BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

Alabama Federal DentalBlue Enrollment Form

Failure to provide requested information may delay the processing of your application.

Please use black ink and print clearly.

Keep the bottom copy for your records.

Mail top copy to:

Blue Cross and Blue Shield of Alabama
Attention: Payment Processing - FEP
P.O. Box 2768
Birmingham, Alabama 35202-2768
1-800-492-8872

For Service Benefit Plan Basic or Standard Option Enrollees Only

To enroll in Alabama Federal DentalBlue you must reside in the service area of Blue Cross and Blue Shield of Alabama. If you enroll in the FEHB Basic Option, you will automatically be enrolled in Alabama Federal DentalBlue Basic Option. The same is true for Standard Option.

If you are a new Standard or Basic Option subscriber, please include a copy of your SF 2809 Form.

Application For Enrollment

EMPLOYEE INFORMATION

*PLEASE PRINT USING UPPERCASE LETTERS: USE BLACK BALL POINT PEN - PRESS FIRMLY) * INDICATES REQUIRED FIELDS*

○ DR. ○ MR. ○ MRS. ○ MS.

LAST NAME* **FIRST NAME***

MAIDEN/MIDDLE NAME SUFFIX (JUNIOR, SENIOR) **SOCIAL SECURITY NUMBER*** ___ – ___ – ____

MAILING ADDRESS*

CITY* **STATE*** **ZIP***

PHONE NUMBER ☐ HOME ☐ WORK ☐ CELL E-MAIL ADDRESS (Optional)

(___) ___ – ____

○ MALE ○ FEMALE **DATE OF BIRTH (MM/DD/YYYY)*** __ / __ / ____

FEP ID NUMBER

R ☐☐☐☐☐☐☐☐

Please check the appropriate FEP Enrollment Code

☐ 104 Standard Self Only
☐ 105 Standard Self and Family
☐ 111 Basic Self Only
☐ 112 Basic Self and Family

☐ *Check here if you are electing coverage due to termination of existing coverage* **DATE OF COVERAGE TERMINATED (MM/DD/YYYY)*** __ / __ / ____

☐ *Check here if you are returning to full-time civilian employment from active military duty.* **DATE OF RETURN EMPLOYMENT (MM/DD/YYYY)*** __ / __ / ____

☐ *Check here if you are transferring in to Alabama from another state within the same federal agency.* **DATE OF TRANSFER IN FROM YOUR 2810 Form (MM/DD/YYYY)*** __ / __ / ____

COVERED DEPENDENTS

List your spouse and/or dependent children below. **Only the dependents enrolled under your Service Benefit Plan coverage are eligible to enroll in Alabama Federal DentalBlue.**

LAST NAME* **FIRST NAME***

MAIDEN/MIDDLE NAME SUFFIX (JUNIOR, SENIOR) **SOCIAL SECURITY NUMBER*** ___ – ___ – ____

RELATIONSHIP GENDER **DATE OF BIRTH (MM/DD/YYYY)***

○ SPOUSE ○ OTHER_____ ○ MALE ○ FEMALE __ / __ / ____

LAST NAME* **FIRST NAME***

MIDDLE NAME SUFFIX (JUNIOR, SENIOR) **SOCIAL SECURITY NUMBER*** ___ – ___ – ____

RELATIONSHIP GENDER **DATE OF BIRTH (MM/DD/YYYY)***

○ CHILD ○ OTHER_____ ○ MALE ○ FEMALE __ / __ / ____

COVERED DEPENDENTS

LAST NAME*

FIRST NAME*

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER* ___ – ___ – ____

RELATIONSHIP

○ CHILD ○ OTHER_____

GENDER

○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY)* __ / __ / ____

LAST NAME*

FIRST NAME*

MIDDLE NAME

SUFFIX (JUNIOR, SENIOR)

SOCIAL SECURITY NUMBER* ___ – ___ – ____

RELATIONSHIP

○ CHILD ○ OTHER_____

GENDER

○ MALE ○ FEMALE

DATE OF BIRTH (MM/DD/YYYY)* __ / __ / ____

If you need to list more dependents, please attach an additional sheet.

ENROLLMENT PERIOD

As long as you remain eligible for enrollment in Alabama Federal DentalBlue, your enrollment period is for the entire calendar year. The Alabama Federal DentalBlue benefits are based upon year-long premiums. (For federal employees hired during the calendar year, who transfer in to Alabama from another state within the same federal agency, or who elect coverage due to termination of existing coverage, the enrollment period and total premium liability are determined based on the effective date of enrollment.) If you cancel your Alabama Federal DentalBlue coverage to enroll in a dental plan other than the national FEP BlueDental plan, you will not be able to re-enroll in Alabama Federal DentalBlue during the next three Open Seasons except if you return to full-time civilian employment from active military duty.

PAYMENT & BILLING

We will accept your premium payments only if they are made from your personal **(non-business)** account. Premiums are payable in advance on a monthly basis.

Please choose either an Automatic Payment Method OR a Billing Method. **Failure to choose either an Automatic Payment Method or a Billing Method will delay the processing of your application.**

AUTOMATIC PAYMENT METHOD *

Select **ONE** payment method.

☐ **E-Check **** ☐ **Debit** ☐ **Credit Card**

** Please complete the included Payment Authorization Agreement and submit it along with this application. If approved, your payment will be charged to your account. It may take up to 30 days to implement automatic payment. You will receive a bill for your premiums until your payment method is established. Courtesy notification will be sent to your email.*

*** For e-check only, please mail us a blank voided check.*

BILLING METHOD

Select **ONE** billing method.

☐ **E-Statement** *You will receive an email notification each month when your billing statement is available. Email address is required.*

Email Address

☐ **Billing Statement** *You will receive a billing statement each month which includes an invoice to return with your premium payment. Courtesy notification will be sent to your email.*

I UNDERSTAND

These benefits are neither offered nor guaranteed under the FEHB Program, but are made available to all enrollees and dependents who are members of the Service Benefit Plan and live in the service area of Blue Cross and Blue Shield of Alabama. If I choose the FEHB Basic Option, I will be enrolled in the Alabama Federal DentalBlue Basic Option. If I choose the FEHB Standard Option, I will be enrolled in the Alabama Federal DentalBlue Standard Option. The cost of these benefits is not included in the FEHB premium, and charges for these services do not count toward any FEHB deductibles or catastrophic protection benefits.These benefits are not subject to the FEHB disputed claims procedures.

I acknowledge and agree:

- that coverage shall become effective only after this application is approved by the Plan and shall be only as stated in the contract issued by the Plan; and
- that any health care provider having information or records pertaining to me or any covered family member is authorized and directed to furnish such information or records at the Plan's request; and
- that each response in this application has been entered by me or at my direction and may be used by the plan to determine eligibility of me and any family member for this coverage and that, if I have misstated or omitted any material information, the Plan may declare such coverage null and void from its issuance; and
- that I will pay premiums by the method selected above.

__ / __ / ____

DATE SIGNED (MM/DD/YYYY)

SIGNATURE OF EMPLOYEE*

BlueCross BlueShield of Alabama

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