



# RIT Student Dental

P.O. Box 22999, Rochester, NY 14692  
A nonprofit independent licensee of the BlueCross BlueShield Association

**Instructions on Back. All Dates = mm/dd/yy**     Check if name change     Check if new address    **Please print clearly.**

✓ CHECK DESIRED ACTION	✓ CHECK DESIRED COVERAGE	✓ CHECK PERSON(S) COVERED			
<input type="checkbox"/> Add Subscriber (AA) Fall Quarter Event Date 9/5/11 Coverage Eff Date 9/5/11	<input checked="" type="checkbox"/> <b>Dental (DE)</b>	Self, Spouse & Child(ren) (A)	Self & Child(ren) (B)	Self & Spouse (C)	Self (D)
<input type="checkbox"/> Add Subscriber (AA) Winter Quarter Event Date 11/28/11 Coverage Eff Date 11/28/11		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Add Subscriber (AA) Spring Quarter Event Date 3/12/12 Coverage Eff Date 3/12/12					
<input type="checkbox"/> Add Subscriber (AA) Summer Quarter Event Date 6/4/12 Coverage Eff Date 6/4/12		Open enrollment in RIT's Student Dental Plan occurs during the first 30 days of each quarter. Please mark the box that you wish coverage to start. If the open enrollment period has already closed for the quarter you have indicated, your coverage will begin on the next available quarter start date.			

**SUBSCRIBER INFORMATION - Must be completed**

Social Security # \_\_\_\_\_ Sex:  M  F Birthdate \_\_\_ / \_\_\_ / \_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Day Phone: [ ] [ ] [ ] - [ ] [ ] [ ] - [ ] [ ] [ ] E-Mail Address: \_\_\_\_\_

**MEDICARE HEALTH INSURANCE CLAIM #**

**FAMILY MEMBER INFORMATION** ✓ Check relationship and complete information.

<input type="checkbox"/> (S)pouse <input type="checkbox"/> (D)ependent <input type="checkbox"/> Student(T) <input type="checkbox"/> (H)disabled <input type="checkbox"/> Other _____ Last Name (if different) _____ First Name _____	Social Security # _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (mm/dd/yy) ___ / ___ / ___
<input type="checkbox"/> (S)pouse <input type="checkbox"/> (D)ependent <input type="checkbox"/> Student(T) <input type="checkbox"/> (H)disabled <input type="checkbox"/> Other _____ Last Name (if different) _____ First Name _____	Social Security # _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (mm/dd/yy) ___ / ___ / ___
<input type="checkbox"/> (S)pouse <input type="checkbox"/> (D)ependent <input type="checkbox"/> Student(T) <input type="checkbox"/> (H)disabled <input type="checkbox"/> Other _____ Last Name (if different) _____ First Name _____	Social Security # _____	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birthdate (mm/dd/yy) ___ / ___ / ___

**OTHER COVERAGE INFORMATION - Must be completed. You may be contacted for additional information.**

**In addition, please provide a copy of your "Certificate of Coverage" from your former health insurance carrier or employer.**

**Have you or any member of your family been enrolled in any other insurance policy in the last 63 days (including Dental, Medicare or Medicaid)?**

Yes     No    ✓ Check:  Medical and/or  Dental    Are you keeping this coverage?     Yes     No

✓ Check previous insurance company from list below and indicate ID #: \_\_\_\_\_

(B) Excellus BlueCross BlueShield, Rochester Region, Blue Choice.

(O) Other - BlueCross BlueShield Plan (outside of Rochester). Indicate Plan Name: \_\_\_\_\_

(C) Other Carrier - Indicate Plan Name: \_\_\_\_\_

**RELEASE - You must sign and date this form to be eligible for insurance.**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation. I have thoroughly read, understand and agree to comply with the terms of the Release on the back.

Subscriber Signature \_\_\_\_\_ Date \_\_\_\_\_

Coverage	Group/Sub Group #	Chk digit	Pkg #	Student Status
Dental	13442-501			✓ (A) Active
Rochester Institute of Technology 13 Lomb Memorial Dr., Rochester, NY 14623 (585) 475-6131				

Group Rep Signature/Date \_\_\_\_\_

## Instructions for completing the Enrollment Form

### Cancel Request

To process a Subscriber or other Member Cancellation, please use the **Membership Cancellation Worksheet**

### FAMILY MEMBER INFORMATION QUALIFIED GUIDELINES:

Use an additional form, if more than three persons.

- A legal spouse (an ex-spouse is not a qualified member as of the divorce date)
- Must be under the dependent age for your group
  - Unmarried child, natural, adopted or stepchild
  - A full time student (indicate under Relationship)
  - Chiefly dependent on you for support
- **Other: Please contact Customer Service for the appropriate form. These dependents have additional eligibility requirements.**  
Dependents pending adoption, grandchild or foster dependents, foreign exchange students, dependents for whom employee/subscriber has legal custody or legal guardianship, or a dependent who is claimed on subscriber's current federal income tax return, or a handicapped dependent who is over the dependent age for your group.

### RELEASE

- I acknowledge and agree that by signing this enrollment form and subsequently accepting services, I and everyone else who is covered under the contract or certificate you issue is bound by the terms and conditions of the contract or certificate applicable to my coverage. This includes, without limitation, the terms and conditions regarding the receipt and release of medical records and information. I make this acknowledgement and agreement on behalf of myself and each other person who now or in the future accept coverage under the terms of the contract applicable to my coverage (who may include, for example, my spouse and my eligible family dependents).
- I hereby accept responsibility for payment of any portion of the premium.
- I understand that any claim by me or one of my eligible family members may be denied and my coverage canceled upon one month's written notice, if I have knowingly included false information.

**If you have any questions, please contact Customer Service at:  
Excellus BlueCross BlueShield, Rochester Region 1-800-724-1674  
TTY: 585-454-2845 or 1-877-398-2282**