BlueCross BlueShield of Illinois

BlueCare Dental℠

SEIU Local 1 Particpating Employers Health Trust

Dental Center (Office) Selection/Change Form

To receive BlueCare Dental℠ HMO benefits, you must receive covered care from a dentist who contracts with the BlueCare Dental HMO network. When selecting a dentist for the first time or changing dentists, please complete this entire form. **This form must be received at the Fund Office by the 15th of the month for coverage to be effective by the 1st of the following month.**

Participant Information

Last Name:

First Name:

Member Alternate ID:

Last 4 Digits of Social Security No: (for verification use only)

Date of Birth: Month: Date: Year:

Address 1:

Address 2:

City: State: Zip:

Daytime Phone: – –

Evening Phone: – –

E-mail:

Preferred Language: (check one) ☐ English ☐ Spanish ☐ Polish ☐ Other _____

Dental Center Information

(Provide new dental center selection for you and your eligible dependents.)

Please use the Dental Directory to choose a dentist
Center ID #: IL001234

	First Name	Last Name	Male	Female	Birth Date
Member:					
Spouse:					
Child:					
Child:					
Child:					
Child:					
Child:					

(Use a separate sheet of paper if additional space is needed.)

Reason for Change: (Please check only if you are changing from a previously selected dental office.)

☐ New home address

☐ Dental Center (Office) closer to home or workplace

☐ New Dental Center (Office) added to network

☐ Dislike present office (please state reason*)

*Reason _____

Visit our Web site at **bcbsil.com** for additional information.

The relationship between Blue Cross and Blue Shield of Illinois and contracting dentists is that of independent contractors.

(tłumaczenie na odwrocie) (traducción en la parte posterior)