

South Glens Falls Central School District
 6 Bluebird Road
 South Glens Falls, NY 12803
 (518) 793-9619

**Blue Shield of Northeastern New York Dental Insurance
 Enrollment Application/Change Form**

Date _____

Subscriber Member ID/Social Security #: _____ District: **South Glens Falls Central School**

Subscriber Name _____ Date of Birth _____

New or **Changes to Subscriber** (enter only corrected data)

Name _____ Date of Birth _____
 Address _____ Martial Status _____
 City _____ Spouse's Dental Insurance _____
 Zip Code _____ Spouse's ID/Social Security # _____
 Home Telephone Number _____ Alternate Telephone Number _____

Send ID Card (s) Dependent Member Name _____

Delete Subscriber, Spouse & Dependents
 Effective _____ Reason Code* _____

Add Spouse or Dependent** or **Delete Spouse or Dependent**
 Dependent Name _____ ID/Social Security # _____
 Date of Birth _____ Sex Male Female
 Effective Date _____ Reason Code* _____

Add Dependent** **Delete Dependent**
 Dependent Name _____ ID/Social Security # _____
 Date of Birth _____ Sex Male Female
 Effective Date _____ Reason Code* _____

Add Dependent** **Delete Dependent**
 Dependent Name _____ ID/Social Security # _____
 Date of Birth _____ Sex Male Female
 Effective Date _____ Reason Code* _____

Add Dependent** **Delete Dependent**
 Dependent Name _____ ID/Social Security # _____
 Date of Birth _____ Sex Male Female
 Effective Date _____ Reason Code* _____

Applicant signature _____ GBA signature _____
 I certify the above information is correct.

- *Reason Codes**
- 1 Termination of Employment
 - 2 Birth/Adoption
 - 3 Dependent over age
 - 4 Student Status change
 - 5 Marriage/Divorce
(Copy of Marriage Certificate/Divorce Decree required)
 - 6 Per Member
 - 7 Opting for other coverage
 - 8 Other _____ (Please specify)
 - 9 Death

BCO's use only

Date processed _____
 Initials _____