

Individual Select Dental HMO Application



OFFICE USE ONLY:

(Maryland Residents)

ID #:	CLASS/PLAN #:
GROUP #:	EFF DATE:

The Dental Network, Inc.
10455 MILL RUN CIRCLE, Owings Mills, MD 21117

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
 2. Sign and return this application in the postage-paid return envelope.
- Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. ***If incomplete, the application will be returned and delay your coverage.***

1. APPLICANT INFORMATION

Last Name	First Name	Initial	Social Security #
Residence Address: (Number and Street, Apt. #)		City and State	Zip Code (9-digit, if known)
Business Address, if different from Residence Address: (Number and Street, Apt. #)		City and State	Zip Code (9-digit, if known)
Date of Birth / /	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner	Plan Type <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual
Home Phone ()	Work Phone ()	E-mail Address	

2. COVERAGE SELECTION: (Check one)

- Individual** - Provides coverage for one person
- Individual & Child** - Provides coverage for an individual and eligible dependent. (If you have more than one child, you must select Family coverage)
- Individual & Adult** - Provides coverage for two eligible adults
- Family** - Provides coverage for up to two eligible adults and eligible dependent(s)

3. ENROLLING FAMILY MEMBER(S) – Complete only if you select Individual & Child, Individual & Adult or Family Coverage (Dental HMO Plan must have a dental office code. Each person can select their own dentist.)

Last Name	First Name	M. I.	Relationship	Social Security #	Date of Birth (Mo/Day/Yr)	SEX	Dental Office Code
Member						<input type="checkbox"/> M <input type="checkbox"/> F	
Spouse/Partner						<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent 1						<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent 2						<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent 3						<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent 4						<input type="checkbox"/> M <input type="checkbox"/> F	

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4. OTHER INSURANCE INFORMATION

IF YOU HAVE OTHER INSURANCE, FAILURE TO COMPLETE THIS SECTION WILL CAUSE SIGNIFICANT DELAYS IN PROCESSING ANY CLAIMS SUBMITTED. YES NO

Is anyone listed on this application covered by other dental insurance, including other Blue Cross and Blue Shield coverage? YES NO

If yes, please provide the following:

Name of family member(s) _____ Insurance Company _____

Policy Number and Type _____ Effective Date _____

5. CONDITIONS OF ENROLLMENT — Please Read This Section Carefully

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the Subscriber (or to a person authorized to act on his/her behalf) upon request.

This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.

Premium payment options are available on an annual and a semiannual basis. Those members who elect the semiannual payment option will be subject to a five dollar (\$5) surcharge per payment, which equates to ten dollars annually.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for The Dental Network policy.

IF YOU HAVE ANY QUESTIONS CONCERNING THE BENEFITS AND SERVICES THAT ARE PROVIDED BY OR EXCLUDED UNDER THIS AGREEMENT, PLEASE CONTACT A MEMBERSHIP SERVICES REPRESENTATIVE BEFORE SIGNING THIS APPLICATION.

WARNING: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Signature of Applicant: X _____ **Date:** _____

NOTE: Applications submitted solely on behalf of applicants under the age of 18, where payment of premium is made by the parent or legal guardian, must be signed by the parent or legal guardian.

Parent or Legal Guardian Signature: X _____ **Date:** _____

Please make checks payable to:

THE DENTAL NETWORK, INC.
and mail to:
P.O. Box 79810
Baltimore, MD 21279-0810

FOR INTERNAL USE ONLY:

Agency Name

Agency Address (Number and Street, Apt.#) _____ (City and State) _____ Zip Code (9-digit, if known) _____

Telephone Number ()	Fax Number ()	E-mail Address
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Annual Premium