

# APPLICATION FOR DENTAL BLUE 65

## DIRECTIONS

- Please print clearly.
- Carefully read and answer all questions. Incomplete applications won't be accepted. Keep one copy of the application for yourself
- Don't send money with this application. You'll receive a bill when payment is due. You'll also receive an invitation to sign up for our eBill option.
- Please complete the application, and:
  - Mail the white copy to:  
**Direct Sales**  
**Blue Cross Blue Shield of Massachusetts**  
**One Enterprise Drive**  
**Quincy, MA 02171-1753**
  - Or fax to: **1-617-246-3633**

## YOU ARE ELIGIBLE TO APPLY FOR A DENTAL BLUE 65 PLAN IF YOU MEET ALL OF THE FOLLOWING REQUIREMENTS:

- You are a resident of Massachusetts and you actually live in Massachusetts
- You are age 65 or older

## QUESTIONS?

- The Dental premium rate and benefits are explained in the Outline of Coverage you received with this application. If you need more information or assistance, call us at **1-800-678-2265**.
- For all other questions, contact Dental Blue 65 Member Service at **1-888-741-4340 (TTY: 711)**.

# PLEASE ANSWER ALL QUESTIONS

I am applying for: <input type="checkbox"/> Dental Blue 65 Preventive <input type="checkbox"/> Dental Blue 65 Basic <input type="checkbox"/> Dental Blue 65 Premier			
Your Social Security Number: _____ - _____ - _____		How often would you like to be billed? <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly	
Would you like your premium payment due on the 1st of the month or the 15th of the month? <input type="checkbox"/> 1st of the month <input type="checkbox"/> 15th of the month			
First Name		Last Name	Middle Initial
Your gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Your date of birth (mm/dd/yy):	Your telephone number: (     )     -	
<b>YOUR PERMANENT HOME ADDRESS:</b>			
Number and Street	City	State	Zip
<b>IF YOU WANT YOUR DENTAL BLUE 65 BILL SENT TO AN ADDRESS OTHER THAN YOUR HOME ADDRESS, COMPLETE THE FOLLOWING SECTION.</b>			
<b>YOUR BILLING ADDRESS ONLY:</b>			
Number and Street	City	State	Zip
Your email address:			
Are you currently a Blue Cross Blue Shield of Massachusetts member? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give your Blue Cross Blue Shield identification number:			
The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me into a Dental plan membership. I understand that I should read the subscriber certificate to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.			
Applicant's Signature: _____		Date: _____	
Will this policy replace an active dental insurance policy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, please complete the Notice of Information Practices form and include it with this application.			

# NOTICE TO APPLICANT

---

If you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Blue Cross Blue Shield of Massachusetts, you must sign and return this form with your application. For your own information and protection, certain facts should be pointed out to you, which could affect your rights to coverage under the new policy.

Health conditions, which you may presently have, may not be covered under the new policy. This could result in a claim for benefits being denied which have been payable under your present policy.

Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

It may be to your advantage to secure the advice of your present carrier or its agent regarding the proposed replacement of your present policy. This is your right under the policy you have chosen.

The above "Notice to Applicant" was delivered to me on:

Applicant's Signature:

Date:

---

---

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-741-4340** (TTY: **711**).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-888-741-4340** (TTY: **711**).



MASSACHUSETTS

© Registered Marks of the Blue Cross and Blue Shield Association. © 2017 Blue Cross and Blue Shield of Massachusetts, Inc., and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.