South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

APPLICATION FOR BLUE DENTAL℠

Application is hereby made for group dental insurance for the Eligible Employees or Members of the Applicant.

Name of Applicant: _____
(Company correct legal name)

Address of Applicant: _____
(Physical)

_____

Classification of Eligible Employees: All full-time, active Employees working at least 30 hours a week, performing the normal duties of the job at one of the Employer's normal places of business or at a location to which the Employee must travel to perform the job. An Employee is considered Actively-at-work if he or she has begun working and is not absent from work due to a leave of absence or temporary layoff. The Employee remains eligible to enroll, and coverage will begin, if the absence is due to a Health Status-related Factor, such as the Employee's health status or medical condition (including both physical and mental illness).If the Employee does not meet this requirement, coverage will begin on the first day of the next Contract Month that the requirement is met.

Effective Date: The date the coverage goes into effect.

Enrollment Date: The date of enrollment in this plan or the first day of the Waiting Period for the enrollment, whichever is earlier.

Special Enrollment: A qualified Employee or Employee's Dependent may enroll only during an initial or annual Open Enrollment Period, unless the Employee or Dependent qualifies for a Special Enrollment Period. An Employee or Dependent will have 31 days to enroll in this coverage as a result of the following events:

1. Loss of other qualifying dental coverage;
2. A change in household size, due to marriage, divorce, the birth or adoption of a child or taking custody of a foster child;
3. Some other qualifying change.

If the Employee is eligible under the plan but is not enrolled, and he or she marries, the Employee and the new spouse may enroll in the plan if enrollment is requested within 31 days of the marriage.

If the Employee is eligible under the plan but not enrolled and the Employee or Employee's spouse has a child, adopts a child or a child is placed with the Employee or Employee's spouse for adoption, the new Dependent(s) may receive coverage under the plan. At the time of birth, adoption or placement for adoption, the Employee and Employee's spouse may also receive coverage.

PARTICIPATION REQUIREMENTS:

Preferred Plans (minimum requirements):

_____ 10 or more Eligible Employees Enrolled
50% or more of Eligible Employees
Contribution of 50% or more toward each Eligible Employee's single premium.

Standard Plans:

_____ 5 or more Eligible Employees Enrolled
Contribution of 30% or more toward each Eligible Employee's single premium.

Participation: Eligible Employees_____ Enrolled Employees _____

Employer Contribution: _____%

When the Employer contributes 100% of the premiums then all persons covered by this contribution are insured on their initial eligibility date regardless of when the application is received.

DENTAL PRODUCT OPTIONS:

Blue Dental 1 _____Open Access _____Select (PPO)
Available only on Preferred Plans

Blue Dental 2 _____Open Access _____Select (PPO)

Blue Dental 3 _____Open Access _____Select (PPO)

Orthodontics _____
Optional benefit and only available to Preferred Plans

Waiting Period for new employees (*1st of the month following full time date of hire):

_____30 Days* _____ 60 days* _____ 90 days Exact

There is a twelve-month waiting period from the Member's Effective Date of coverage for Major Restorative Care. The Corporation will waive any part of the twelve-month waiting period that Members have already met under a previous Group Dental Plan if that plan has been in effect for at least twelve months and there has not been more than a 63-day break in coverage.

Upon approval, the Effective Date of Contract under this application shall be 12:01 a.m., standard time on the ____ day of _____, _____, at the address indicated above and such coverage will continue until terminated in accordance with the provisions of the Contract between the Applicant and Blue Cross and Blue Shield of South Carolina.

It is understood and agreed that the Applicant will pay Blue Cross and Blue Shield of South Carolina, in advance, the premiums specified in Schedule A of the Master Contract on behalf of the Applicant's Employees who meet the eligibility requirements as specified in this application and that this application when received by the Applicant, shall form a part of the Contract between Blue Cross and Blue Shield of South Carolina and the Applicant. Coverage is not effective unless and until approved in writing by the Underwriting department at Blue Cross and Blue Shield of South Carolina's home office. The Applicant further understands and agrees that the premiums for the group policy must be paid by the policyholder from policyholder's funds or from funds contributed by the insured persons, or from both.

The Applicant hereby expressly acknowledges its understanding that this application constitutes a Contract solely between the Applicant and the Corporation. The Corporation is an independent corporation operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans. The “Association” permits the Corporation to use the Blue Cross and Blue Shield service marks in the State of South Carolina, and that the Corporation is not contracting as the agent of the Association.

The Applicant further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than the Corporation and that no person, entity or organization other than the Corporation shall be held accountable or liable to the Applicant for any of the Corporation's obligations to the Applicant created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of the Corporation other than those obligations created under other provisions of this Contract.

Dated at (City) _____, South Carolina, this _____day of _____, _____

_____	BLUE CROSS AND BLUE SHIELD
Name of Applicant (Company Name)	OF SOUTH CAROLINA
By: _____	By: _____
(Authorized Signature)	(Authorized Signature)

Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you're assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice.

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance online at contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在協助的對象，有關於本健康計畫方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đở với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-389-4838 (Vietnamese)

이 건보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187 로 연락주십시오. 귀하의 비용 부담없이 한국어로 도와드립니다. PC 명조 (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839 . (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص خطة الصحة هذه، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة.للتحدث مع مترجم اتصل ب 1-844-396-0189 (Arabic)

Si ou menm oswa yon moun w ap ede gen kesyon konsènan plan sante sa a, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de ce plan médical, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-396-0190 . (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなた、またはあなたがお世話をされている方が、この健康保険 についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

اگر شما یا فردی که به او کمک می کنید سؤالاتی در باره‌ی این برنامه‌ی بهداشتی داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با مترجم، لطفاً با شماره‌ی 1-844-398-6233 تماس حاصل نمایید. (Persian-Farsi)
