



P.O. Box 27630  
Albuquerque, New Mexico 87125-7630  
Or FAX to: 505-837-8950

# Dental Enrollment / Change Application

1 Employee's Last Name, First, Middle Initial (PLEASE PRINT CLEARLY)		Social Security or ID #		Date Hired/Rehired	Effective Date	
Mailing Address		City	State	Zip Code	Employer	Group No.
Physical Address		City	State	Zip Code	Job Title	No. of Hours Worked Weekly
Home Phone	Work Phone	E-mail Address		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced		

2 New Enrollment? If yes, check one:  
 New (Go to #4)     Re-Enrollment (Go to #4)     Switch Enroll (Go to #4)     Special Enrollment (explain)

3 Change to Coverage/Contract? If yes, check all that apply:  
 Termination of Contract\*     Add or Drop Dependent\*     Name Change\*     Address Change  
 \*Reason For Change (circle one):    Marriage    Divorce    Birth    Adoption    Death    Other (explain) \_\_\_\_\_

DATE OF CHANGE TO COVERAGE/CONTRACT: \_\_\_\_\_ (date subject to approval/eligibility)

4 Dental Plan Option		Dental Coverage Type	
Plan Name: _____	<input type="checkbox"/> Six-month continuation	<input type="checkbox"/> Other _____	<input type="checkbox"/> Employee <input type="checkbox"/> Emp/Spouse
Plan Code: _____	<input type="checkbox"/> Group-Administered COBRA		<input type="checkbox"/> Emp/Child <input type="checkbox"/> Family
			<input type="checkbox"/> Emp/Children

I certify that the below-named children are financially dependent on me or dependent because of a court order.

5 List all members to add/drop							
Last Name	First	Initial	Add/Drop (A/D)	Relationship	Gender M/F	Date of Birth Mo/Day/Year	
Employee				SELF			
Legal Spouse							
Legal Dependent							
Legal Dependent							
Legal Dependent							
Legal Dependent							

**NOTE: If a dependent child is over age**, indicate if the child is eligible due to student status (self-insured groups only) or a handicapping disability.

IF YOU AND YOUR SPOUSE ARE USING DIFFERENT LAST NAMES, CHECK APPLICABLE BOX:

Common Law Marriage     Wife Retaining Name

Common law marriages are not recognized in the state of New Mexico. If the relationship originated in a state that does recognize common law marriage, BCBSNM will honor the relationship as a common law marriage. Proof of common law marriage will be required.

6 Do you or members of your family have dental coverage other than the applied for coverage?  No     Yes

If "YES", give carrier name: \_\_\_\_\_

7 **EMPLOYEE AUTHORIZATION FOR PAYROLL DEDUCTION/DEPENDENT CERTIFICATION:** I apply for the coverage offered to me and my dependents shown above and authorize my employer to periodically deduct from my earnings, until further notice, amounts equal to the required contributions. I understand that services will be available subject to the exclusions, limitations, and conditions described in the group member's certificate/benefit booklet. I certify that the above information is correct to the best of my knowledge and belief. I also certify that the above-named children are dependent on me for more than 50 percent of their support in a normal parent-child relationship.

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Office Use Only	UW							
	Date received	Date processed	<input type="checkbox"/> Contract <input type="checkbox"/> Dependent		Change Code	Effective Date		
	Cert./I.D. No.	Group No.	BCBS ED	Contract Code				