Enrollment Application/Change Form

Please read the instructions on the inside thoroughly before completing this enrollment application/change form.
If your group offers a Consumer Choice health plan you have the option to choose a Consumer Choice of Benefits Health Insurance Plan or Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies or evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health insurance policy or health plan for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies or evidences of coverage in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy or evidence of coverage (Certificate of Coverage).

Please Note: If your group offers a Consumer Choice health plan you have the option to choose a Consumer Choice of Benefits Health Insurance Plan or Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies or evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health insurance policy or health plan for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies or evidences of coverage in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy or evidence of coverage (Certificate of Coverage).
**SECTION 1 — ENROLLMENT EVENTS**

Are you applying as a result of a Special Enrollment Event?

- [ ] New Enrollee
- [ ] Add Dependent
- [ ] Open Enrollment
- [ ] Other Change(s)

Event:
- [ ] Marriage
- [ ] Birth
- [ ] Adoption or Suit for Adoption (Provide Legal Documents)
- [ ] Court Order (Provide Court Order or decree)
- [ ] Loss of Other Coverage (Provide Certificate of Creditable Coverage)
- [ ] Other (Explain):

NOTE: Declaration of Coverage (Complete Sections 2, 9, & 10)

**SECTION 2 — PLEASE TELL US ABOUT YOURSELF**

- **Last Name**
- **First Name**
- **MI (opt)**
- **Suffix**
- **Birth Date (MM/DD/YYYY)**
- **Social Security No.**
- **Home/Cell Phone No.**
- **City**
- **State**
- **Zip**

**E-Mail Address**

- [ ] Male
- [ ] Female

**Name of Employer**

- **Job Title**
- **Business Phone No.**
- **Employment Date (MM/DD/YYYY)**

Eligibility Status:
- [ ] Active Employee
- [ ] Retired Employee - Date of Retirement: __________________________
- [ ] State Continuation of Group Coverage (insured plans only)
- [ ] Dependent State Continuation of Group Coverage (insured plans only)

**SECTION 3 — SELECT YOUR COVERAGE**

**Health Coverage (select one)**

- [ ] BlueChoice PPO
- [ ] BlueAdvantage HMO
- [ ] 7-character Plan # (required)

**Who is covered? (select one)**

- [ ] Employee Only
- [ ] Employee /Spouse
- [ ] Employee /Child(ren)
- [ ] Family
- [ ] I am not applying for Health coverage

**BlueCare Dental Coverage**

- [ ] Yes
- [ ] No

**Dental Coverage**

- [ ] Yes
- [ ] No
- [ ] Plan # (required)

**Who is covered? (select one)**

- [ ] Employee Only
- [ ] Employee /Spouse
- [ ] Employee /Child(ren)
- [ ] Family
- [ ] I am not applying for Dental coverage

**Primary Language:**

- [ ] Check here to request a Spanish HMO Member Handbook

**If "Yes", describe special communication materials needed:**

**SECTION 4 — COVERAGE OPTIONS**

**SELECT A PCP FOR HMO OR POS ONLY**

**Employee/Enrollee’s Name**

- **PCP Name**
- **PCP No.**
- **New Patient?**
- [ ] Y [ ] N

**Dependent’s Name**

- **Husband**
- **Wife**
- **Dependent’s PCP Name**
- **PCP No.**
- **New Patient?**
- [ ] Y [ ] N

**Dependent’s Social Security No.**

- **Birth Date (MM/DD/YYYY)**
- **Address (if different) - No. and Street Address**
- **City**
- **State**
- **Zip**

**Dependent’s Social Security No.**

- **Birth Date (MM/DD/YYYY)**
- **Home Address, if different — No. and Street Name/City/State/Zip**

**Dependent’s Social Security No.**

- **Birth Date (MM/DD/YYYY)**
- **Home Address, if different — No. and Street Name/City/State/Zip**

**Dependent’s Social Security No.**

- **Birth Date (MM/DD/YYYY)**
- **Home Address, if different — No. and Street Name/City/State/Zip**

**Dependent's Name**

- **Son**
- **Daughter**
- **Other Eligible Dependent**

**Birth Date (MM/DD/YYYY)**

- **Home Address, if different — No. and Street Name/City/State/Zip**

**Dependent’s Social Security No.**

- **Birth Date (MM/DD/YYYY)**
- **Home Address, if different — No. and Street Name/City/State/Zip**

**Dependent’s Social Security No.**

- **Birth Date (MM/DD/YYYY)**
- **Home Address, if different — No. and Street Name/City/State/Zip**

**Dependent’s Social Security No.**

- **Birth Date (MM/DD/YYYY)**
- **Home Address, if different — No. and Street Name/City/State/Zip**

If not your natural child, stepchild, eligible foster child, adopted child, or child in Suit for Adoption, are you (or your spouse) responsible for this dependent?

- [ ] Y [ ] N

If "Yes", describe special communication materials needed:
SECTION 5 — GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D), AND DISABILITY INSURANCE COVERAGES

Employee Occupation/Job Title: ___________________________ Wage Rate $___________ per _____ hour _____ week _____ month _____ year

Group Basic Term Life & AD&D: □ I do not apply □ I do apply Amount $___________

Group Dependents’ Life: □ I do not apply □ I do apply

Group Supplemental Life: □ I do not apply □ I do apply

Employee Election: $___________ Spouse Election: $___________ Child Election: $___________

Short Term Disability (STD): □ I do not apply □ I do apply

Long Term Disability (LTD): □ I do not apply □ I do apply

Primary Beneficiary: First Name Initial Last Name Relationship Birth Date (MM/DD/YYYY) Social Security No.

Contingent Beneficiary: First Name Initial Last Name Relationship Birth Date (MM/DD/YYYY) Social Security No.

SECTION 6 — DISABLED DEPENDENT

Name of Disabled Dependent: ___________________________ Nature of Disability: ___________________________

Name of Disabled Dependent: ___________________________ Nature of Disability: ___________________________

If disabled child is over the dependent age limit of your employer’s plan, please attach a completed Dependent Child’s Statement of Disability form.

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>
<thead>
<tr>
<th>Group Coverage</th>
<th>Name and Address of Other Insurance Carrier</th>
<th>Effective Date (MM/DD/YYYY)</th>
<th>Type of Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Yes □ No</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name of Policyholder: ___________________________ Birth Date (MM/DD/YYYY) □ Male □ Female Relationship to Applicant

Employer’s Name: ___________________________ Employee Occupation/Job Title: ___________________________ Wage Rate $___________

Employer’s Name: ___________________________ Health Group No. Health ID No. Dental Group No. Dental ID No.

SECTION 8 — MEDICARE COVERAGE INFORMATION

Name of person covered:

Medicare A (Hospital) Effective Date: ________________ __ End Date: ________________ __

Medicare B (Medical) Effective Date: ________________ __ End Date: ________________ __

Medicare D (Drug) Effective Date: ________________ __ End Date: ________________ __

Medicare D (Drug) Carrier: ________________________________ ______

Please indicate reason for Medicare Eligibility: □ Entitled Age □ Entitled Disability □ End-Stage Renal Disease □ Disability and Current Renal Disease

Medicare HIC No. (From Medicare Card): ___________________________

Name of person covered:

Medicare A (Hospital) Effective Date: ________________ __ End Date: ________________ __

Medicare B (Medical) Effective Date: ________________ __ End Date: ________________ __

Medicare D (Drug) Effective Date: ________________ __ End Date: ________________ __

Medicare D (Drug) Carrier: ________________________________ ______

Please indicate reason for Medicare Eligibility: □ Entitled Age □ Entitled Disability □ End-Stage Renal Disease □ Disability and Current Renal Disease

Medicare HIC No. (From Medicare Card): ___________________________

SECTION 9 — DECLARATION OF 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.

Name □ Employee □ Spouse □ Child Reason for Declining Health: □ Other Group Health Coverage; Carrier: ___________________________

□ Other Individual Health Coverage; Carrier: ___________________________ □ Medicare □ Medicaid □ Other, Explain: ___________________________

□ Medicare □ Medicaid □ Other, Explain: ___________________________

□ Medicare □ Medicaid □ Other, Explain: ___________________________

□ Medicare □ Medicaid □ Other, Explain: ___________________________

□ Medicare □ Medicaid □ Other, Explain: ___________________________

Section 10 — COVERAGE CONDITIONS

□ I am an employee of the Employer named in this Enrollment Application. I am eligible to participate in the coverage(s) offered by my Employer’s plan, which is either underwritten or administered by Blue Cross and Blue Shield of Texas (BCBSTX) or Dearborn National® Life Insurance Company. On behalf of myself and any dependents listed on this Enrollment Application, I apply for these 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 misrepresentation 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).

□ 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). As applies to HMO coverage, I will accept an electronic copy of my coverage documents (whether certificate of coverage or benefit booklet) if my Employer requests that BCBS of Texas deliver the information electronically. I understand that a hard copy is available to me upon request.

□ I understand that 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.

□ I understand that communications that are required by law may be delivered to me electronically with my consent. I understand that if I consent to receiving my documents electronically, that I have a right to obtain a paper copy and to withdraw my consent.

Applicant’s Signature ___________________________ Date ___________________________