III — Coverage Selection  Type of Dental Coverage Desired (Check a buy-up option if desired. You understand that any buy-up election may increase your premium.)

Preferred-Care Dental Base Plans  (Check one.)

☐ BlueDental 1000-Preventive (Type I)/Basic (Type II)
  Diagnostic and Preventive Services; Basic Restorative Services, Endodontics and Extractions
  (There is a 6 waiting period for Type II Services.)
  Deductible: $50 for Type II
  Coinsurance: 0% (Type I) / 20% (Type II)
  Calendar Year Maximum: $1,000
  OR  ☐ $1,200
  OR  ☐ $1,500

☐ BlueDental Plus 1000-Preventive (Type I)/Basic (Type II)/Major (Type III)
  Diagnostic and Preventive Services; Basic Restorative Services, Endodontics and Extractions; Major Restorative Services, Maintenance of Prosthodontics, and Periodontics
  (There is a 12 month waiting period for Type III Services.)
  Deductible: $50 (Type II) / $200 (Type III)
  Coinsurance: 0% (Type I) / 20% (Type II) / 50% (Type III)
  Calendar Year Maximum: $1,000
  OR  ☐ $1,200
  OR  ☐ $1,500

☐ Yes  ☐ No  Have you and/or any person applying for coverage been covered under a previous dental insurance plan? If yes, please provide the following information. Please note: Coverage must be in force for the past 6 months with no gap in coverage in order to waive any applicable waiting periods for Type 2 services. Name(s) of individuals covered: ____________________________
Carrier name(s): ____________________________  Policy ID number(s): ____________________________
Effective date(s): ____________________________  Termination date(s): ____________________________
**IV — Billing Information**

1. LAST NAME:  
   FIRST NAME:  
   MIDDLE INITIAL:

2. *HOME ADDRESS:  
   *CITY:  
   *STATE:  
   *COUNTY:  
   *ZIP CODE:

3. *BILLING ADDRESS (If different than above):  
   ☐ Billing Only  
   ☐ Billing and All Correspondence:  
   *CITY:  
   *STATE:  
   *COUNTY:  
   *ZIP CODE:

4. DAYTIME PHONE NUMBER:  
5. HOME PHONE NUMBER:  
6. E-MAIL ADDRESS:  
   Blue KC may use this e-mail address for:  
   ☐ Application notifications.

If you or your dependent currently have individual or group health coverage through Blue KC, please specify your certificate number (this information can be found on your Blue KC member I.D. card):  
__________________________________________________________________________________________

*(Please provide all member I.D. numbers)*

* Home address denotes applicant’s permanent legal address and must be completed. Alternate address should be selected if billing, I.D. cards, etc. should go to a different address than the applicant’s home address.

**V — Payment Option**

The membership premium is to be:  
☐ Automatically deducted (electronic funds transfer) from my checking account monthly;  
☐ Charged to my credit card;  
☐ Billed to my home every month;

**VI — Agreement**

I request coverage under the Preferred-Care Dental Contract issued by Blue Cross and Blue Shield of Kansas City (“Blue KC”). I understand services will be available subject to the exclusions, limitations and benefits described in the Contract. I understand that any misstatement on this enrollment application may result in a denial of a claim and/or discontinuation of coverage. I understand that if at any time it is determined by Blue KC that a person listed on this application did not meet the policy’s definition of dependent, or I misrepresented any of the information contained herein, Blue KC has the right to cancel or rescind coverage for the person or for all persons under the application, and to recover any benefit payments for such ineligible person(s). I understand no statement I make voids my coverage or reduces my benefits after my coverage has been in force for two (2) years from the effective date, unless my statements are material to the risk assumed and contained in my written application. I understand my dental records will be maintained with strict confidentiality by Blue KC in accordance with applicable federal and state laws. I understand that the Contract and other documents, notices and communications regarding my coverage may be transmitted electronically.

(Parent or guardian signature required for minors under the age of 18.)

APPLICANT’S (PARENT/GUARDIAN) SIGNATURE:  
PRINTED NAME:  
DATE:

SPOUSE’S SIGNATURE (IF ENROLLING):  
PRINTED NAME:  
DATE:

**VII — Agent Representation (if applicable)**

I represent that to the best of my knowledge all statements are complete and accurate.

AGENT USE ONLY:

BROKER SIGNATURE:  
DATE:

PRINTED NAME:  
TELEPHONE NUMBER:  
BLUE KC 6-DIGIT BROKER I.D. NUMBER:  
REQUIRED:
How would you like to eliminate the hassle of writing a check each month for your healthcare premium?

• With electronic funds transfer, your monthly premium is automatically deducted from your checking account.
• Your premium will be paid automatically, on time, each and every month.
• Your account will be drafted on the 1st of each month or next business day
  □ Please debit my account for one premium payment in the amount of $____________________
  □ Please debit my account automatically each month for the full premium amount due.

Just complete the section below and sign.

NOTE: You authorize Blue Cross and Blue Shield of Kansas City (Blue KC) to initiate recurring ACH/electronic debits to your account in the amount of your monthly premium on or around the first day of each month. Even if your premium amount changes in the future, this automatic draft will remain in effect until you notify Blue KC to cancel this authorization.

To cancel your electronic funds transfer authorization, your request must be received 15 days prior to your electronic funds transfer withdrawal date. Payment for additional products purchased by current members will default to your current payment option. Please note that the first month’s premium will be processed immediately.

NAME

SOCIAL SECURITY NO. - - -

NAME OF BANK

NAME ON ACCOUNT

ROUTING NUMBER (9-DIGIT NUMBER)

BANK ACCOUNT NUMBER

Yes. I want electronic funds transfer.

SIGNATURE

DATE / /

CREDIT OR DEBIT CARD AUTHORIZATION: We offer the convenience of paying by credit or debit card. Payment by credit or debit card can be accepted for a payment of one or more premiums; or with your signed authorization, we can automatically charge your credit or debit card for your full premium each month. To pay by credit or debit card, select one of the following options (all information must be complete for processing):

□ Please charge my credit or debit card for one premium payment in the amount of $____________________

□ Please charge my credit or debit card automatically each month for the full premium amount due. I understand that my credit or debit card will be charged each month on the 1st day of the month or next business day.

Choose only one: □ Visa □ Master Card □ American Express □ Discover

ACCOUNT NUMBER

CVV CODE

EXPIRATION DATE / /

CARDHOLDER NAME

BILLING STREET ADDRESS

SIGNATURE

DATE / /

CITY STATE ZIP CODE

NOTE: You authorize Blue Cross and Blue Shield of Kansas City (Blue KC) to initiate recurring ACH/electronic debits to your account in the amount of your monthly premium on or around the first day of each month. Even if your premium amount changes in the future, this automatic draft will remain in effect until you notify Blue KC to cancel this authorization.

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