



INSURERS OF IDAHO

Dental Application Coversheet

****Please note Dental Applications **must be accompanied with a payment** in order to be processed; please call with questions or concerns.**

Dear Applicant,

Thank you for choosing INSURERS OF IDAHO. We look forward to assisting you.

I would like confirmation that you have received my application.

- Please email me.
- Please call me.

I would like to be updated periodically on the applications status.

- Please update me by email.
- Please call me with updates.

Yes, please submit my application to multiple carriers.

Your Contact Information

Email:

Phone number:

Mail completed applications to:

Insurers of Idaho/ Applications
2965 E Tarpon Dr Ste 170
Meridian, ID 83642

**DENTAL BLUE® PPO
INDIVIDUAL ENROLLMENT APPLICATION**



Applicant Information *(Applicants age 65 and older are not eligible)*

| | | | | | |
|--|-----------------|---|--|--|------------|
| Your Name <i>(first, initial, last)</i> | | Date of Birth <i>(mm/dd/yy)</i> / / | Social Security Number / / | Business Phone | Home Phone |
| Mailing Address <i>(street or route)</i> | | City, State, Zip Code | | | County |
| Billing Address <i>(if different from mailing address)</i> | | City, State, Zip Code | | | County |
| Name of Employer | Your Occupation | Idaho resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how long? _____ | Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | <input type="checkbox"/> Male <input type="checkbox"/> Female | |

Program Information

Dental Blue 1000 (\$1,000 Benefit Period Max) *(six-month waiting period for basic care/12-month waiting period for major care)*
 Dental Blue 1500 (\$1,500 Benefit Period Max)
Requested Effective Date ____/____/____ *(Earliest effective date will be the 1st of the month following approval.)*

Other Coverage Information

Is any person listed on this application now covered or has he or she been covered by any kind of dental insurance? YES NO If YES:
 Name(s) of other dental insurance carrier(s) _____ Policy number(s) _____
 City/State _____
 Person(s) covered under the policy _____
 Is any person on the application covered by a medical health insurance policy? Applicant YES NO Family Member YES NO

Change Request

Change current enrollment because of:
 Marriage Divorce Birth Death Court Order *(copy required)* Other Date of event ____/____/____

Additional Family Member Information *(Family members age 65 and older are not eligible)*

List additional enrolling family members including any unmarried child who is under age 19; or who is under age 23 and a full-time student and financially dependent upon you; or who is medically certified as disabled and dependent upon you for support (copy of certification required).

| | | | | |
|--|---|--|-----|--|
| Family Member's Name <i>(first, initial, last)</i> | Relationship to Applicant <i>(spouse, child, stepchild, etc.)</i> | Date of Birth <i>(mm/dd/yy)</i> / / | Age | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Family Member's Name <i>(first, initial, last)</i> | | Date of Birth <i>(mm/dd/yy)</i> / / | Age | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Family Member's Name <i>(first, initial, last)</i> | | Date of Birth <i>(mm/dd/yy)</i> / / | Age | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Family Member's Name <i>(first, initial, last)</i> | | Date of Birth <i>(mm/dd/yy)</i> / / | Age | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Family Member's Name <i>(first, initial, last)</i> | | Date of Birth <i>(mm/dd/yy)</i> / / | Age | <input type="checkbox"/> Male <input type="checkbox"/> Female |

Parental or Guardian Consent to Application *(Only if applicant is under age 18)*

I represent that the person listed as the applicant on this application is under 18 years of age and is applying for Blue Cross of Idaho health coverage with my full knowledge and consent. I accept full responsibility for the payment of premiums and the information provided on this application.

| | | |
|-----------|------------|------|
| Signature | Print Name | Date |
|-----------|------------|------|

Independent Producer's Name David J. Watton **BCI** 6297BC

Office Use Only

| | | | | |
|-------------|-------------|------------------|------------|---------|
| Program No. | Enrollee ID | Effective Date | Class | Plan |
| Reason Code | Bill Mode | Payment Received | Receipt ID | Auditor |

Street Address: 3000 E. Pine Ave., Meridian, ID 83642-5995 • Mailing Address: P.O. Box 7408, Boise, ID 83707-1408 • (208) 345-4550

