



Please type or write clearly in black or blue ink

Section A: Employer Provided Information																		
Group Name:		1. Life Group #:	2. Dental Group #	3. Division #:	4.													
Coverage Effective Date:		5. Date of Hire:	6. Occupation:		7. Class:	8.												
Work Status: <input type="checkbox"/> Actively at Work <input type="checkbox"/> Cobra <input type="checkbox"/> Retired		9. Retirement Date:	10. Paid: <input type="checkbox"/> Hourly <input type="checkbox"/> Salary	11. Annual Salary: \$	12. Hours worked per week:	13. <input type="checkbox"/> Open Enrollment: (Dental Only)	14.											
Section B: Employee Information (Refer to Section E. for Additional Employee Information)																		
Last Name:		15. First Name:	16. M.I.:	17. Gender: <input type="checkbox"/> M <input type="checkbox"/> F	18. Date of Birth:		19.											
Address:		20. Apt.#:	21. City:	22. State:	23. Zip:	24. Social Security No.:		25.										
County:		26. Home Phone #:	27. Bus. Phone #:	28. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed		29.												
Section C: Dental Coverage Selection																		
(If yes, select one of the Plans below.) Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage. Child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage. Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage. (If child selected, all children must be enrolled.)																		
Plan Type Requested: <input type="checkbox"/> BlueDental Choice (PPO) <input type="checkbox"/> BlueDental Choice Plus (PPO) <input type="checkbox"/> BlueDental Freedom (Indemnity) <input type="checkbox"/> BlueDental Choice Copayment (PPO) <input type="checkbox"/> BlueDental Care (Prepaid) <input type="checkbox"/> Other																		
Section D: Life and Disability Coverage Selection																		
(If yes, select coverages below.) Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage. Child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage. Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage. (If child selected, all children must be enrolled.)																		
Coverage Requested: <input type="checkbox"/> Basic Term Life \$ _____ <input type="checkbox"/> Accidental Death & Dismemberment (AD&D) \$ _____ <input type="checkbox"/> Dependent Life <input type="checkbox"/> Short Term Disability (STD) <input type="checkbox"/> Supplemental Life \$ _____ <input type="checkbox"/> Supplemental AD&D <input type="checkbox"/> Hospital Indemnity (Select Only One) <input type="checkbox"/> Emp/Spouse <input type="checkbox"/> Emp/Child(ren) <input type="checkbox"/> Emp/Family <input type="checkbox"/> Long Term Disability (LTD) <input type="checkbox"/> LTD Buy-Up																		
Voluntary Coverages: (If spouse Voluntary Life or AD&D is selected, spouse information must be provided in Section E.) Life: <input type="checkbox"/> Employee \$ _____ <input type="checkbox"/> Spouse \$ _____ <input type="checkbox"/> Child(ren) \$ _____ AD&D: <input type="checkbox"/> Employee \$ _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren) <input type="checkbox"/> Voluntary Short Term Disability (VSTD) <input type="checkbox"/> Voluntary Long Term Disability (VLTD)																		
Your Group Life Beneficiary Information. Attach separate sheet, if needed, with additional beneficiaries, sign and date. This will revoke any existing beneficiary designation you may have. Total % must = 100%.																		
Primary Beneficiary:		DOB:	Relation to You:		% of Share:	36.												
Secondary (Contingent) Beneficiary:		DOB:	Relation to You:		% of Share:													
Secondary (Contingent) Beneficiary:		DOB:	Relation to You:		% of Share:													
Section E: Employee and Dependent Information-Attach separate sheet, if needed, with additional dependent information, sign and date.																		
Last Name (if different than employee), First Name, M.I.		37.	Social Security Number	38.	Birth Date	39.	Gender (M/F)	40.	Check if Disabled	41.	Relation to You	42.	BlueDental Care Prepaid Dental Facility ID Number (check box if a current patient)	43.	Check if			44.
															<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee															<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse									<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child									<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child									<input type="checkbox"/>						<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Section F: Other Dental Insurance Information (This section must be completed for claims processing)																		
In addition to this policy, do you or your dependents have any other Dental insurance under a group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete below.																		
Name of Person:		46. Group Name & #:		47. Policy #:		48.												
Insurance Co./Name and Address:						49.												
Section G: Acceptance of Coverage (Please read before signing)				Section H: Refusal of Any/All Coverage (Please read before signing)														
I wish to apply for any coverage checked YES under Parts C and D above. I have read and understand the Acceptance of Coverage on the reverse side of this form. I certify the statements on this application, including any attachment to it, are true and complete to the best of my knowledge and belief. (If you checked NO for any coverage under Parts C or D, sign and date Part H also.)				50.														
Signature:				Date														
I do not wish to apply for any coverage checked NO under Parts C and D above. I understand there may be additional requirements if I decide to apply at a later time.				51.														
Signature:				Date														
FRAUD NOTICE: I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.																		



Section I: Acceptance of Coverage Authorization

I hereby apply for the coverage checked "Yes" on the front of this form. My employer has selected the coverage through Florida Combined Life Insurance Company, Inc. (FCL). I authorize my employer to deduct from my earnings my premium contribution (if any). I understand all of the following: 1. If my coverage is to be issued and continued, I must meet all the group contract's requirements; 2. if my dependents' coverage, if any, is to be issued and continued, my dependents must meet all the group contract's requirements; and (3) if I am not actively at work on my proposed coverage effective date, my effective date for certain coverages **may** be deferred until the date I return to active work.

I understand a dependent cannot be: (1) covered as both a dependent and an employee, including married employees of the same employer, (2) covered under more than one employee, or (3) full-time military.

I understand that my employer is not an agent of FCL. I also understand that my employer is responsible for notifying all employees of: 1. all effective dates; 2. all termination dates; 3. any Employee Retirement Income Security Act (ERISA) rights or responsibilities; and 4. all other matters pertaining to coverage under the group contract.

If an overpayment is made, I authorize FCL to recover the excess from any person or entity to which payment is made.

I acknowledge that, if I apply for FCL dental coverage later, coverage will not be available until the next open enrollment. I also understand if I apply later for coverages, other than dental, I **may** be required to furnish evidence of insurability.

I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I hereby certify that the statements on this application, including any attachment to it, are true and complete. I understand and agree that any misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage.

A photocopy of this application shall be as valid as the original. However, the original application is required to evaluate this application. I agree to be bound by the group contract's terms and conditions. I understand that this application is hereby made a part of the group contract. I will attach it to my certificate of coverage, when issued.