HIGHMARK. | Blue Edge Dental

BLUE EDGE DENTAL
APPLICATION FOR INDIVIDUAL DENTAL INSURANCE

POLICYHOLDER'S INFORMATION

Requested Effective Date | **Social Security Number**

Policyholder's Name *(Last)* *(First)* *(Middle Initial)* *(Suffix)* ❑ Male ❑ Female

Phone Number ( ) ❑ Home ❑ Work ❑ Other | **Date of Birth**

Home Address **City** **State** **Zip Code**

DEPENDENT INFORMATION

Last Name / First Name / Middle Initial	Social Security Number	Birth Date Month	Day	Year	Gender	Disabled
Spouse					❑ Male ❑ Female	
Dependent (A)					❑ Male ❑ Female	❑ Yes ❑ No
Dependent (B)					❑ Male ❑ Female	❑ Yes ❑ No
Dependent (C)					❑ Male ❑ Female	❑ Yes ❑ No
Dependent (D)					❑ Male ❑ Female	❑ Yes ❑ No

GENERAL INFORMATION

My Individual Dental Insurance will be covering: ❑ Self ❑ Two Person ❑ Family

Plan Selection: ❑ Premier ❑ High ❑ Value ❑ Basic

Monthly premium payment: $ _____

READ AND SIGN BELOW

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 subjects such person to criminal and civil penalties.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Highmark's Notice of Privacy Practices is available on Highmark's Web site, or from the Highmark Privacy Office.

Applicant's Signature **Date**

PAYMENT INFORMATION

Payment Enclosed $	Group Number 034000-00	Company Code 13	Applicant's Social Security Number

Mail to Highmark Health Insurance Company, P.O. Box 382061, Pittsburgh, PA 15251-8061

PRODUCER USE ONLY

PRODUCER'S CERTIFICATE

Attention Producer:

If you have questions concerning the completion of this application, please call the Producer Line at 1-866-602-1248.

If this section is not fully completed, commission will not be paid.

HHIC Agency No. 5 5 5 4 4

HHIC Producer No. 0 0 4 8 3

Agency Name Robert T. Nelson Insurance Agency

Producer's Name Nelson (LAST) Robert (FIRST) T (MI)

Producer's Signature Robert T. NELSON

Business Phone (724) 266-0301
(Area Code)

Mail to Highmark Health Insurance Company, P.O. Box 382061, Pittsburgh, PA 15251-8061 or to our agency for processing.