Please read the instructions on the inside thoroughly before completing this enrollment application/change form.
### SECTION 1 EVENTS

Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection.

**New Enrollee:** Complete all sections where applicable.

**Add Dependent:** Complete all sections where applicable.
- If you are enrolling a court-ordered dependent for coverage beyond the automatic 31-day period for coverage, you must submit a copy of the court order or decree.
- If you are applying for coverage for a disabled dependent over the age limit of your employer’s plan, please provide the additional information requested in Section 5. Additional documentation may be required as addressed in that section.
- If student dependent coverage is part of your employer’s plan and you are adding or enrolling a dependent child age 26 or over who is a student, you may be required to submit a completed Student Certification form.

**Open Enrollment:** The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current membership.

**Special Enrollment Event:** If you qualify, special enrollment is any change to your current membership such as marriage*, divorce**, adoption, suit for adoption, leave/layoff, moving out of the service area, etc. This change may occur outside of open enrollment.

**Effective Date of Benefits:** Field is mandatory.

**Completion of Other Eligibility Requirements:** Check this box only if your employer has eligibility requirements that you have met/completed prior to enrollment, such as measurement period or orientation period.

**Cancel Enrollee/Cancel Dependent/Cancel Coverage:** Complete Sections 1, 2, 4 (skip Section 4 if declining coverage) and 9. In Section 4 include name, social security number and date of birth of individual(s) canceling.

### SECTION 2 YOUR INFORMATION

Complete this section with details about yourself even if you are declining coverage.

### SECTION 3 YOUR COVERAGE

Complete all portions related to the coverages for which you are applying. Please list the seven character plan ID for your selected benefit design (example for a small group plan: B634ADT) in the plan # field. If you are unsure of your group size or do not know your plan ID, please ask for guidance from your employer.

If you are enrolling for life or disability insurance, enter the information requested. When listing the beneficiary, provide both the first and last name and the relationship to you. List all beneficiaries that apply.

### SECTION 4 COVERAGE OPTIONS

Complete all areas that apply to you and each dependent.

For HMO Plans Only:
- Blue Essentials AccessSM or Blue Premier AccessSM plans do not require a PCP selection.
- Those applying for Blue Advantage HMOSM, Blue EssentialsSM or Blue PremierSM plans are required to select a primary care physician/practitioner (PCP) for each covered individual. List the name of the physician/practitioner and the provider number from the provider directory or Provider Finder® at bcbstx.com. Be sure to check the appropriate box for a new patient.
- ATTENTION FEMALE MEMBERS: If you select an HMO plan that requires PCP selection, remember that your PCP’s network may affect your choice of an OB/GYN.
- You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. However, for HMO members, the OB/GYN from whom you receive services must belong to the same physician practice group or independent practice association (IPA) as your PCP. This is another reason to make certain that your PCP’s network includes the specialists – particularly the OB/GYN – and hospitals that you prefer. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your PCP.

**Change Primary Care Physician/Practitioner:** Complete Section 1 and check the “Other Change(s)” box; then, complete Sections 2, 3, 4 and 9. In Section 4, please include enrollee’s or dependent’s name, social security number, date of birth, and name and number of the new PCP.

**Change Address/Name:** Complete Section 1 and check the “Other Change(s)” box; then, complete Sections 2 and 9.

### SECTION 5 DISABLED DEPENDENT

A disabled dependent must be medically certified as disabled and dependent upon you or your spouse***/domestic partner in order to be considered for coverage if disabled dependent coverage is part of your employer’s plan. A Disabled Dependent Authorization and Disabled Dependent Certification form must be completed and submitted with this enrollment application, if applicable.

### SECTION 6 OTHER COVERAGE

Complete this section if you or any dependent have other group or individual health and/or dental coverage (if applicable) that will not be canceled when the coverage under this application becomes effective.

### SECTION 7 MEDICARE COVERAGE

Complete this section if you or any of your dependents are covered by Medicare. Enter the start and end dates for the coverage that applies. Your Medicare HIC number must be listed (it can be found on your Medicare ID card). Check the reason for your Medicare coverage.

### SECTION 8 DECLINATION OF COVERAGE

Complete this section if you are declining health coverage for yourself and your dependents. Anyone declining coverage for any reason should complete Section 8, not just those declining because of other coverage.

**IMPORTANT NOTICE:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption, suit for adoption or placement of a foster child in your home, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption, suit for adoption or placement of an eligible foster child in your home.

### SECTION 9 COVERAGE CONDITIONS

Sign your name and date the enrollment application if you agree to the conditions set forth in this section. Your enrollment application should be submitted to your employer’s Enrollment Department, which will then submit your form by mail or email to: BCBSXT • Group Accounts Dept. • PO Box 655730 • Dallas, TX 75265-5730.

* The term “marriage” includes legal marriage and the establishment of a domestic partnership (coverage subject to your employer’s plan).
** The term “divorce” includes legal divorce and the comparable termination of a domestic partnership (coverage subject to your employer’s plan).
*** The use of the term “spouse” includes a legal spouse. It also includes a party to a domestic partnership (coverage subject to your employer’s plan).

Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

Forms referenced above may be obtained by accessing the Blue Cross and Blue Shield of Texas website at bcbstx.com, or from your employer. If you are a current member and have questions, you may also call the Customer Service number on the back of your member ID card.
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.

SECTION 1 — ENROLLMENT EVENTS

Please check all that apply — if you are declining coverage, complete sections 2, 8 and 9 only

☐ New Enrollee  ☐ Add Dependent  ☐ Open Enrollment  ☐ Other Changes

☐ No  ☐ Yes, Event Date: ___ / ___ / ___

Event:  ☐ New Hire  ☐ Marriage*  ☐ Birth

☐ Adoption or Suit for Adoption (provide legal documents)

☐ Court Order (provide court order or decree)

☐ Loss of Other Coverage

☐ Other (explain): __________________________

Effective Date of Benefits:  ___ / ___ / ___

☐ Completion of Other Eligibility Requirements

SECTION 2 — PLEASE TELL US ABOUT YOURSELF:

COMPLETE EVEN IF DECLINING COVERAGE

Last Name  First Name  MI (opt)  Suffix  Birth Date (MM/DD/YYYY)  Social Security #

Mailing Address - Street - Apt #  City  State  ZIP code  Home/Cell Phone #  Employment Date (MM/DD/YYYY)

Email Address

Name of Employer  Job Title  Business Phone #  Employment Date (MM/DD/YYYY)

☐ Male

☐ Female

Eligibility Status:

☐ Active Employee

☐ Retired Employee - Date of Retirement: ___ / ___ / ___

☐ State Continuation of Group Coverage (insured plans only)

☐ COBRA Continuation

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Small Group Plans (2-50 Employees)

Health Coverage (select one)

☐ Blue Premier Access℠  ☐ Blue Choice PPO℠  ☐ Blue Essentials℠  ☐ Blue Advantage HMO℠  ☐ Other

Plan # (required) __________________________

Who is covered for health? (select one)

☐ Employee Only

☐ Employee/Spouse ***

☐ Employee/Child(ren)

☐ Family

☐ I am not applying for Health coverage

BlueCare Dental℠ Coverage

☐ Yes

☐ No

Who is covered for dental? (select one)

☐ Employee Only

☐ Employee/Spouse

☐ Employee/Child(ren)

☐ Family

☐ I am not applying for Dental coverage

Large Group Plans (more than 50 Employees)

Health Coverage (select one)

☐ Blue Choice PPO℠  ☐ Blue Essentials℠  ☐ Blue Premier Access℠  ☐ Other

Plan # __________________________

Who is covered for health? (select one)

☐ Employee Only

☐ Employee/Spouse

☐ Employee/Child(ren)

☐ Family

☐ I am not applying for Health coverage

Dental Coverage

☐ Yes

☐ No

Plan # (required) __________________________

Who is covered for dental? (select one)

☐ Employee Only

☐ Employee/Spouse

☐ Employee/Child(ren)

☐ Family

☐ I am not applying for Dental coverage

Group Term Life, Accidental Death and Dismemberment (AD&D) and Disability Insurance^:

☐ I am not applying for Group Term Life, AD&D or Disability Insurance coverage

Employee Occupation/Job Title: __________________________

Wage Rate $___________ per hour  ___/___/___ per week  ___/___/___ per month  ___/___/___ per year

Group Basic Term Life and 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

☐ I do not apply

☐ I do apply

Long-Term Disability

☐ I do not apply

☐ I do apply

Primary Beneficiary

First Name Initial Last Name Relationship Birth Date (MM/DD/YYYY) Social Security #

Contingent Beneficiary

First Name Initial Last Name Relationship Birth Date (MM/DD/YYYY) Social Security #

* The term “marriage” includes legal marriage and the establishment of a domestic partnership (coverage subject to your employer’s plan).

** The term “divorce” includes legal divorce and the comparable termination of a domestic partnership (coverage subject to your employer’s plan).

*** The use of the term “spouse” includes a legal spouse. It also includes a party to a domestic partnership (coverage subject to your employer’s plan).

^ Life and Disability insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.
## SECTION 4 — COVERAGE OPTIONS

<table>
<thead>
<tr>
<th>Employee/Enrollee’s Name</th>
<th>PCP Name</th>
<th>PCP #</th>
<th>New Patient?</th>
<th>HMO OB/GYN Name (optional)</th>
<th>HMO OB/GYN #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent’s Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Husband/Wife</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Domestic Partner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dependent’s Social Security #</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth Date (MM/DD/YYYY)</td>
<td>Address (if different) - # and Street Address</td>
<td>City</td>
<td>State</td>
<td>ZIP code</td>
<td></td>
</tr>
<tr>
<td>Dependent’s Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Son/Daughter/Other Eligible Dependent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth Date (MM/DD/YYYY)</td>
<td>Home Address (if different) Street/City/State/ZIP code</td>
<td>Is this a dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption?</td>
<td>Y</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>Dependent’s Social Security #</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Birth Date (MM/DD/YYYY)</td>
<td>Home Address (if different) Street/City/State/ZIP code</td>
<td>Is this a dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption?</td>
<td>Y</td>
<td>N</td>
<td></td>
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<tr>
<td>Dependent’s Name</td>
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<td></td>
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<td></td>
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</tr>
<tr>
<td>Birth Date (MM/DD/YYYY)</td>
<td>Home Address (if different) Street/City/State/ZIP code</td>
<td>Is this a dependent a natural child, stepchild, foster child, adopted child, or a child in suit for adoption?</td>
<td>Y</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION 5 — DISABLED DEPENDENT**

<table>
<thead>
<tr>
<th>Name of Disabled Dependent</th>
<th>Nature of Disability</th>
</tr>
</thead>
</table>

- If disabled child is over the dependent age limit of your employer’s plan, please attach a completed Disabled Dependent Authorization and Disabled Dependent Physician Certification.

**SECTION 6 — OTHER COVERAGE INFORMATION**

**PLEASE COMPLETE ALL AREAS THAT APPLY**

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

<table>
<thead>
<tr>
<th>Group Coverage</th>
<th>Individual Coverage</th>
<th>Effective Date (MM/DD/YYYY)</th>
<th>Type of Policy</th>
<th>Name and Address of Other Insurance Carrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Medicare A (Hospital)</td>
<td></td>
<td>* Employee Only *</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>Medicare B (Medical)</td>
<td></td>
<td>* Employee/Spouse *</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Medicare D (Drug)</td>
<td></td>
<td>* Employee/Child(ren) *</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>Medicare B (Medical)</td>
<td></td>
<td>* Family *</td>
</tr>
</tbody>
</table>

**SECTION 7 — MEDICARE COVERAGE INFORMATION**

**PLEASE COMPLETE IF APPLICABLE**

Name of person covered:
- Medicare A (Hospital) Effective Date: __________ End Date: __________ Medicare HIC # (From Medicare Card)
- Medicare B (Medical) Effective Date: __________ End Date: __________
- Medicare D (Drug) Effective Date: __________ End Date: __________

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

**SECTION 8 — 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Reason for declining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>Health: Other Group Health Coverage – Carrier: Medicaid Oregon Other Individual Health Coverage – Carrier: Medicare Medicaid Other (explain)</td>
</tr>
<tr>
<td></td>
<td>Other Individual Health Coverage – Carrier: Medicaid Oregon Other (explain)</td>
</tr>
<tr>
<td></td>
<td>I am not enrolled in any health insurance plan, but do not want this coverage</td>
</tr>
<tr>
<td>Employee</td>
<td>Dental: Other Group Dental Coverage Medicaid Oregon Individual Dental Coverage Other (explain)</td>
</tr>
<tr>
<td></td>
<td>Other (explain)</td>
</tr>
<tr>
<td>Spouse</td>
<td>Reason for declining: Other Group Health Coverage Medicaid Oregon Individual Health Coverage Other (explain)</td>
</tr>
<tr>
<td></td>
<td>Other (explain)</td>
</tr>
<tr>
<td>Dependent</td>
<td>Reason for declining: Other Group Health Coverage Medicaid Oregon Individual Health Coverage Other (explain)</td>
</tr>
<tr>
<td></td>
<td>Other (explain)</td>
</tr>
<tr>
<td>Dependent</td>
<td>Reason for declining: Other Group Health Coverage Medicaid Oregon Individual Health Coverage Other (explain)</td>
</tr>
<tr>
<td></td>
<td>Other (explain)</td>
</tr>
</tbody>
</table>

**WARNING:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

Applicant’s Signature: ___________________________ Date: __________