Employee Dental Insurance Benefits Application

BlueCross BlueShield of Illinois

Homewood-Flossmoor Community High School District 233

Employee Information

Reason for Enrollment:

☐ New Hire ☐ Open Enrollment ☐ Special Enrollment (Qualifying Event Reason: _____)

☐ Termination

Effective Date _____

Name (Last) _____ (First) _____ (MI) _____

Mailing Address _____ Apt# _____

City _____ State _____ Zip _____

Home (or Cell) Number _____ Email _____

Social Security Number _____ Date of Birth _____ ☐ Male ☐ Female

Marital Status ☐ Married ☐ Single ☐ Civil Union ☐ Domestic Partner

Date of Hire _____ Hours/Week _____ Location _____

Job Title/Occupation _____

Dental Coverage — *BlueCross BlueShield of IL*

Effective date of hire (Unless Qualifying Event or Open Enrollment)

Employee:	**Spouse:**	**Children:**
☐ Elect ☐ Waive*	☐ Elect ☐ Waive	☐ Elect ☐ Waive

*I am waiving group dental coverage for the following reason(s): (check all that apply)

☐ Spouse Employer's Plan

☐ Cobra/State Continuation

☐ Individual Coverage (Non-Group Plan)

☐ Medicare or other Government Program

☐ Other (Please Explain): _____

For employee contribution amounts, please reference the document sent under separate cover.

Dependent Enrollment Information

NOTE: In order to enroll a dependent, you must provide a photocopy of documentation to establish your dependents' eligibility. (E.g. marriage certificate for a spouse, birth certificate for children.)
Dependents will not be enrolled until proper documentation is supplied.

SPOUSE/Name (Last) ______________________________ (First) ________________________ (MI) _____
☐ Male
Social Security Number ____________________________ Date of Birth ___________________ ☐ Female

Dependent/Name (Last) ___________________________ (First) ________________________ (MI) _____
☐ Male
Social Security Number ____________________________ Date of Birth ____________________ ☐ Female

Dependent/Name (Last) ___________________________ (First) ________________________ (MI) _____
☐ Male
Social Security Number ____________________________ Date of Birth ____________________ ☐ Female

Dependent/Name (Last) ___________________________ (First) ________________________ (MI) _____
☐ Male
Social Security Number ____________________________ Date of Birth ____________________ ☐ Female

Dependent/Name (Last) ___________________________ (First) ________________________ (MI) _____
☐ Male
Social Security Number ____________________________ Date of Birth ____________________ ☐ Female

Dependent/Name (Last) ___________________________ (First) ________________________ (MI) _____
☐ Male
Social Security Number ____________________________ Date of Birth ____________________ ☐ Female

Signature

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Blue Cross/Blue Shield of IL.

A copy of this form will be as valid as the original.

Employee Signature____ Date Signed ________________