



RIT Student Dental

P.O. Box 21146, Eagan, MN 55121

A nonprofit independent licensee of the BlueCross BlueShield Association

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) Fall Semester Event Date [09/01/2018] Coverage Eff Date [09/01/2018]	<input type="checkbox"/> RIT Student Option A <input type="checkbox"/> RIT Student Option B	Self, Spouse & Child(ren) (A)	Self & Child(ren) (B)	Self & Spouse (C)	Self (D)
<input type="checkbox"/> Add Subscriber (AA) Winter Semester Event Date [01/01/2019] Coverage Eff Date [01/01/2019]		<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
Open enrollment in RIT's Student Dental Plan occurs during the first 30 days of 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, your coverage will begin on the next available semester start date.					

SUBSCRIBER INFORMATION - Must be completed

Student Identification # _____ Sex: M F Birthdate ___/___/___

Last Name _____ First _____

Street _____

City _____ State _____ Zip _____

Day Phone: []-[]-[] E-Mail Address: _____

MEDICARE HEALTH INSURANCE CLAIM # _____

FAMILY MEMBER INFORMATION ✓ Check relationship and complete information.

<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 _____	Student Identification # _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (mm/dd/yy) ___/___/___
<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 _____	Student Identification # _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (mm/dd/yy) ___/___/___
<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 _____	Student Identification # _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (mm/dd/yy) ___/___/___

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

In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.

Have you or any member of your family been enrolled in any other insurance policy in the last 63 days (including Dental, Medicare or Medicaid)?

Yes No Check: Medical and/or Dental Are you keeping this coverage? Yes No

✓ Check previous insurance company from list below and indicate ID #: _____

(B) Excellus BlueCross BlueShield, Rochester Region, Blue Choice.

(O) Other - BlueCross BlueShield Plan (outside of Rochester). Indicate Plan Name: _____

(C) Other Carrier - Indicate Plan Name: _____

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

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. 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.

I have thoroughly read, understand and agree to comply with the terms of this section.

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/Sub Group #	Chk digit	Pkg #	Student Status <input checked="" type="checkbox"/> (A) Active
Dental	00055599			Rochester Institute of Technology, 13 Lomb Memorial Dr., Rochester, NY 14623 (585) 475-6131

[Group Rep Signature/Date]

Instructions for completing the Enrollment Form

Cancel Request

To process a Subscriber or other Member Cancellation, please use the **Membership Cancellation Worksheet**

FAMILY MEMBER INFORMATION

Use an additional form, if more than three persons.

QUALIFIED GUIDELINES:

- 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)
 - Chiefly dependent on you for support
- **Other: Please contact Customer Service for the appropriate form. These dependents have additional eligibility requirements.**
Dependents pending adoption, grandchild or foster dependents, foreign exchange students, dependents for whom employee/subscriber has legal custody or legal guardianship, or a dependent who is claimed on subscriber's current federal income tax return, or a handicapped dependent who is over the dependent age for your group.

**If you have any questions, please contact Customer Service at:
Excellus BlueCross BlueShield, Rochester Region 1-800-724-1675
TTY: 1-800-421-1220**

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services and are a Child Health Plus or Managed Medicaid member, please call 1-800-650-4359. If you are an Essential Plan member, please call 1-877-626-9298. All others please call 1-800-499-1275.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Si usted es un asegurado de Child Health Plus o Managed Medicaid, llame al número 1-800-650-4359. Si usted es un asegurado de Essential Plan, llame al número 1-877-626-9298. Todos los demás pueden llamar al número 1-800-499-1275.

注意：如果您说中文，您可免费获得语言协助服务。如果您是 Child Health Plus 或 Managed Medicaid 会员，请拨打 1-800-650-4359。如果您是 Essential Plan 会员，请拨打 1-877-626-9298。如非上述会员，请您拨打 1-800-499-1275。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. Если вы являетесь участником программы Child Health Plus или Managed Medicaid, позвоните по телефону 1-800-650-4359. Если вы являетесь участником программы Essential Plan, позвоните по телефону 1-877-626-9298. Всех остальных просим звонить по телефону 1-800-499-1275.

Atansyon: Si ou pa pale Kreyòl Ayisyen, gen èd gratis nan lang ki disponib pou ou. Si ou se yon manm Child Health Plus oswa Managed Medicaid, tanpri rele nimewo 1-800-650-4359. Si ou se yon manm Essential Plan, tanpri rele nimewo 1-877-626-9298. Tout lòt moun yo, tanpri rele nimewo 1-800-499-1275.

알려드립니다: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. Child Health Plus 또는 Managed Medicaid 회원이신 경우, 1-800-650-4359번으로 전화해 주십시오. Essential Plan 회원이신 경우, 1-877-626-9298번으로 전화해 주십시오. 기타의 경우 1-800-499-1275번으로 전화해 주십시오.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Se siete iscritti a un programma Child Health Plus o Managed Medicaid, chiamate il numero 1-800-650-4359. Se siete iscritti a un programma Essential Plan, chiamate il numero 1-877-626-9298. In tutti gli altri casi, chiamate il numero 1-800-499-1275.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך. אויב איר זענט א Managed Medicaid מעמבער, 1-800-650-4359. אויב איר זענט א Essential Plan מעמבער, 1-877-626-9298. אלע אנדערע ביטע רופט 1-800-499-1275.

নজর দিন: যদি আপনি বাংলায় কথা বলেন তাহলে আপনার জন্য বিনামূল্যের সাহায্য উপলভ্য রয়েছে। আপনি Child Health Plus বা Managed Medicaid এর সদস্য হলে অনুগ্রহ করে 1-800-650-4359 নম্বরে ফোন করুন। আপনি Essential Plan এর সদস্য হলে অনুগ্রহ করে 1-877-626-9298 নম্বরে ফোন করুন। অন্যান্য সমস্ত প্রশ্নের জন্য, অনুগ্রহ করে 1-800-499-1275 নম্বরে কল করুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Jeśli jesteś członkiem ubezpieczenia Health Plus lub Managed Medicaid, zadzwoń pod nr 1-800-650-4359. Jeśli jesteś członkiem ubezpieczenia Essential Plan, zadzwoń pod nr 1-877-626-9298. Pozostałe osoby powinny dzwonić pod nr 1-800-499-1275.

Child تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. إذا كنت عضواً في Health Plus أو Managed Medicaid، يرجى الاتصال على الرقم 1-800-650-4359. إذا كنت عضواً في Essential Plan، يرجى الاتصال على الرقم 1-877-626-9298. لجميع البرامج الأخرى، يرجى الاتصال على الرقم 1-800-499-1275.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Si vous êtes un membre du programme Child Health Plus ou Managed Medicaid, veuillez appeler le 1-800-650-4359. Si vous êtes un membre du programme Essential Plan, veuillez appeler le 1-877-626-9298. Si vous êtes dans une autre situation, veuillez appeler le 1-800-499-1275.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے مفت میں زبان کی مدد دستیاب ہے۔ اگر آپ Child Health Plus یا Managed Medicaid کے ممبر ہیں تو براہ کرم 1-800-650-4359 پر کال کریں۔ اگر آپ Essential Plan کے ممبر ہیں تو براہ کرم 1-877-626-9298 پر کال کریں۔ باقی سبھی لوگ براہ کرم 1-800-499-1275 پر کال کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may magagamit kang libreng tulong sa wika. Kung isa kang miyembro ng Child Health Plus o Managed Medicaid, mangyaring tumawag sa 1-800-650-4359. Kung isa kang miyembro ng Essential Plan, mangyaring tumawag sa 1-877-626-9298. Para sa lahat ng iba pa, mangyaring tumawag sa 1-800-499-1275.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Αν είστε μέλος των προγραμμάτων Child Health Plus ή Managed Medicaid, καλέστε στο 1-800-650-4359. Αν είστε μέλος του προγράμματος Essential Plan, καλέστε στο 1-877-626-9298. Διαφορετικά, καλέστε στο 1-800-499-1275.

Vini re: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Nëse jeni anëtar i "Child Health Plus" ose "Managed Medicaid", ju lutemi të telefononi numrin 1-800-650-4359. Nëse jeni anëtar i planit bazë, ju lutemi të telefononi numrin 1-877-626-9298. Të gjithë personave të tjerë iu lutemi që të telefonojnë numrin 1-800-499-1275.