BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

Application For Individual Dental Coverage

APPLICATION COMPLETION CHECKLIST

Application

- Complete application with black ball point pen
- Be sure to complete all questions in full (incomplete applications cause unnecessary delays or declines)
- Sign and Date application where appropriate
- If more space is needed for any answers, attach a separate piece of paper
- Send this cover sheet with the application

Mail, Fax or Email application

- Submit this cover sheet and application by **mail** to:
  Blue Cross and Blue Shield of Nebraska
  Individual Underwriting Department
  PO Box 2417
  Omaha, NE 68103-2417
- **Fax** this cover sheet and application to: (402) 548.4685 or the number provided to you by your agent
- **Email** this cover sheet and application to: IndContractInstallation@nebraskablue.com
- Please call your agent/broker or call us at 888.592.8960 for additional questions

For Broker/Agent Use Only

Premium Calculation: Add the rate for each member. A three-month premium is required with the application. The DentalEssentials brochure with rate information is available at www.nebraskablue.com. Choose Explore Plans, then click Dental

Attn: Individual Case Installation

Broker Name: _____

Broker Email: _____

Broker Phone Number: _____

Payment due $ _____

Date payment mailed _____

Customer Name: _____

Single Premium $ _____

Spouse Premium $ _____

Child Age: _____ Premium $ _____

Child Age: _____ Premium $ _____

Child Age: _____ Premium $ _____

BlueCross BlueShield Nebraska

Individual Underwriting Department
PO Box 2417
Omaha, NE 68103-2417

Individual Dental Application

Primary applicant must be age 19 or older to be eligible for coverage.
A check for the first three months' premium is required with the application.

Please print and press firmly using black ink

Section I — Insured Information

a. Social Security Number	b. Insured's Name (Last, First, MI, Title)	c. Date of Birth (mm/dd/yyyy)
d. Gender ☐ Female ☐ Male	e. Address (Street, PO Box, Apt #, City, State, Zip +4 Code)	
f. Telephone Number	g. Your Place of Employment	h. E-mail Address

Section II — Spouse and Dependent Information

*** List below your spouse and dependent(s) applying for coverage.** List in order of age - oldest first. Children under 26 are eligible if they meet eligibility requirements. Documentation of eligibility may be requested by us.

Full Name	Date of Birth (mm/dd/yyyy)	Gender	Relation to Proposed Insured
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	
		☐ Male ☐ Female	

Section III — Coverage Information

1. Have/Are you, your spouse or any dependent applying for this coverage:
   - a. ever been a Blue Cross and Blue Shield member? ☐ Yes ☐ No
   - b. currently a Blue Cross and Blue Shield member? ☐ Yes ☐ No
   - c. ever previously applied for Blue Cross and Blue Shield coverage? ☐ Yes ☐ No
   - d. currently eligible for Blue Cross and Blue Shield coverage under a group plan? ☐ Yes ☐ No

   If "Yes", please provide details below.

Blue Cross Blue Shield Plan	ID Number(s)	Group or Individual	Are you replacing this coverage?	If replacing group coverage, termination date and reason
☐ BCBS - Nebraska ☐ BCBS - Other: _____		☐ Group ☐ Individual	☐ Yes ☐ No	

2. Are you, your spouse or any dependent applying for this coverage eligible for or enrolled in Medicare ☐ Yes ☐ No
   If yes, please provide details below.

Part A Effective Date	Part B Effective Date

3. Do you currently have a Medicare Supplement or Medicare Advantage plan with BCBSNE or have submitted an application at the time of this dental application ☐ Yes ☐ No

   If "Yes", please provide details below:

Section IV — Plan Information

Type of Coverage:

☐ Individual ☐ Individual + Spouse ☐ Individual + Child(ren)
☐ Family Coverage (Applicant + spouse + child(ren))

DentalEssentials Options: (select one)

☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ Option 4

Section V Plan Information - Payment Type

An initial non-refundable premium payment of three times the monthly rate is required for the first three months of coverage.

Monthly Direct Bill

Address (Street, Apt #): _____

City, State, Zip+4 Code: _____

For additional payment options, register for a myblue account at www.mynebraskablue.com after receiving your ID card. Registering allows you to set up recurring payments, make one-time payments and see billing statements and history.

Current Medicare Supplement/Medicare Advantage members only:

☐ Monthly Auto-Debit

Members who are enrolled in a BCBSNE Medicare Supplement or Medicare Advantage plan may continue with their current automatic debit payment method by completing the Debit Authorization form. Please attach the form to this application. If you would like to change your payment method, please select Direct Bill or register on www.mynebraskablue.com.

Social Security Number: _____

Insured's Name (Last, First): _____

Section VI Acknowledgement and Authorizations

Acknowledgement

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN.

1. I certify that I am a permanent resident of the State of Nebraska
2. I represent that any answers in this application are true and complete to the best of my knowledge and belief, and acknowledge that Blue Cross and Blue Shield of Nebraska has relied on these answers in determining whether or not to accept this application.
3. **I understand that any intentional misrepresentation in this application may cause the coverage to be void.** I further understand that no insurance is effective until this application is approved, the policy is issued and the first full premium has been received by us at our home office in Omaha, Nebraska.
4. I understand that this Contact required an initial premium payment for the first three (3) months of coverage. Payment must accompany the application for coverage. This initial payment is non-refundable, unless otherwise required by law.
5. Effective date is the 1st of the month following application approval. All benefits are subject to the terms of the Contract. I understand that this Contact includes a 6-month waiting period for Coverage B services, and a 12-month waiting period for Coverage C services (if applicable), unless otherwise waived by Blue Cross and Blue Shield of Nebraska.
6. I understand that any person, who, knowingly and with intent to deceive, files an application for insurance or statement of claims which either (1) contains materially false information, or (2) conceals materially pertinent information, commits a fraudulent insurance act which is a crime; and that such person is subject to criminal and civil penalties.
7. If my application was taken by a depositor bank agent, I have been verbally told the following: the insurance product is not a deposit or other obligation of or guaranteed by, any bank or affiliate of any bank; and the insurance product is not insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank, or an affiliate of the bank.

Section VII Signatures

Signature _____ Date _____

Signature of Spouse (if applying for coverage) _____ Date _____

Signature of Agent _____ Date _____

Printed Name of Agent _____ Agent Number _____

For Agent Use Only	Single Premium: $ _____	Spouse Premium: $ _____	Dependent(s) Premium: $_____	Total Premium: $ _____