

Use for the following counties: Allegany, Chautauqua, Cattaraugus, Erie, Genesee, Niagara, Orleans, and Wyoming counties

**POLICYHOLDER'S INFORMATION**

Requested Effective Date				Social Security Number				
Policyholder's Name (Last)		(First)		(Middle Initial)		(Suffix)		<input type="checkbox"/> Male
								<input type="checkbox"/> Female
Phone Number ( )		<input type="checkbox"/> Home	<input type="checkbox"/> Work	<input type="checkbox"/> Cell	Date of Birth	Email		
Home Address				City		State		Zip Code

**DEPENDENT INFORMATION**

Last Name / First Name / Middle Initial	Social Security Number	Birth Date			Gender	Dis-abled
		Month	Day	Year		
Spouse					<input type="checkbox"/> Male <input type="checkbox"/> Female	
Dependent (A)					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent (B)					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent (C)					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent (D)					<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No

**GENERAL INFORMATION**

My Individual Dental Insurance will be covering:

Self       Self and Children       Self and Spouse/Domestic Partner       Family

Plan Selection:

Premier       Value

Monthly premium payment: \$ \_\_\_\_\_

**READ AND SIGN BELOW**

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 Blue Cross Blue Shield of Western New York 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 BCBSWNY's Notice of Privacy Practices is available on Highmark BCBSWNY's website, or from the Highmark BCBSWNY Privacy Office.

**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 SHALL ALSO BE SUBJECT TO CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.**

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**PAYMENT INFORMATION**

Payment Enclosed \$	Group Number	Company Code 66	Applicant's Social Security Number
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Mail to Highmark Blue Cross Blue Shield of Western New York, P.O. Box 640728, Pittsburgh, PA 15264-0728

**Only producers need to bother with this next section.  
If you aren't a producer, you do not need to fill this page out.**

## Producers Certificate

If this section is not fully completed, we will not pay a commission.

NATIONAL PRODUCER NUMBER (NPN)

**08623799**

AGENCY NAME

**Small Business Services of WNY LLC**

PRODUCER'S NAME (LAST, FIRST, MIDDLE INITIAL)

PRODUCER'S SIGNATURE

BUSINESS PHONE NUMBER

( **716** ) **632-6905**

### A PRODUCER must complete this section to act on the applicant's behalf.

- 1.** Consider how the applicant answered your questions. Do you know of any factors impacting the applicant's eligibility? What about his/her dependents applying for this coverage?

Yes  No

PRODUCER SIGNATURE

DATE

AGENCY

**Small Business Services of WNY LLC**

- 2.** Have you provided the applicant with all relevant marketing materials?

Yes  No

- 3.** Have you advised the applicant of the features of the product that he/she has selected, including satisfying his/her deductible(s)?

Yes  No

- 4.** Is this applicant a current customer of Highmark BCBSWNY?

Yes  No

- 5.** Have you retained a signed copy of this application for your records?

Yes  No

#### Note: No producer may:

1. Accept risk or pass on any eligibility requirements;
2. Make or alter the terms of the Application or policy; or
3. Waive any of Highmark BCBSWNY's rights or requirements.



Highmark Blue Cross Blue Shield of Western New York  
c/o Highmark Inc.  
120 Fifth Ave.  
Pittsburgh, PA 15222

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### Internal use only

NATIONAL PRODUCER NUMBER (NPN)