Application for Adult Dental Individual Coverage
The Adult Dental Individual Coverage is underwritten by QCC Insurance Company

Instructions:
1. This application should be used if you wish to enroll in an individual Adult Dental plan purchased directly from Independence Blue Cross. The health plans available through this application are not eligible for federal premium tax credits or cost-sharing reductions available under the health care law.

2. Please complete all sections and print clearly in black ink.

3. Read carefully and sign the enclosed Declarations and Conditions of Enrollment.

4. Provide information about your spouse, domestic partner, and dependents, if they are also applying for coverage. If you need additional space, attach a separate sheet with your signature and date (Sections C and G).

5. Select one of the following payment options for your adult dental plan.
   First payment:
   • Credit/debit and prepaid debit cards are accepted for the first month’s premium. You can:
     • Pay by phone by calling 1-888-879-4891 (TTY: 711)
     • Or, visit ibx.com/payment for instructions on how to pay online through e-Bill

   If you would rather make your first payment by check, mail it along with this application to the address on the form.
   Ongoing payments:
   For instructions on how to set up ongoing payments, visit ibx.com/payment or call 1-866-346-2081 (TTY: 711).

   Important: Receipt of your initial payment does not constitute enrollment in this plan. Your coverage will not begin until this application has been processed, an effective date assigned, and your payment received. Failure to provide all information requested may result in a delay in the processing of your application. If we are unable to process your application, your check will be returned by mail.

6. Once your materials are complete, be sure to make a copy for your records. Mail your application to:
   Independence Blue Cross
   P.O. Box 8240
   Philadelphia, PA 19101

All future premium payments should be remitted to the address on your monthly invoice. If you have any questions or need help completing this application, contact Independence Blue Cross at 1-844-762-2140, Monday through Friday, between 8 a.m. and 6 p.m. You can also apply online by visiting us at www.ibx.com/enrolldental.
Application for Adult Dental Individual Coverage
The Adult Dental Individual Coverage is underwritten by QCC Insurance Company*

In order to be eligible for coverage, the following must be true:

• The primary applicant must be 19 or older.
• Applicants must be residents of Bucks, Chester, Delaware, Montgomery, or Philadelphia counties in Pennsylvania.
• Dependent children must be between 19 – 26 years old.

SECTION A — Plan Selections

<table>
<thead>
<tr>
<th>Type of coverage</th>
<th>Reason for application</th>
<th>Method of payment</th>
<th>For office use only</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Individual</td>
<td>☐ New enrollment</td>
<td>☐ Check enclosed</td>
<td>Effective date</td>
</tr>
<tr>
<td>☐ Individual and spouse or domestic partner</td>
<td>☐ Add spouse or domestic partner</td>
<td>☐ Credit Card / Debit Card / Pre-Paid Debit Card (first payment only) – call 1-888-879-4891 or visit ibx.com/payment</td>
<td></td>
</tr>
<tr>
<td>☐ Individual and dependent child(ren)</td>
<td>☐ Add dependent child(ren)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Family</td>
<td>☐ Renewal (plan change)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Choice of Plan

☐ Standalone Dental
☐ Adult Dental Preferred
☐ Adult Dental Premier

SECTION B — Primary Applicant Information (must be 19 or older)

Primary applicant name: Last, First, Middle initial

Social Security Number (required)              Birth date (mm/dd/yy) | Age | Gender: ☐ M ☐ F

*Available to eligible individuals only (see section G : Declarations and Conditions of Enrollment).
### SECTION C — Family Information (if applying)

Spouse or Domestic Partner name: Last, First, Middle initial

<table>
<thead>
<tr>
<th>Social Security Number (required)</th>
<th>Birth date (mm/dd/yy)</th>
<th>Age</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ /</td>
<td></td>
<td>M   F</td>
</tr>
</tbody>
</table>

Dependent name: Last, First, Middle initial

<table>
<thead>
<tr>
<th>Social Security Number (required)</th>
<th>Birth date (mm/dd/yy)</th>
<th>Age</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ /</td>
<td></td>
<td>M   F</td>
</tr>
</tbody>
</table>

Dependent name: Last, First, Middle initial

<table>
<thead>
<tr>
<th>Social Security Number (required)</th>
<th>Birth date (mm/dd/yy)</th>
<th>Age</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ /</td>
<td></td>
<td>M   F</td>
</tr>
</tbody>
</table>

Dependent name: Last, First, Middle initial

<table>
<thead>
<tr>
<th>Social Security Number (required)</th>
<th>Birth date (mm/dd/yy)</th>
<th>Age</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/ /</td>
<td></td>
<td>M   F</td>
</tr>
</tbody>
</table>

### SECTION D — Personal Information

<table>
<thead>
<tr>
<th>Residence address</th>
<th>Mailing address (if different from residence address)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street (P.O. Box not acceptable)</td>
<td>Street</td>
</tr>
<tr>
<td>City</td>
<td>State</td>
</tr>
<tr>
<td>County</td>
<td>County</td>
</tr>
</tbody>
</table>

### SECTION E — Contact Information

<table>
<thead>
<tr>
<th>Home phone number</th>
<th>Mobile phone number</th>
<th>Email address</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
<td>( )</td>
<td></td>
</tr>
</tbody>
</table>

Best time to call:

- Morning
- Afternoon

Best location to call:

- Home
- Mobile

### SECTION F — Household Information

A. Do all applicants reside in the same household?  Yes No
If no, provide reason: ________________________________________________________________
________________________________________________________________________________

B. Do all applicants reside in one of the following counties: Bucks, Chester, Delaware, Montgomery, or Philadelphia?  Yes No
If no, provide reason: ________________________________________________________________
________________________________________________________________________________

Address: ____________________________
________________________________________________________________________________

Form #16970 (Rev. 1.20)
SECTION G — Declarations and Conditions of Enrollment

Please read carefully before signing below.

By applying to QCC Insurance Company (“the company”) for coverage for myself and the dependents listed in Section C, I understand and agree to the following:

1. a) For your effective coverage date, please see the information in the Premium Rate Letter.
   b) Coverage does not begin until this application is processed by the company with an effective date of coverage assigned and payment has been received.
   c) Credit card/debit card payments and pre-paid debit card payments are acceptable for the first month’s premium payment only.
   d) Receipt of the initial payment does not constitute enrollment under any program.
   e) This coverage is provided only to residents of the geographical area of Bucks, Chester, Delaware, Montgomery, and Philadelphia counties, Pennsylvania, served by the company. The company reserves the right to investigate and confirm your residence.

2. The company may void this non-group benefit policy within three (3) years of the effective date if it is found that this non-group benefit policy was obtained or maintained by intentionally supplying a material misrepresentation of fact, except in the case of fraud, for which there is no time limit for voiding the policy.

3. The terms and conditions of the coverage will be controlled by the written agreement with the company, and the company may adopt policies, procedures, rules, and interpretations to administer benefits under the policy. It is recognized that the coverage will only apply to admissions that occur and services that are provided on or after the effective date of coverage.

4. By enrolling in this benefit program, I acknowledge that in connection with the administration of, or delivery or receipt of benefits, under the non-group policy, the company will use and disclose PHI (protected health information) for purposes of Treatment, Payment, and Operations (TPO) as this term is defined by federal law.

5. 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.

6. I can confirm that no one applying for health insurance on this application is incarcerated (detained or jailed).

Signature(s) required

I acknowledge that I have read, understand all statements in this application, and have supplied the requested information. The information supplied on the application and any signed addendum is accurate and complete to the best of my knowledge. No material information has been withheld or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, the application will either be rejected or returned for completion.

---

X
Applicant/Parent or Legal Guardian signature

Date (mm/dd/yy)

X
Applicant spouse or domestic partner signature
(if applying for coverage)

Date (mm/dd/yy)
SECTION H — Statement of Accountability (if applicable)

To be completed if the applicant cannot complete or has not completed the application:

I, ____________________________, have read and completed the application form for the primary applicant for the following reason(s):

☐ Applicant does not speak English  ☐ Applicant does not read English
☐ Applicant does not write in English  ☐ Other (please explain)

I translated and fully explained the “Declarations and Conditions of Enrollment.” I also translated the contents of this form and to the best of my knowledge obtained and listed all the requested information disclosed by:

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature of translator (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

_____/_____/______
Date (mm/dd/yy) (required)

Relationship to applicant

SECTION I — Broker Information (if applicable)

<table>
<thead>
<tr>
<th>National Producer Number (NPN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Producer broker code</td>
</tr>
<tr>
<td>Primary broker code</td>
</tr>
<tr>
<td>Primary broker name</td>
</tr>
<tr>
<td>Telephone number</td>
</tr>
<tr>
<td>Telephone number</td>
</tr>
</tbody>
</table>

Independence Sale Representative (if applicable)

<table>
<thead>
<tr>
<th>National Producer Number (NPN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sales representative code</td>
</tr>
<tr>
<td>Name of sales representative</td>
</tr>
</tbody>
</table>

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Form #16970 (Rev. 1.20)
SECTION J — Assistance with Completing this Application (if applicable)

You can choose an authorized representative. You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an “authorized representative.” If you ever need to change your authorized representative, contact Independence Blue Cross. If you’re a legally appointed representative for someone on this application, submit proof with the application.

<table>
<thead>
<tr>
<th>Name of authorized representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>(First name, Middle name, Last name)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Apartment or Suite number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>ZIP code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>( )</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Organization name</th>
<th>ID number (if applicable)</th>
</tr>
</thead>
</table>

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with Independence Blue Cross.

Your signature / Date

Mail to:

Independence Blue Cross
P.O. Box 8240
Philadelphia, PA 19101

All future premium payments should be remitted to the address on your current invoice. If you have any questions, contact Independence Blue Cross at 1-844-762-2140 between 8 a.m. and 6 p.m.

By voluntarily giving Independence Blue Cross my mobile phone number and/or e-mail address, I authorize Independence Blue Cross and its subsidiaries (collectively “Independence”) to send me information/data about Independence, including, but not limited to, information about my account and other insurance products and services. Independence may contact me via e-mail, automated text, and/or phone call. For text, message and data rates may apply. Not required to purchase goods and services from Independence Blue Cross. Text STOP to stop and HELP for help. Terms and conditions at www.myhelpsite.net/ibx. Any information provided by me to Independence is subject to Independence’s Privacy Policy.

Independence Blue Cross offers products, through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

Independence dental plans are administered by United Concordia Companies, Inc., an independent company.

Independence

Form #16970 (Rev. 1.20)


Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।


Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。
1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما قرایه می‌باشد. به شماره 1-800-275-2583 تماس بگیرید.


Urdu:
توجه، درکاری: اگر آپ اردو زبان بولتے ہیں تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب بین۔ کال گیری 1-800-275-2583.

Mon-Khmer, Cambodian: បទសេចប៉ាប់សម្រាប់ប្រារពន្ធការបញ្ហាអត្បប្រយ័ត្ន-ការរៀបចំនូវប្រការក្នុងប្រទេសពាណិជ្ជកម្មកម្ពុជា និងប្រទេសអង់គ្លេស ការប្រការសម្រាប់ការជួយការប្រការក្នុងប្រទេសមួយនឹងប្រទេសអង់គ្លេស នូវការជួយអំពីសេចក្តីថ្លាស់ប្រយោជន៍ 1-800-275-2583។

Y0041_HM_17_47643 Accepted 10/14/2016

Taglines as of 10/14/2016

Form #16970 (Rev. 1.20)
Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711), By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.