STATE

DELTA DENTAL

☐ NEW ENROLLMENT ☐ COVERAGE CHANGE ☐ NAME CHANGE ☐ ADDRESS CHANGE ☐ CHANGE OF DEPENDENTS ☐ TERMINATION

☐ DELTAPREMIER
☐ DELTAPREFERRED OPTION
☐ DELTACARE

☐ COBRA

SOCIAL SECURITY NUMBER	LAST NAME	FIRST	MI	DATE OF BIRTH	SEX
					☐ F ☐ M

ADDRESS (New address if different) ZIP CODE

GROUP NUMBER SUBLOCATION GROUP NAME

DELTACARE PROVIDER (if applicable) OFFICE NUMBER

(1.) COVERAGE CHANGE FORMER COVERAGE NEW COVERAGE

(2.) NAME CHANGE FORMER LISTED NAME NEW LISTED NAME

(3.) DEPENDENT CHANGE Choose one please ☐ ADD DEPENDENTS LISTED BELOW ☐ DELETE DEPENDENTS LISTED BELOW

(4.) IS THERE COVERAGE UNDER ANOTHER DENTAL PLAN?	NAME AND ADDRESS OF CARRIER(S)	GROUP NUMBER	NAME AND ADDRESS OF EMPLOYER
☐ YES ☐ NO			

	LAST NAME (IF DIFFERENT)	FIRST NAME	MIDDLE INITIAL	SEX	DATE OF BIRTH MO. DAY YR.	SOCIAL SECURITY NUMBER (if available)
SPOUSE				M F		
CHILDREN				M F		
				M F		
				M F		
				M F		
				M F		

EFFECTIVE DATE OF ABOVE CHANGE(S):

REASON FOR ABOVE CHANGE(S):

SUBSCRIBER SIGNATURE: _____

Capital BlueCross

APPLICATION TO ENROLL OR CHANGE ENROLLMENT

(Please print or type)

Keystone HEALTH PLAN CENTRAL

1-800-962-2242 **www.capbluecross.com** **1-800-669-7061**

GROUP ADMINISTRATOR: You must complete all areas in the box below before submitting this application to Capital BlueCross.

Employer's Name

Group Name *(if different from above)*

Group Number | Subgroup Number | Class

Does Employer employ 20 or more employees under the MSP laws? ☐ Yes ☐ No

Does Employer employ 100 or more employees under the MSP laws? ☐ Yes ☐ No

Employer's Address *(for Association Groups Only)*

Member Firm ID

Effective Date of Above

Effective Date of Coverage/Change: / /

Date Hired: / / Has waiting period been met? ☐ Yes ☐ No

TYPE OF ACTIVITY

☐ Enrollment ☐ Change of Enrollment ☐ Termination

REASON CODES *(See back for codes and descriptions)*

☐ Open Enrollment

☐ Initial Eligibility Change: CODE Date of Change / /

☐ Life Status Change: CODE Date of Change / /

☐ Termination: CODE Date of Change / /

☐ Other (Please Explain) Date of Change / /

SUBSCRIBER: Please refer to the attached Instruction Sheet when completing sections 1 through 10 of this form.

1. SUBSCRIBER INFORMATION:

Subscriber Identification ___ ___ ___ ___ ___ ___ ___ ___ ___ | Birth Date / / | ☐ Male ☐ Female

Subscriber Name (Last, First, M.I.) | ☐ Single ☐ Married

Mailing Address (Include street address, city, state and ZIP Code) | New Address? ☐ Yes ☐ No | County

Home/Cell Phone Number ( ) | Work Phone Number / Ext. ( ) | Email Address

Employment Status:
☐ Active (Full-Time) ☐ Retired—(Date) _____ ☐ Hourly ☐ Exempt ☐ Union
☐ Active (Part-Time) ☐ Other—(Explain) _____ ☐ Salary ☐ Non-Exempt ☐ Non-Union

Average Number of Hours Worked Per Week

2. ENROLLMENT/CHANGE INFORMATION

3. COVERAGE SELECTION/CHANGE

4. PRIMARY CARE PHYSICIAN

First Name & Middle Initial (Show Last Name if different from Subscriber)	Social Security Number	Birth Date	ADD or REMOVE?	Trad.	Comp.	PPO	PPO *Plus*	POS	HMO	Senior	Drug	Dental	Vision*	Indicate Practice Names & Codes (Refer to Applicable Provider Directory)
SUBSCRIBER			☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
Spouse ☐ Male ☐ Female		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
☐ Son ☐ Dau		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No
☐ Other		/ /	☐ ADD ☐ REMOVE											PCP Code #: Current Patient? ☐ Yes ☐ No

If you need an alternate address for a spouse or dependent, please see No. 2 on the INSTRUCTION SHEET.

*National Vision Administrators, LLC, an independent company, administers and is solely responsible for these vision programs. These are not Capital BlueCross products and services.

PCP selection required for *POS* and *HMO*, optional for PPO *Plus*.

5. MEDICARE COVERAGE INFORMATION

Complete Medicare Information for Subscriber and/or Dependents CURRENTLY enrolled for Medicare. Please list the starting date for each reason in the applicable date field. *(Refer to your red, white and blue Medicare Health Insurance Card for the Medicare Claim Number and effective dates.)*

Name of Subscriber or Dependent	Medicare Claim Number	Effective Date(s) Hospital (Part A)	Effective Date(s) Medical (Part B)	Reason/Effective Date for Medicare coverage ☐ Age	☐ Disabled	☐ ESRD
		/ /	/ /	Effective Date: / /	Effective Date: / /	Effective Date: / /
		/ /	/ /	Effective Date: / /	Effective Date: / /	Effective Date: / /

6. HANDICAPPED DEPENDENTS

Name of Handicapped Dependent

7. OTHER INSURANCE COVERAGE

Complete if YOU or ANY OF YOUR DEPENDENTS have health care coverage with **any other** insurance company. If completed, you may receive additional information. *(Please attach a separate sheet of paper if additional space is needed.)*

Name of Subscriber or Dependent	Name of Health Care Plan/Insurance Co.	Identification/Policy Number

8. STUDENT INFORMATION

Complete the following information for DEPENDENTS who are 19 YEARS OLD OR OLDER and enrolled as full-time students at an accredited school or college/university. *(Please attach a separate sheet of paper if additional space is needed.)*

Student's Name	Name of School or College/University	Expected Graduation Date
		/
		/

9. CHANGE THE FOLLOWING INFORMATION

Change is for ☐ Subscriber ☐ Dependent (Name)

	From	To
Name		
Birth Date	/ /	/ /
Social Security Number	___ ___ ___ / ___ ___ / ___ ___ ___ ___	___ ___ ___ / ___ ___ / ___ ___ ___ ___

10. STATEMENT OF APPLICATION

By signing this application, I am indicating that I have read the statement of application on the back of the form. I verify that the information given is true and correct.

Subscriber's Signature | Date

NF-2 (3/2009)

White - Capital BlueCross Copy Yellow - Group Administrator Copy Pink - Subscriber Copy