

Group # Section # Dept # Social Security Number



BlueCross BlueShield of Texas

Dearborn National

Group # Section # Dept # Category

SECTION 1 - ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY - IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2 AND 10 ONLY.

New Enrollee Add Dependent
Are you applying as a result of a Special Enrollment Event?
Event: Marriage Birth, Adoption, Suit for Adoption
Court Order (see instructions)
Loss of Other Coverage (provide Certification of Coverage)
Other (Explain):

Add Coverage: Health Dental
Term Life Dependent Life
Short Term Disability (STD)
Long Term Disability (LTD)

Cancel Enrollee Cancel Dependent
List names of those canceling in Section 4 below
Event: Divorce Death
Terminated Employment
Other

Indicate Event Date: / /

Indicate Event Date: / /

Cancel Coverage: Health Dental Term Life
Dependent Life STD LTD

SECTION 2 - PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

Form with fields: Last Name, First Name, MI (opt), Suffix, Date of Birth, Social Security Number, Mailing Address - Street - Apt#, City, State, Zip, E-Mail Address, Male, Female, Business Phone #, Cell Phone #, Home Phone #, Name of Employer, Date of Employment, Do you usually work at least 30 hours a week for this employer?

Eligibility Status: Active Employee Retired Employee - Date of Retirement: COBRA Continuation
Continuation of Group Coverage (insured plans only)
Dependent Continuation of Group Coverage (insured plans, only)

SECTION 3 - SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Health (select one)
PPO HMO
BlueEdge HCA BlueEdge HSA
HMO Consumer Choice Plan (small group only)
PPO Consumer Choice Plan (small group, only)
Other:
Plan #, if known:

Enrollees (select one)
Employee Only
Employee /Spouse
Employee /Child(ren)
Family
I am not applying for health coverage

Dental
Yes
No
Plan #, if known:

Enrollees (select one)
Employee Only
Employee /Spouse
Employee /Child(ren)
Family
I am not applying for dental coverage

Complete only if you are applying for HMO coverage:
Primary Language: Check here to request a Spanish Member Handbook
Do you have a disability affecting your ability to communicate or read? Yes No
If "Yes", describe special communication materials needed:

SECTION 4 - COVERAGE OPTIONS SELECT A PCP FOR HMO OR POS ONLY.

Form with multiple rows for Employee/Enrollee and Dependents, including fields for Name, PCP Name, PCP No., New Patient?, Social Security No., DOB, Home Address, City, State, Zip.

SECTION 5 - GROUP TERM LIFE ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) AND DISABILITY INSURANCE COVERAGES

Form with fields for Employee Occupation/Job title, Wage rate, Group Basic Term Life & AD&D, Group Dependents' Life, Group Supplemental Life, Employee election, Spouse election, Child election, Short Term Disability (STD), Long Term Disability (LTD), Primary Beneficiary, Contingent Beneficiary.

Last Name:

Social Security Number: | - - |

H Group #

SECTION 6 - PREVIOUS COVERAGE INFORMATION

Do NOT COMPLETE IF APPLYING FOR HMO OR IN-HOSPITAL INDEMNITY COVERAGE

In order to receive credit for pre-existing condition waiting periods, you must provide information about the last 12 months of coverage (18 months if new/current coverage is self-funded) for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy to this enrollment application. (If more than one plan was in effect, or if information is different for dependents, attach additional pages.) If Medicare, please complete the Medicare Coverage Information in Section 8.

List names of every individual covered:

Table with columns: Name of Primary Enrollee, Date of Birth, Gender, Relationship to Applicant, Group or Policy No., ID Number, Employer's Name, Employment Date, Effective Date, Will Coverage be Continued?, Type of Coverage, Type of Policy.

SECTION 7 - OTHER COVERAGE INFORMATION

Complete this section only if you or any of your dependents have other health and / or dental coverage that will not be cancelled when the coverage under this application becomes effective. List names of each individual covered:

Table with columns: Type of Coverage, Group Coverage, Name and Address of Other Health Care Company, Name of Policyholder, Date of Birth, Gender, Relationship to Applicant, Type of Policy, ID Number, Employment Date, Effective Date of Coverage, Group or Policy Number, Employer's Name.

SECTION 8 - MEDICARE COVERAGE INFORMATION

Form for Medicare coverage information including Name of person covered, Medicare HIC#, Medicare Part A (hospital), Medicare Part B (medical), Medicare Part D (prescription drugs), and check reason for Medicare eligibility.

Form for Medicare coverage information (repeated) including Name of person covered, Medicare HIC#, Medicare Part A (hospital), Medicare Part B (medical), Medicare Part D (prescription drugs), and check reason for Medicare eligibility.

SECTION 9 - DISABLED DEPENDENT

Form for disabled dependent information including Name of disabled dependent, Nature of disability, and questions about permanent disability and work ability.

SECTION 10 - DECLINATION OF HEALTH COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage as well as a pre-existing condition waiting period.

Form for declining health coverage for Employee, Spouse, and Child(ren) with reasons for declining.

SECTION 11 - COVERAGE CONDITIONS

- I am an employee of the Employer named in this Enrollment Application. I am eligible to participate in the coverage(s) afforded by my Employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Texas (BCBSTX) or Fort Dearborn Life Insurance Company (FDL). On behalf of myself and any dependents listed on this Enrollment Application, I apply for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any intentional misinterpretation of a material fact made by me will invalidate my coverage(s).
Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s).
For individuals age 19 and over, I understand that the Health coverage for which I am applying may have a pre-existing condition exclusion waiting period. (Does not apply to HMO or In-Hospital Indemnity coverage.)
I agree that my Employer acts as my agent. I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s).
I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are applicable to me.

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

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