

ENROLLMENT APPLICATION/CHANGE FORM



Group #

Section #

Social Security #

Account #

Category

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

Cancel Enrollee Cancel Dependent
Cancel Coverage: Health Dental
 Term Life Dependent Life
 Short-Term Disability Long-Term Disability
 List names of those canceling 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 #
Mailing Address - Street - Apt #			City	State	ZIP code
Email Address		<input type="checkbox"/> Male <input type="checkbox"/> Female	Home/Cell Phone #		
Name of Employer	Job Title	Business Phone #	Employment Date (MM/DD/YYYY)	Do you usually work at least 30 hours a week for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Eligibility Status: <input type="checkbox"/> Active Employee <input type="checkbox"/> Retired Employee - Date of Retirement: _____ <input type="checkbox"/> COBRA Continuation <input type="checkbox"/> State Continuation of Group Coverage (insured plans only) <input type="checkbox"/> Dependent State Continuation of Group Coverage (insured plans only)					

SECTION 3 — SELECT YOUR COVERAGE PLEASE CHECK ALL THAT APPLY

Small Group Plans (2-50 Employees)

Health Coverage (select one) <input type="checkbox"/> Blue Premier Access SM <input type="checkbox"/> Blue Choice PPO SM <input type="checkbox"/> Blue Essentials SM <input type="checkbox"/> Blue Advantage HMO SM <input type="checkbox"/> Blue Essentials Access SM <input type="checkbox"/> Other _____ Plan # (required) _____	Who is covered for health? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse*** <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Health coverage	BlueCare DentalSM Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Who is covered for dental? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Dental coverage
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Large Group Plans (more than 50 Employees)

Health Coverage (select one) <input type="checkbox"/> Blue Choice PPO SM <input type="checkbox"/> Blue Essentials SM <input type="checkbox"/> Blue Premier SM <input type="checkbox"/> Blue Essentials Access SM <input type="checkbox"/> Blue Premier Access SM <input type="checkbox"/> Other _____ Plan # _____	Who is covered for health? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Health coverage	Dental Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No Plan # (required) _____	Who is covered for dental? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Dental coverage
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Primary Language: _____ English Spanish Other
 Do you have a disability affecting your ability to communicate or read? Yes No
 If "Yes," describe special communication materials needed: _____

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 week month 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, Accidental Death & Dismemberment 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.

Last Name: _____

Social Security #: _____

Group #

SECTION 4 — COVERAGE OPTIONS PLEASE COMPLETE ALL AREAS THAT APPLY. PCP SELECTION IS REQUIRED FOR BLUE ADVANTAGE, BLUE PREMIER AND BLUE ESSENTIALS PLANS. PCP SELECTION IS NOT REQUIRED FOR BLUE PREMIER ACCESS AND BLUE ESSENTIALS ACCESS PLANS.

Employee/Enrollee's Name PCP Name PCP # New Patient? HMO OB/GYN Name (optional) HMO OB/GYN #
Dependent's Name PCP Name PCP # New Patient? HMO OB/GYN Name (optional) HMO OB/GYN #
Dependent's Social Security # Birth Date (MM/DD/YYYY) Address (if different) - # and Street Address City State ZIP code
Dependent's Name PCP Name PCP # New Patient? HMO OB/GYN Name (optional) HMO OB/GYN #
Dependent's Name PCP Name PCP # New Patient? HMO OB/GYN Name (optional) HMO OB/GYN #
Dependent's Name PCP Name PCP # New Patient? HMO OB/GYN Name (optional) HMO OB/GYN #

SECTION 5 — DISABLED DEPENDENT PLEASE COMPLETE IF APPLICABLE

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 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:
Group Coverage Individual Coverage Name and Address of Other Insurance Carrier Effective Date (MM/DD/YYYY) Type of Policy
Name of Policyholder Birth Date (MM/DD/YYYY) Relationship to Applicant
Employer's Name Employment Date (MM/DD/YYYY) Health Group # Health ID # Dental Group # Dental ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION PLEASE COMPLETE IF APPLICABLE

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

SECTION 8 — DECLINATION OF COVERAGE PLEASE COMPLETE IF YOU ARE DECLINING 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 Reason for declining Health: Other Group Health Coverage - Carrier: Medicare Medicaid
Name Reason for declining Dental: Other Group Dental Coverage Medicaid Individual Dental Coverage
Name Reason for declining: Other Group Health Coverage Medicare Medicaid Other Individual Health Coverage
Name Reason for declining: Other Group Health Coverage Medicare Medicaid Other Individual Health Coverage
Name Reason for declining: Other Group Health Coverage Medicare Medicaid Other Individual Health Coverage

SECTION 9 — 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 Dearborn Life Insurance Company. 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 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 insurance 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.
I understand that written communications that are required by law may be delivered to me electronically, with my consent. I understand that if I withdraw consent to receive my documents electronically, that will receive a written communication in paper form. Accept receiving communications electronically Reject receiving communications electronically
I understand to withdraw consent to receive documents electronically, I will need to call the Customer Service number on the back of my member ID card.
I understand to update information needed for BCBSTX to contact me electronically, I will need to call the Customer Service number on the back of my member ID card.
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 _____