



Please type or write clearly in black or blue ink

Section A: Employer Provided Information																									
Group Name:				1. Life Group #:			2. Dental Group #			3. Division #:															
Coverage Effective Date:				5. Date of Hire:			6. Occupation:			7. Class:															
Work Status: <input type="checkbox"/> Actively at Work <input type="checkbox"/> Cobra <input type="checkbox"/> Retired				9. Retirement Date:			10. Paid: <input type="checkbox"/> Hourly <input type="checkbox"/> Salary			11. Annual Salary: \$			12. Hours worked per week:		13. <input type="checkbox"/> Open Enrollment: (Dental Only)										
Section B: Employee Information (Refer to Section E. for Additional Employee Information)																									
Last Name:				15. First Name:			16. M.I.:		17. Gender: <input type="checkbox"/> M <input type="checkbox"/> F		18. Date of Birth (DOB):														
Address:				20. Apt.#:		21. City:		22. State:		23. Zip:		24. Social Security #:													
26. County:			27. Home Phone #:			28. Business Phone #:			29. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed																
Section C: Dental Coverage Selection																									
(If yes, select one of the Plans below.) Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage. Child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage. Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage. (If child selected, all children must be enrolled.)																									
Plan Type Requested: <input type="checkbox"/> BlueDental Choice (PPO) <input type="checkbox"/> BlueDental Choice Plus (PPO) <input type="checkbox"/> BlueDental Freedom (Indemnity) <input type="checkbox"/> BlueDental Choice Copayment (PPO) <input type="checkbox"/> BlueDental Care (Prepaid) <input type="checkbox"/> Other																									
Section D: Life and Disability Coverage Selection																									
(If yes, select coverages below.) Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage. Child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage. Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No, I decline Coverage. (If child selected, all children must be enrolled.)																									
Coverage Requested: <input type="checkbox"/> Basic Term Life \$ _____ <input type="checkbox"/> Accidental Death & Dismemberment (AD&D) \$ _____ <input type="checkbox"/> Dependent Life <input type="checkbox"/> Short Term Disability (STD) <input type="checkbox"/> Supplemental Life \$ _____ <input type="checkbox"/> Hospital Indemnity (Select Only One) <input type="checkbox"/> Emp/Spouse <input type="checkbox"/> Emp/Child(ren) <input type="checkbox"/> Emp/Family <input type="checkbox"/> Long Term Disability (LTD) <input type="checkbox"/> LTD Buy-Up																									
Voluntary Coverages: (If spouse Voluntary Life or AD&D is selected, spouse information must be provided in Section E.) Life: <input type="checkbox"/> Employee \$ _____ <input type="checkbox"/> Spouse \$ _____ <input type="checkbox"/> Child(ren) \$ _____ AD&D: <input type="checkbox"/> Employee \$ _____ <input type="checkbox"/> Spouse _____ <input type="checkbox"/> Child(ren) _____ <input type="checkbox"/> Voluntary Short Term Disability (VSTD) <input type="checkbox"/> Voluntary Long Term Disability (VLTD)																									
Your Group Life Beneficiary Information Attach separate sheet, if needed, with additional beneficiaries, sign and date. Total % must = 100%.																									
Primary Beneficiary:				DOB:			Relation to You:			% of Share:															
Secondary (Contingent) Beneficiary:				DOB:			Relation to You:			% of Share:															
Secondary (Contingent) Beneficiary:				DOB:			Relation to You:			% of Share:															
Section E: Employee and Dependent Information Attach separate sheet, if needed, sign and date #37 - #47 Check all that apply																									
35. First Name, M.I., Last Name (Please provide information in the corresponding numbered spaces below.)				37.		38. Marital Status		39.		40.		41.		42.		43.		44.		45.		46.		47.	
36. Social Security Number (Please provide in spaces below.)				Relation to You (DP = Domestic partner)		Married <input type="checkbox"/> Unmarried No Children <input type="checkbox"/>		Gender (M/F)		Date of Birth (mm/dd/yyyy)		Disabled <input type="checkbox"/>		Lives with You <input type="checkbox"/>		You Support Financially <input type="checkbox"/>		Student FT/PT <input type="checkbox"/>		BlueDental Care Facility ID #		Florida Resident <input type="checkbox"/>		Covered by Medicaid <input type="checkbox"/>	
Employee				<input type="checkbox"/> Spouse or <input type="checkbox"/> DP		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
35.				<input type="checkbox"/> Child or <input type="checkbox"/> DP Child		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
35.				<input type="checkbox"/> Child or <input type="checkbox"/> DP Child		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
35.				<input type="checkbox"/> Child or <input type="checkbox"/> DP Child		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Section F: Other Dental Insurance Information (This section must be completed for claims processing)																									
In addition to this policy, do you or your dependents have any other Dental insurance under a group plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete below.																									
Name of Person:				49. Group Name & #:				50. Policy #:																	
Insurance Co./Name and Address:																									



Section G: Acceptance of Coverage (Please read before signing)	Section H: Refusal of Any/All Coverage (Please read before signing)
I wish to apply for any coverage checked YES under Parts C and D above. I have read and understand the Acceptance of Coverage on the reverse side of this form. I certify the statements on this application, including any attachment to it, are true and complete to the best of my knowledge and belief. <i>(If you checked NO for any coverage under Parts C or D, sign and date Part H also.)</i>	I do not wish to apply for any coverage checked NO under Parts C and D above. I understand there may be additional requirements if I decide to apply at a later time.
Signature: _____ Date _____	Signature: _____ Date _____

FRAUD NOTICE: I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Section I: Acceptance of Coverage Authorization

I hereby apply for the coverage checked "Yes" on the front of this form. My employer has selected the coverage through Florida Combined Life Insurance Company, Inc. (FCL). I authorize my employer to deduct from my earnings my premium contribution (if any). I understand all of the following: 1. If my coverage is to be issued and continued, I must meet all the group contract's requirements; 2. if my dependents' coverage, if any, is to be issued and continued, my dependents must meet all the group contract's requirements; and (3) if I am not actively at work on my proposed coverage effective date, my effective date for certain coverages **may** be deferred until the date I return to active work.

I understand a dependent cannot be: (1) covered as both a dependent and an employee, including married employees of the same employer, (2) covered under more than one employee, or (3) full-time military.

I understand that my employer is not an agent of FCL. I also understand that my employer is responsible for notifying all employees of: 1. all effective dates; 2. all termination dates; 3. any Employee Retirement Income Security Act (ERISA) rights or responsibilities; and 4. all other matters pertaining to coverage under the group contract.

If an overpayment is made, I authorize FCL to recover the excess from any person or entity to which payment is made.

I acknowledge that, if I apply for FCL dental coverage later, coverage will not be available until the next open enrollment. I also understand if I apply later for coverages, other than dental, I **may** be required to furnish evidence of insurability.

I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I hereby certify that the statements on this application, including any attachment to it, are true and complete. I understand and agree that any misrepresentations, omissions, concealment of facts, or incorrect statements may result in denial of benefits and/or termination of coverage.

A photocopy of this application shall be as valid as the original. However, the original application is required to evaluate this application. I agree to be bound by the group contract's terms and conditions. I understand that this application is hereby made a part of the group contract. I will attach it to my certificate of coverage, when issued.



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Dental Benefits for Indian River County BOCC

Financial Features	BlueDental Choice Plus Voluntary Standard Option				BlueDental Choice Plus Voluntary High Option			
	In-Network		Out-of-Network		In-Network		Out-of-Network	
Deductible (Basic & Major Services Only)								
Per Person Per Plan Year	\$50		\$100		\$25		\$75	
Per Family Per Plan Year	\$150		\$300		\$75		\$225	
<i>In-Network deductible credits apply to Out-of-Network deductible and Out-of-Network deductible credits apply to In-Network deductible.</i>								
Coinsurance *	We Pay	You Pay	We Pay	You Pay	We Pay	You Pay	We Pay	You Pay
PREVENTIVE **	100%	0%	80%	20%	100%	0%	100%	0%
BASIC **	80%	20%	70%	30%	100%	0%	80%	20%
MAJOR **	50%	50%	40%	60%	60%	40%	50%	50%
Service Highlights								
Oral Evaluations (Exams)	Preventative				Preventative			
Bitewing X-ray	Preventative				Preventative			
Prophylaxis (Cleanings) – Adult/Child	Preventative				Preventative			
Fluoride Treatment (Child Only)	Preventative				Preventative			
Office Visits	Preventative				Preventative			
X-rays – Intraoral/Complete Series/Panoramic	Preventative				Preventative			
Sealants	Preventative				Preventative			
Amalgam Restorations (Silver Fillings)	Basic				Basic			
Resin-Based Restorations (Anterior and Posterior)	Basic				Basic			
Extractions	Basic				Basic			
Surgical Extractions	Basic				Basic			
Root Canal Therapy	Basic				Basic			
Periodontal Treatment	Basic				Basic			
Crowns	Major				Major			
Osseous Surgery	Major				Major			
Complete Dentures	Major				Major			
Partial Dentures	Major				Major			
Fixed Partial Dentures (Bridges)	Major				Major			
Surgical Placement of Implant Body: Endosteal Implant	Major				Major			
Implant Supported Porcelain Fused to Metal Crown (titanium, high noble metal)	Major				Major			
Orthodontia Services (children to age 19)	None				Child(ren) to age 19 only			
Orthodontia Lifetime Maximum					\$1,000			
BlueDental Pays					50%			
Benefit Waiting Period					None			
Waiting Period (Major Services)	None				None			
Calendar Year Maximum Per Person	\$1,000				\$1,500			
Procedures Performed By Specialist	Covered				Covered			
Dental Rollover	Yes				Yes			

The information provided above is a summary of benefits for the group Choice certificate. It is intended to highlight key points of the Dental Plan and is provided to the employee as an aid in deciding whether to enroll in the Plan. This summary should in no way be construed as a part of the contract. Possession of this summary in no way implies coverage nor does it guarantee benefits under the plan.

* Percentage of fee schedule

** Some limitations may apply

*** Based on 90th percentile of UCR; the majority of dentists' fees are within our allowed charges; however, you will be responsible for any fees in excess of allowed amounts.



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Florida Life and Health Insurance Guaranty Association

Limitations

- Any retreatment of root canals are payable one (1) year after completion date of root canal therapy.
- Restorations made of amalgam, silicate, acrylic, and composite materials to restore diseased teeth are only payable on the same tooth surface once every twelve (12) consecutive months.
- The gingivectomy or gingivoplasty per quadrant allowance will be paid when two or more teeth are billed on the same date of service, same quadrant.
- Sealants are limited to the first and second molars for primary teeth and the bicuspid and molars for the permanent teeth of dependent children.
- General anesthesia and intravenous sedation is payable only if given in connection with covered surgical procedures.
- Periodontal prophylaxis is limited to two (2) times per plan year. Periodontal prophylaxis will be considered as the same benefit and subject to the same limits as a routine prophylaxis. The total benefit for prophylaxis is limited to two (2) times per plan year.
- Periodontal services are limited to insureds age eighteen (18) and older.
- Services performed outside the United States, its territories and possessions are not covered, except for palliative emergency treatment.
- Multiple amalgam or composite restorations on one surface will be considered one restoration. The allowance includes insulating base and local anesthesia.

Exclusions

The following are excluded under this plan:

- Coverage for installation of an initial prosthodontic appliance that replaces any teeth missing prior to an insured's effective date of coverage, (until the insured has been covered under the contract for twelve [12] consecutive months), unless otherwise specified.
- Services or supplies which are not medically necessary according to accepted standards of dental practice, as determined by our consulting dentists, or which are not recommended or approved by the attending dentist.
- Charges for services or supplies when billed by other than a dentist.
- Benefits for services rendered by a member of an employee's family, (his spouse and the children, brothers, sisters and parents of either the employee or his spouse).
- Services rendered primarily for cosmetic purposes.
- Charges incurred for failure to keep a dental appointment.
- Services rendered through a medical department, clinic or similar facility provided or maintained by, or on the behalf of, an employer, mutual benefit association, labor union, trustee or similar persons or groups.
- Medical services related to the treatment of temporomandibular joint (TMJ) (temporal bone—lower jaw) dysfunctions (craniomandibular disorders, craniofacial disorders).
- Experimental or investigational treatment.
- Dental services received or rendered:
 - through or in a veteran's hospital or government facility due to a service connected disability
 - which are covered and paid under Worker's Compensation or similar law
 - which are coordinated with another insurance policy providing dental benefits for the same charges, to the extent that the total amount payable under both plans exceeds 100% of the total expenses that are incurred
- Services for which the insured incurs no charge.
- Procedures, appliances, or restorations necessary to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, restoration of tooth structure lost from attrition and restoration for malalignment of teeth.
- Local anesthesia when billed separately by a dentist.
- Any services paid or payable under the insured's health insurance contract.
- Services not listed in the Benefits section of this plan.
- Charges for a more expensive service, procedure, or course of treatment than is customarily provided by the dental profession, consistent with sound professional standards of dental practice for the dental condition concerned. Payment for such charges under this certificate will be based on the allowance for the least costly service, procedure, or course of treatment.
- Any additional treatment required due to the insured's failure to follow instructions, or lack of cooperation with the dentist.
- Treatment for any illness, injury, or medical conditions arising out of: war or act of war (whether declared or undeclared), participation in a felony, riot or insurrection, service in the armed forces or auxiliary units, and attempted suicide or intentionally self-inflicted injury, whether sane or insane.
- Services rendered before the effective date of coverage.
- Services rendered after termination of coverage, except as provided under the plan's "Extension of Benefits upon Contract Termination."
- Charges for services or supplies for sterilization. Charges for sterilization are included in the allowance for other covered dental procedures.
- Any denture or bridge replacement made necessary by reason of loss, theft, or alteration by an insured.
- Services in connection with any crown, inlay or onlay restoration, or for any denture or bridge if treatment began prior to the insured's coverage under this certificate.
- Duplicate or temporary denture, crown, or bridge.
- Labial veneer restorations.
- General anesthesia and intravenous sedation administered exclusively for patient management or comfort.
- Charges for nitrous oxide.
- Services with respect to congenital (hereditary) or developmental malformations or cosmetic reasons, including but not limited to cleft palate, maxillary or mandibular (upper or lower) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- Prescribed drugs, premedication or analgesia.
- Extra oral grafts (grafting of tissues from outside the mouth to oral tissues).
- Charges for oral hygiene, plaque control, or diet instruction.
- Charges for orthodontia services, unless shown on the Group Dental Benefit Summary page



Florida Combined Life 2011/2012 Dental Rate Sheet

Florida Combined Life · Customer Service: (877) 203-9921 · Website: www.bcbsfl.com

BlueDental Choice Plus Plan

Indian River County Board of County Commissioners

LOW OPTION PLAN	Tier of Coverage	Employee Cost
Monthly Premiums	Employee Only	\$27.02
	Employee + Spouse	\$62.39
	Employee + Child(ren)	\$56.71
	Employee + Family	\$92.09

HIGH OPTION PLAN	Tier of Coverage	Employee Cost
Monthly Premiums	Employee Only	\$37.35
	Employee + Spouse	\$87.68
	Employee + Child(ren)	\$91.63
	Employee + Family	\$141.99

