



Dental Membership Enrollment Form

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

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

Employee's Name:		Last			First			Middle Initial			Social Security Number									
Gender:		Male		Female		Marital Status:		Single		Married		Widowed		Divorced		Legally Separated		Date of Birth (Month-Day-Year)		
		<input type="checkbox"/>		<input type="checkbox"/>				<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>				/ /		
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*					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			
<input type="checkbox"/> Employee and Spouse					* If waiving coverage for employee and/or any eligible family members, you must complete Part D.								
<input type="checkbox"/> Employee and Dependent Child(ren)													
<input type="checkbox"/> Family													

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

Anthem Blue Cross and Blue Shield is the trade name of Anthem Health Plans of Virginia, Inc. Independent licensee of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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