



**AAAS Employee Benefit Fund**  
 11245 Chantilly Parkway Court  
 Pike Road, AL 36064  
 kay@aaas.us | f 334.834.1818



## DENTAL - Application for Enrollment/Changes

GROUP
77220

Employer Company Name				Employer Phone Number				
Employee Name (Last)		(First)		(Initial)		Employee Phone Number		
Street Address			City		State	Zip	Employee Date of Birth	
<b>CHECK ONE:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female		<b>CHECK ONE:</b> <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed		Employee's Social Security Number			Date of Hire	
<b>LIST ALL ELIGIBLE DEPENDENTS TO ENROLL</b>				<b>SOCIAL SECURITY NUMBER</b>		<b>DATE OF BIRTH</b>		
<b>LAST NAME</b>	<b>FIRST NAME</b>	<b>INITIAL</b>			<b>RELATIONSHIP</b>	<b>M</b>	<b>D</b>	<b>Y</b>
1.					<input type="checkbox"/> Husband <input type="checkbox"/> Wife			
2.					<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
3.					<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
4.					<input type="checkbox"/> Son <input type="checkbox"/> Daughter			
5.					<input type="checkbox"/> Son <input type="checkbox"/> Daughter			

### NATURE OF APPLICATION – CHOOSE ONE

<b>NEW CONTRACT APPLICATION</b>	<b>CHANGE OF CONTRACT</b>	<b>ADD DEPENDENT</b>	<b>REMOVE DEPENDENT</b>
<input type="radio"/> New EMPLOYEE ONLY <input type="radio"/> New EMPLOYEE + FAMILY	<input type="radio"/> Name Change <input type="radio"/> Address Change <input type="radio"/> Type of Coverage Change ___ Single to family ___ Family to Single	<input type="radio"/> Add Spouse <input type="radio"/> Add Dependent Child	<input type="radio"/> Divorce ___ Remove all dependents ___ Remove spouse only <input type="radio"/> Death <input type="radio"/> Loss of Eligibility Reason _____

**EVENT AND DATE OCCURRED:** (Examples: Marriage, Birth, Divorce, Death) \_\_\_\_\_

<b>Do you or your dependents currently have coverage with BC/BS of AL?</b> <b>YES NO</b> If yes, list your contract number. _____	<b>Do you or your dependents have coverage with another group dental plan?</b> <b>YES NO</b> Ins. Co. Name _____ Contract # _____
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I apply for the Group Dental Benefit Certificate or Group Agreement for which I am eligible. My application is subject to the terms and conditions of the agreement between my Group (my employer) and you (Blue Cross and Blue Shield of Alabama). If you accept this application, you will send me an ID card. My Group's contract with you is made up of 1) my Group's application to you; 2) the Group Health Benefits Certificate or Group Agreement, and 3) any written amendments to the Certificate or Group Agreement. My contract with you is made up of these three items and this and any later application by me to you. My coverage will be through this contract. I name my Group as my Group Agent or Remitting Agent. I ask my Group to pay you direct and I give my Group the right to deduct my part of your fees from my pay (if applicable). Everything I say in this application is true. I give up all rights to service if I have not told the complete truth everywhere in this application. You may take back any monies paid for me or my family and pay no more if you find I did not tell the complete truth. I understand that any misrepresentation is fraud and will be pursued to the fullest extent allowed by the law including all compensatory and punitive damages as well as costs and attorney's fees. Coverage will not begin until you accept this application in writing.

If you do not accept my application, the only thing you have to do is return any fees I paid. You may pay providers directly for service to me. I ask my doctor, hospital or anyone else to give all medical records of me or my family to you. You may release those records to anyone necessary in order to administer the contract. This applies to anyone I have listed or added. This begins now and continues as long as you need to decide about this application and process any of our claims.

I will cooperate with you. If you need information about other health policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I understand that if I did not enroll within 30 days of my initial eligibility or as a special enrollee, my next opportunity to enroll would be at open enrollment.

<b>SIGNATURE OF EMPLOYER</b>	<b>DATE</b>	<b>SIGNATURE OF EMPLOYEE</b>	<b>DATE</b>
<b>EMPLOYER ADDRESS</b>		<b>REQUESTED START DATE</b>	

### AAASEBF Use Only

<b>Effective Date</b>	<b>Division #</b>	<b>Contract #</b>	<b>B</b>
			<b>A</b>