



Dental Membership Enrollment Form

Anthem
 Dental Enrollment Department
 PO Box 1193
 Minneapolis MN 55440-1193

PART A – EMPLOYEE INFORMATION – Employee complete Parts A thru D and return form to benefit administrator.

Employee's Name:			Last			First			Middle Initial			Social Security Number				
												/ /				
Gender:		Male <input type="checkbox"/> Female <input type="checkbox"/>		Marital Status:		Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/>								Date of Birth (Month-Day-Year)		
														/ /		
Employee's Address:		Address						Home Phone Number			Work Phone Number					
		City						State			Zip Code					

PART B – ENROLLMENT INFORMATION

Select Coverage Type (Check One Box Only):		Complete If Multiple Plan Options Are Offered	
<input type="checkbox"/> Employee Only* <input type="checkbox"/> No Coverage* <input type="checkbox"/> Employee and Spouse <input type="checkbox"/> Employee and Dependent Child(ren) <input type="checkbox"/> Family		I elect to participate in the following Plan: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan C <input type="checkbox"/> Plan D	
* If waiving coverage for employee and/or any eligible family members, you must complete Part D.			

PART C – DEPENDENT INFORMATION

Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender		Date of Birth Month/Day/Year		Full Time Student?		Unmarried?	
		M	F	/	/	Y	N	Y	N
Spouse		M	F	/	/				
Dependent Child		M	F	/	/	Y	N	Y	N
Dependent Child		M	F	/	/	Y	N	Y	N
Dependent Child		M	F	/	/	Y	N	Y	N

PART D – EMPLOYEE SIGNATURE – Select One

Do you (the employee) have other dental coverage? Yes No Do your dependents have other dental coverage? Yes No
 Name of Carrier: _____ Policy/Identification Number: _____

I waive coverage for myself and/or my dependents and understand that by waiving coverage, whether entirely or partially paid by my employer, that I waive the right to change this selection unless permitted in the group contract's participation requirements and enrollment restrictions. Anthem Blue Cross and Blue Shield reserves the right to decline any further dental enrollment changes.

Employee Signature: _____ **Date:** _____

I am enrolling myself and/or my dependents and authorize payroll deductions, if applicable. I have read, or have had read to me, the completed application and I realize that any false statement or misrepresentation in the application may result in a loss of coverage under the policy. **Employee Signature:** _____ **Date:** _____

PART E – GROUP ENROLLMENT INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

<input type="checkbox"/> New Group Hire Date: _____/_____/_____ Prior Coverage Start Date (if applicable): _____/_____/_____ Coverage Effective Date: _____/_____/_____		<input type="checkbox"/> Rehire Date Lay Off Began: _____/_____/_____ Date Rehired: _____/_____/_____	
<input type="checkbox"/> Existing Anthem Dental Group Hire Date: _____/_____/_____ Prior Coverage Start Date (if applicable): _____/_____/_____ Coverage Effective Date: _____/_____/_____		<input type="checkbox"/> Return from Leave of Absence Date Leave Began: _____/_____/_____ Date Returned to Work: _____/_____/_____	
<input type="checkbox"/> New Hire – Apply Probationary Period (if applicable) to determine Effective Date Hire Date: _____/_____/_____ Effective Date: _____/_____/_____		<input type="checkbox"/> Open Enrollment Effective Date: _____/_____/_____	
		<input type="checkbox"/> Previously Waived Coverage or Loss of Coverage Qualifying Event Reason: _____ Hire Date: _____/_____/_____ Event Date: _____/_____/_____ Effective Date: _____/_____/_____	
Group Name:		Group & Subgroup Numbers:	
Group Representative's Signature:		Date: _____ Phone Number: () _____	

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Employer Instructions

- Review Parts A, B, C, and D to be sure all information is complete, accurate and legible.
- When reporting effective dates use contractual start and stop guidelines as defined in your contract (i.e., first of month, end of month, or actual dates).

Employer Complete Part: E - Group Enrollment Information

- Check one reason for enrollment and provide requested information including coverage effective dates.
- **New Group** – New customer initial employee enrollment. Complete the Prior Coverage Start Date if your plan benefits include waiting periods and credit for prior creditable coverage applies.
- **Existing Dental Group** – Enrolling additional employees from an acquisition/merger who were not previously offered/enrolled in your dental plan. Complete the Prior Coverage Start Date only if your plan benefits include waiting periods and credit for prior creditable coverage applies.
- **New Hire** – Enroll newly hired employee. If a probationary period applies, the coverage effective date is after the probationary period.
- **Open Enrollment** – An employee is enrolling during group's open enrollment period.
- **Rehire** – A former employee was rehired.
- **Return From Leave of Absence** – An employee is returning from leave of absence.
- **Employee Status Change** – The employee's employment status changed and the employee is now eligible for dental benefits.
- **Previously Waived Coverage or Loss of Coverage** – If an employee waives coverage; he/she can only enroll at a later date if the group contract includes an Open Enrollment period or if the individual has a loss of other insurance coverage. If an employee or dependent involuntarily loses coverage and are now eligible to enroll, complete this section.
- **Group Name** – Provide group name as listed in your contract.
- **Group and Subgroup Number** – Provide applicable numbers for individual employee.
- **Group Representative** – Sign, date, and provide your phone number.

Send Completed Forms To:
Anthem
Attention: Dental Enrollment Department
PO Box 1193
Minneapolis MN 55440-1193