BlueCross BlueShield of Georgia

Dental Membership Maintenance Form

Blue Cross and Blue Shield of Georgia
Dental Enrollment Department
PO Box 1193
Minneapolis MN 55440-1193

INSTRUCTIONS PROVIDED ON BACK

PART A – EMPLOYEE INFORMATION

Employee's Name:	Last	First	Middle Initial				**Social Security Number** / /
Gender:	Male ☐	Female ☐	**Marital Status:**	Single ☐	Married ☐	Widowed ☐	Divorced ☐	Legally Separated ☐	**Date of Birth (Month-Day-Year)** / /
Employee's Address: ☐ **Check If New Address**	Address					Home Phone Number	Work Phone Number
	City			State	Zip Code		

PART B – CHANGE REQUEST **- Check All Categories That Apply – Provide Information Requested By Category**

☐ **Name Change**
Former Name:_____
New Name: _____

☐ **Terminate Employee and All Dependent Coverage**
Date of Termination: _____/_____/_____
Date Coverage Ends: _____/_____/_____

☐ **Change Employee Group/Subgroup** (Move individual to different group/subgroup number, including COBRA subgroup)
From:_____ To:_____
Effective Date of Change: _____/_____/_____

☐ **Change Plan Option at Open Enrollment** (Applies only if Group offers multiple Plan Options)
I elect to participate in the following Plan:
☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D

☐ **Change Coverage Type Due to Qualifying Event –** List Qualifying Event Code next to correct Coverage Type and complete Part C if Adding or Dropping Dependents **Qualifying Event Code**: **A** – Adoption **B** – Birth **D** – Divorce/Legal Separation **E** – Death **L** – Loss of Coverage **M** – Marriage **O –** Group Open Enrollment **S –** Dependent No Longer Eligible

Qualifying Event Code	Coverage Type Change Request Category	Date of Qualifying Event	Effective Date of Change
	Employee Only	/ /	/ /
	Employee & Spouse	/ /	/ /
	Employee & Dependent Child(ren)	/ /	/ /
	Family	/ /	/ /

PART C – DEPENDENT INFORMATION – **Adding or Dropping Dependents May Require a Coverage Type Change in Part B**

Add	Drop	Relationship To Employee	First Name, Middle Initial, Last Name (Include Last Name Only if Different From Employee's)	Gender		Date of Birth Month/Day/Year	Full Time Student?		Unmarried?	
☐	☐	Spouse		☐M	☐F	/ /				
☐	☐	Dependent Child		☐M	☐F	/ /	☐Y	☐N	☐Y	☐N
☐	☐	Dependent Child		☐M	☐F	/ /	☐Y	☐N	☐Y	☐N
☐	☐	Dependent Child		☐M	☐F	/ /	☐Y	☐N	☐Y	☐N

PART D – COBRA – **Employee Note:** Complete **Only** if enrolling for COBRA benefits and may require subgroup change

Qualifying Event Number:
1 Employee Termination or Reduction of Work Hours
2 Employee Death
3 Employee Total Disability
4 Divorce or Legal Separation
5 Employee Eligible For Medicare
6 Dependent No Longer Eligible

Coverage Continuation Applies To:	Event Number	Date of Qualifying Event	Social Security Number
☐ Employee & All Dependents Currently Enrolled		/ /	
☐ Employee Only		/ /	
☐ Spouse Only		/ /	- -
☐ Dependent(s) Only – List Names in Part C		/ /	- -
☐ Employee & Spouse		/ /	
☐ Employee & Dependent Child(ren)–List Names in Part C		/ /	

PART E – GROUP INFORMATION - THIS PART TO BE COMPLETED BY EMPLOYER

Group Name:	**Group & Subgroup Numbers**: --
Group Representative's Signature:	**Date:** **Phone Number:** ( )

Print&Submit **Reset**

Instructions for Completion of Membership Maintenance Form

Important Information:

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 purposes of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Important Notes:

- Type or print clearly with a pen.
- All dates should be written in MM/DD/YYYY format.
- When reporting effective dates, use contractual start and stop guidelines as defined in your contract (i.e., first of the month, end of month, or actual dates).
- Before submitting, review it to ensure you have provided all necessary information.
- If information is missing or illegible, this form will be returned to you and may delay your enrollment.
- Enrollment requests are generally completed within five business days of receipt by Blue Cross and Blue Shield of Georgia Dental.

PART A: EMPLOYEE INFORMATION – Complete all sections.

PART B: CHANGE REQUEST – Check one or more categories that apply and provide information as requested by category.

- **Name Change** – Provide name as previously reported and new name.
- **Terminate Employee and All Dependents** – Only use this section if the employee and all dependent coverage is being terminated.
- **Change Employee Group/Subgroup** – Move employee from one group/subgroup number to another for benefit, reporting or COBRA purposes.
- **Change Plan Option –** Applies only to employer groups that offer more than one Plan Option and have Open Enrollment. An employee may select a new Plan Option during the Group's Open Enrollment.
- **Coverage Type Change** – Complete this section to change *Coverage Type* and to add or drop dependent coverage. *Coverage Type* change requires a qualifying event (i.e., marriage, divorce, etc.) List Qualifying Event Code on line next to correct Coverage Type. Provide detailed information for each dependent being added or dropped in Part C.

PART C: DEPENDENT INFORMATION

- List dependents to be added or dropped when making a change to *Coverage Type* in Part B.
- Complete all sections for each dependent.
- If more than four dependents are being reported, attach a list of additional dependent information in same format.

PART D: COBRA – Complete this section only if an individual has selected continuation of coverage under COBRA.

- Select a *Coverage Type*, the appropriate *Qualifying Event Number, and Date of Qualifying Event* and *Effective Date of Coverage.*
- If employee is not enrolling for COBRA, provide Social Security Number of individual who is being enrolled.
- If group has a separate COBRA subgroup, it must be provided in Part B.

PART E: GROUP INFORMATION – Completed By Employer

- **Group Name** – Provide group name as listed in your contract.
- **Group and Subgroup Number** – Provide applicable numbers for individual employee.
- **Group Representative** – Sign, date, and provide your phone number.

Send Completed Form To:

Blue Cross and Blue Shield of Georgia Dental
Attn: Dental Enrollment Department
PO Box 1193
Minneapolis MN 55440-1193