South Glens Falls School District
42 Merritt Road, Suite 1
South Glens Falls, NY 12803

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.

BCO's use only

Date processed_____

Initials_____

***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

****Dependent eligibility to age 26 only for dependents who do not otherwise have employer based health insurance available**