



# RIT Student Dental

A nonprofit independent licensee of the Blue Cross Blue Shield Association

P.O. Box 21146 Eagan, MN 55121-0146

Instructions on Back. All Dates = mm/dd/yy  Check if name change  Check if new address

Please print clearly.

✓ CHECK DESIRED ACTION	✓ CHECK DESIRED COVERAGE	✓ CHECK PERSON(S) COVERED			
<input type="checkbox"/> Add Subscriber (AA) Coverage Effective Date _____	<b>RIT Student Option A</b> <input type="checkbox"/> (EHB)	Self, Spouse & Child(ren) (A)	Self & Child(ren) (B)	Self & Spouse (C)	Self (D)
<input type="checkbox"/> Add Subscriber (AA) Coverage Effective Date _____	<b>RIT Student Option B</b> <input type="checkbox"/> (EHC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Add Subscriber (AA Special Enrollment Period (SEP) Special Enrollment Period ____/____/____ Coverage Effective Date ____/____/____	Open enrollment in RIT's Student Dental Plan occurs during the first 30 days of your eligibility each semester. Please mark the box that you wish coverage to start. If the open enrollment period has already closed for the semester you have indicated, and if enrollment is not due to eligibility for a special enrollment period, your coverage will begin on the next available enrollment period.				
<input type="checkbox"/> Add Dependent (AB) Special Enrollment Period (SEP) Special Enrollment Period ____/____/____ Coverage Effective Date ____/____/____	<input type="checkbox"/> Cancel Subscriber (S) <input type="checkbox"/> Cancel Dependent (M) Reason Code (see back) _____ Cancellation Date ____/____/____				

**SUBSCRIBER INFORMATION - Must be completed**

Social Security # \_\_\_\_\_ Gender:  M  F  X Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Day Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Gender identity (optional):  
 Transgender Male  
 Transgender Female  
 Prefer not to say  
 Non-binary  
 Prefer to self-describe: \_\_\_\_\_

**MEDICARE HEALTH INSURANCE CLAIM #** \_\_\_\_\_ Part A Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Part B Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**FAMILY MEMBER INFORMATION** ✓ Check relationship and indicate dependent name or indicate dependent name and birthdate to be cancelled.

Relationship	Social Security #	Gender	Birthdate (mm/dd/yy)	Gender identity (optional)
<input type="checkbox"/> (S)pouse <input type="checkbox"/> (D)ependent <input type="checkbox"/> Student(T) <input type="checkbox"/> (H)disabled <input type="checkbox"/> Other _____ Last Name (if different) _____ First Name _____	_____	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	____/____/____	<input type="checkbox"/> Transgender Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Transgender Female <input type="checkbox"/> Prefer to self-describe: _____
<input type="checkbox"/> (S)pouse <input type="checkbox"/> (D)ependent <input type="checkbox"/> Student(T) <input type="checkbox"/> (H)disabled <input type="checkbox"/> Other _____ Last Name (if different) _____ First Name _____	_____	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	____/____/____	<input type="checkbox"/> Transgender Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Transgender Female <input type="checkbox"/> Prefer to self-describe: _____
<input type="checkbox"/> (S)pouse <input type="checkbox"/> (D)ependent <input type="checkbox"/> Student(T) <input type="checkbox"/> (H)disabled <input type="checkbox"/> Other _____ Last Name (if different) _____ First Name _____	_____	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X	____/____/____	<input type="checkbox"/> Transgender Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Transgender Female <input type="checkbox"/> Prefer to self-describe: _____

**OTHER COVERAGE INFORMATION - Must be completed. You may be contacted for additional information.**

Have you or any member of your family been enrolled in any other insurance policy (including Dental, Medicare or Medicaid)?  
 Yes  No If yes, ✓ Check:  Medical and/or  Dental

What is the effective date of the other coverage?  Medical: \_\_\_\_/\_\_\_\_/\_\_\_\_  Dental: \_\_\_\_/\_\_\_\_/\_\_\_\_

What is the name of the other carrier(s)? \_\_\_\_\_

Are you keeping the coverage?  Yes  No If no, when will the coverage end?  Medical: \_\_\_\_/\_\_\_\_/\_\_\_\_  Dental: \_\_\_\_/\_\_\_\_/\_\_\_\_

Policyholder's name \_\_\_\_\_ ID#(s) \_\_\_\_\_

Who did the insurance cover?  Self Only  Self & Spouse/Domestic Partner  Self & Child(ren)  Family

**RELEASE - You must sign and date this form to be eligible for insurance.**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_

Coverage	Group/Subgroup #	Class	Enrollment Code	Student Status
Dental				✓ (A) Active

Name of School: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_

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Group Rep Signature/Date: \_\_\_\_\_

## Instructions for completing the Enrollment Form

**DESIRED ACTION** Check the appropriate action and indicate the Date(s) in the space provided. A Special Enrollment Period is the date of a specific occurrence, due to change in status, marriage, divorce, birth or adoption, anniversary date, or rate change. Your request **must** be received within 30 days of the Special Enrollment Period date. Please see your School Representative for events that fall outside the 30-day period. If New Add Subscriber, Add Dependent or Change Coverage, you must also check Desired Coverage and Persons Covered and Family Member information sections.

### Cancel Request

To process a Subscriber or Member Cancellation, please use the **Membership Cancellation Worksheet – OR -**

#### To Cancel a Student/Subscriber (entire policy) using this Form:

- check Subscriber (S) box
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information

#### To Cancel a Dependent using this Form:

- check Dependent (M) box
- indicate Reason Code in space provided (see codes below)
- indicate Cancellation Date in space provided
- complete Subscriber Information
- Complete Member Name and Member Birthdate

### Cancel Subscriber Reasons

SB05 – Per Group Request  
SB06 – Subscriber No Longer Wants Coverage (subscriber request)

SB07 – Subscriber Deceased  
SB09 – Enrolled in Error

### Cancel Dependent Reasons

M011 – No Longer a Student  
M002 – Deceased  
M003 – Subscriber No Longer Wants to Cover Dependent  
M013 – Ineligible Dependent

M004 – Enrolled in Error  
M005 – Divorced  
M007 – Dependent No Longer Wants Coverage  
M008 – Moved Out of Area

**FAMILY MEMBER QUALIFIED GUIDELINES:** Use an additional form, if more than three persons.

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the dependent age for your group
  - Unmarried child, natural, adopted or stepchild
  - A full time student (indicate under Relationship)
- **Other: Please contact Customer Service for the appropriate form. These dependents have additional eligibility requirements.** Legally adopted dependents, dependents pending adoption, dependents for whom student has legal guardianship, or an adult disabled dependent who is over the dependent age for your group.

### RELEASE

- I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract or certificate you issue is bound by the terms and conditions of the contract or certificate applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who accepts coverage under the terms of the contract applicable to my coverage (who may include, for example my spouse and my eligible family dependents).
- I hereby accept responsibility for payment of any portion of the premium.
- **Gender and gender identity:** Excellus BlueCross BlueShield does not discriminate on the basis of gender identity, gender expression or behavior. In order to ensure that you are receiving access to high quality, affordable health care based on your individual needs, we ask that you consider completing this **optional gender identity section** of the application. Excellus BlueCross BlueShield will not limit coverage or impose any additional cost-sharing for any otherwise-covered services that are ordinarily available to individuals of one sex, to a transgender individual, based on the fact that an individual's sex assigned at birth, gender identity, gender expression or behavior or gender otherwise recorded is different from the gender for which health care services are ordinarily available.
- I hereby represent that all information furnished by me hereon is true and complete to the best of my knowledge. I understand that any claim by me or one of my eligible family members may be denied and my coverage canceled upon one month's written notice, if I have knowingly included false information.

**If you have any questions, please contact Customer Service at:**

**Excellus BlueCross BlueShield**  
**1-800-724-1675**  
**TTY: 585-424-2845 or 1-800-662-1220**