MASSACHUSETTS

Dental Blue® 65

APPLICATION FOR DENTAL BLUE 65

DIRECTIONS

- Please print clearly.
- Carefully read and answer all questions. Incomplete applications won't be accepted. Keep one copy of the application for yourself.
- Don't send money with this application. You'll receive a bill when payment is due. You'll also receive an invitation to sign up for our eBill option.
- **Please complete and return to:**
  Blue Cross Blue Shield of Massachusetts
  Enrollment Department
  P.O. Box 55011
  Boston, MA 02205
- Or, fax the application to **1-617-246-8506.**
- To enroll by phone, call **1-800-678-2265**.

You're eligible to apply for a Dental Blue 65 plan if you meet all of the following requirements:

- You're a resident of Massachusetts and you actually live in Massachusetts
- You're age 65 or older

Questions?

- The dental premium rate and benefits are explained in the Outline of Coverage you received with this application. If you need more information or assistance, call us at **1-800-678-2265**.
- For all other questions, call Dental Blue 65 Member Service at **1-888-741-4340** (TTY: **711**).

Individuals experiencing homelessness

- If you want to join a plan but have no permanent residence, a Post Office Box, an address of a shelter or clinic, or the address where you receive mail (e.g., social security checks) may be considered your permanent residence address.

Please answer all questions.

I am applying for:

☐ Dental Blue® 65 Preventive ($24.32/month) ☐ Dental Blue® 65 Basic ($38.85/month) ☐ Dental Blue® 65 Premier ($72.56/month)

Your Social Security Number:*

_____ - _____ - _____

How often would you like to be billed?

☐ Monthly ☐ Quarterly

Would you like your premium payment due on the 1st of the month or the 15th of the month?

☐ 1st of the month ☐ 15th of the month

First Name: Last Name: Middle Initial:

Your gender:

☐ Male ☐ Female ☐ Non-Binary

Your complete date of birth:

(___ ___ _____)

MM DD YYYY

Your telephone number:

( ) –

Your permanent home address:

Number and Street

City: State: ZIP Code:

If you want your Dental Blue 65 bill sent to an address other than your home address, complete the following section.

Your billing address only:

Number and Street

City: State: ZIP Code:

Your email address (Optional):

By providing your email, you are opting in to receiving your plan materials digitally. You can opt out at any time.

Are you currently a Blue Cross Blue Shield of Massachusetts member? ☐ Yes ☐ No

If yes, provide your Blue Cross Blue Shield identification number:

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me into a dental plan membership. I understand that I should read the subscriber certificate to understand my benefits and any restrictions that apply to my health care plan. I understand that Blue Cross and Blue Shield may obtain personal and medical information about me to carry out its business, and that it may use and disclose that information in accordance with law. I acknowledge that I may obtain further information about the collection, use, and disclosure of my information in "Our Commitment to Confidentiality," Blue Cross and Blue Shield's notice of privacy practices.

Applicant's Signature: Date:

Will this policy replace an active dental insurance policy? ☐ Yes ☐ No

If yes, please complete the "Notice to Applicant" form and include it with this application.

Please also indicate below if the policy will replace an existing policy with continuous, uninterrupted coverage for:

☐ 6 months of Basic Restorative benefits ☐ 12 months of Major Restorative benefits

* Under the Affordable Care Act, we're required to collect your Social Security Number when you enroll in one of our plans.

NOTICE TO APPLICANT

If you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Blue Cross Blue Shield of Massachusetts, you must sign and return this form with your application. For your own information and protection, certain facts should be pointed out to you, which could affect your rights to coverage under the new policy.

Health conditions, which you may presently have, may not be covered under the new policy. This could result in a claim for benefits being denied that have been payable under your present policy.

Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.

Questions in the application for the new policy must be answered truthfully and completely; otherwise, the validity of the policy and the payment of any benefits thereunder may be voided.

It may be to your advantage to secure the advice of your present carrier or its agent regarding the proposed replacement of your present policy. This is your right under the policy you have chosen.

Applicant's Signature: Date:

FOR MORE INFORMATION OR HELP WITH ENROLLMENT

Call **1-800-678-2265** (TTY: **711**),
Monday through Friday, 8:00 a.m. to 5:00 p.m. ET
bluecrossma.com/medicare

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-678-2265** (TTY: **711**).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-678-2265** (TTY: **711**).

001636247

55-0167-23 (9/22)