INSTRUCTIONS

GENERAL INFORMATION	• Please print your answers in either black or blue ink in all unshaded blanks. Shaded areas are for the use of Regence BlueCross BlueShield of Utah and/or Regence ValueCare. • Incomplete and/or illegible information may result in delayed coverage. If an item is not applicable, write "N/A." • Be sure to sign and date the form.
MEMBER INFORMATION	• Include current address to ensure all pertinent mailing information will reach you. • Your Social Security Number is critical as all claims for you and your dependents are processed using your Social Security Number.
ENROLLED MEMBERS	• Including yourself, please list the sex, name, birthdate (month, day and year) and Social Security Number of every eligible dependent to be covered under the requested insurance program. Please list surnames of dependents which differ from yours. • For every dependent covered by another group plan, complete the appropriate dental carrier name(s). Make sure complete information is given for every dependent covered by other plans for coordination of benefits. Incomplete information may result in delayed claims processing. • If you decline enrollment in this plan for yourself and/or any of your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll the omitted individual(s) in this plan, provided that you request enrollment within 30 days after the other coverage of the individual(s) ends. ("Decline enrollment" includes omission of the individual from this application.) In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.