MASSACHUSETTS

Dental Blue® Healthy Supplement Enrollment Form

For Service Benefit Plan Enrollees Only

To enroll in Dental Blue Healthy Supplement, you must reside in Massachusetts.

Are you a new Service Benefit Plan subscriber for 2012? ☐ Yes ☐ No

If you are a new Service Benefit Plan subscriber for 2012, please include a copy of your SF 2809 form, if available.

Enrollee Information

Last Name	First Name	Initial	Date of Birth	Social Security Number
Street Address		City	State	Zip Code
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FEP ID Number	Enrollment Code	Employing Agency		
Work Phone Number		Home Phone Number		

Select Coverage

Please note: You **must** select the same type of enrollment that you currently have in the Service Benefit Plan.

Check one:
☐ Self Only
☐ Self + One
☐ Family (3+)

List your spouse and/or dependent children below. Dependents are covered up to age 26. Only the dependents enrolled under your Service Benefit Plan coverage are eligible to enroll in Dental Blue Healthy Supplement.

First Name	Initial	Date of Birth	Social Security Number	Sex (M/F)	Last Name (if different)	Relationship

If you need to list more dependents, please attach an additional sheet.

Please read and complete reverse side.

Enrollment Period

As long as you remain eligible for enrollment in Dental Blue Healthy Supplement, your enrollment period is the entire calendar year. Dental Blue Healthy Supplement benefits are based on year-long premiums. (For federal employees hired during the calendar year, the enrollment period and total premium liability are determined based on the effective date of enrollment.) **If you cancel your Dental Blue Healthy Supplement coverage during the year by ceasing to pay premiums or by requesting a mid-year cancellation, you will not be able to re-enroll during the next three Open Seasons.**

Mail This Form

Mail the completed form to:

Blue Cross Blue Shield of Massachusetts
Dental Blue Healthy Supplement
Enrollment Department
P.O. Box 55380
Boston, MA 02205-8338

Payment Information

Blue Cross and Blue Shield of Massachusetts, Inc., is authorized to bill me monthly for the premiums for Dental Blue Healthy Supplement.

Please check:

❑ Please bill me monthly, in advance, for my dental premiums.

Signature Date

I Understand . . .

These benefits are neither offered nor guaranteed under the FEHBP/FEDVIP, but are made available to all enrollees and dependents who are members of the Service Benefit Plan and live in the service area of Blue Cross and Blue Shield of Massachusetts, Inc. The cost of these benefits is not included in the FEHBP/FEDVIP premium, and charges for these services do not count toward any FEHBP deductibles or catastrophic protection benefits. These benefits are not subject to the FEHBP/FEDVIP disputed claims procedures.

I acknowledge and agree:

- that coverage shall become effective only after this application is approved by the Plan and shall be only as stated in the contract issued by the Plan; and
- that any health care provider having information or records pertaining to me or any covered family member is authorized and directed to furnish such information or records at the Plan's request; and
- that each response in this application has been entered by me or at my direction and may be used by the Plan to determine eligibility of me and any family member for this coverage and that, if I have misstated or omitted any material information, the Plan may declare such coverage null and void from its issuance; and
- that I will pay premiums as stated in the brochure.

Signature Date