ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Texas — Dearborn National

Group No.	Section No.	Dept No.	Social Security No.
Group No.	Section No.	Dept No.	Category

SECTION 1 — ENROLLMENT EVENTS
PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 10, & 11 ONLY

☐ New Enrollee ☐ Add Dependent ☐ Open Enrollment ☐ Other Change(s)
Are you applying as a result of a Special Enrollment Event?
☐ No ☐ Yes, Event Date: ___/___/___
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: Declination of Coverage (Complete Sections 2, 10, & 11)

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

☐ Cancel Enrollee ☐ Cancel Dependent
Cancel Coverage: ☐ Health ☐ Dental ☐ Term Life ☐ Dependent Life ☐ STD ☐ LTD
List names of those cancelling in Section 4 below
Event: ☐ Divorce ☐ Death ☐ Terminated Employment ☐ Other
Indicate Event Date: ___/___/___

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 No.
					– –

Mailing Address - Street - Apt No.	City	State	Zip

E-Mail Address	☐ Male ☐ Female	Home/Cell Phone No.

Name of Employer	Job Title	Business Phone No.	Employment Date (MM/DD/YYYY)	Do you usually work at least 30 hours a week for this employer? ☐ Yes ☐ No

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

SECTION 3 — SELECT YOUR COVERAGE
PLEASE CHECK ALL THAT APPLY

Health Coverage (select one)
☐ PPO ☐ HMO
☐ Blue Options ☐ BlueEdge HCA ☐ BlueEdge HSA
☐ HMO Consumer Choice Plan (small group only)
☐ PPO Consumer Choice Plan (small group only)
☐ EPO
☐ Other: ___
Plan #, if known: ___

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

Dental Coverage
☐ Yes
☐ No
Plan No., if known: ___

Dental 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

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 Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent ___	Dependent's Social Security No.	Dependent's PCP Name	PCP No.	New Patient? ☐Y ☐N
Birth Date (MM/DD/YYYY) / Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, adopted child, or a child in Suit for Adoption? ☐Y ☐N	If not your natural child, stepchild, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent? ☐Y ☐N		
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent ___	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐Y ☐N
Birth Date (MM/DD/YYYY) / Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, adopted child, or a child in Suit for Adoption? ☐Y ☐N	If not your natural child, stepchild, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent? ☐Y ☐N		
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent ___	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐Y ☐N
Birth Date (MM/DD/YYYY) / Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, adopted child, or a child in Suit for Adoption? ☐Y ☐N	If not your natural child, stepchild, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent? ☐Y ☐N		

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

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

Last Name: Social Security No.: | — — | Group # ☐☐☐☐☐☐

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 — PREVIOUS HEALTH COVERAGE INFORMATION

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

In order to receive credit for preexisting 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 Creditable 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 9. Please see instruction page for more information.

List names of every individual covered:

Previous Coverage Policyholder Name	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent	Group or Policy No.	ID Number

Name of Previous Insurance Company, TPA, HMO:	Effective Date (MM/DD/YYYY)	Type of Coverage ☐ Health ☐ Dental	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Employer's Name:	Employment Date under Previous Coverage (MM/DD/YYYY)	Will Coverage be Continued? ☐ Health ☐ Dental If No, Expected Cancel Date (MM/DD/YYYY) _____

SECTION 8 — 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:**

Group Coverage ☐ Yes ☐ No	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Name of Policyholder	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent

Employer's Name	Employment Date (MM/DD/YYYY)	Health Group No.	Health ID No.	Dental Group No.	Dental ID No.

SECTION 9 — 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: _____	Medicare HIC No. (From Medicare Card)

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

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: _____	Medicare HIC No. (From Medicare Card)

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

SECTION 10 — DECLINATION 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 as well as a preexisting condition waiting period.

Name ☐ Employee	Reason for Declining Health: ☐ Other Group Health Coverage; Carrier: _____ ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage; Carrier: _____ ☐ Other, Explain: _____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Employee	Reason for Declining Dental: ☐ Other Group Dental Coverage ☐ Medicaid ☐ Individual Dental Coverage ☐ Other, Explain: _____ ☐ I am not enrolled in any Dental insurance plan, but do not want this coverage.
Name ☐ Spouse	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other, Explain: _____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other, Explain: _____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other, Explain: _____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.

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 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 Contracts(s)/Plan(s).
- For individuals age 19 and over, I understand that the Health coverage for which I am applying may have a preexisting 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). 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 BCBSTX deliver the information electronically. I understand that a hard copy is available to me upon request.
- 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 _____