ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Texas   Dearborn ★ National

Group #	Section #	Dept #	Social Security #
Group #	Section #	Dept #	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, 9 AND 10 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
☐ Other (Explain): __________

Effective Date of Benefits: ___/___/____ ☐Completion of Other Eligibility Requirements **NOTE:** Declination of Coverage (Complete Sections 2, 9 and 10)

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 #
Mailing Address - Street - Apt #		City		State	ZIP code
Email Address		☐ Male ☐ 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? ☐ 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

Small Group Plans (2-50 employees)

Health Coverage (select one)	Who is covered? (select one)	BlueCare Dental℠ Coverage	Who is covered? (select one)
☐ Blue Premier℠ ☐ Blue Choice PPO℠ ☐ Blue Premier Access℠ ☐ Blue Advantage HMO℠ ☐ Blue Essentials℠ ☐ Blue Essentials Access℠ Plan # (required) ______	☐ Employee Only ☐ Employee /Spouse ☐ Employee /Child(ren) ☐ Family ☐ I am not applying for Health coverage	☐ Yes ☐ No	☐ 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)	Who is covered? (select one)	Dental Coverage	Who is covered? (select one)
☐ Blue Choice PPO ☐ Blue Essentials ☐ Blue Premier ☐ Blue Essentials Access ☐ Blue Premier Access ☐ Other ______ Plan # ______	☐ Employee Only ☐ Employee /Spouse ☐ Employee /Child(ren) ☐ Family ☐ I am not applying for Health coverage	☐ Yes ☐ No Plan # (required)	☐ 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
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

PCP SELECTION IS REQUIRED FOR 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? ☐Y ☐N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Dependent's Name ☐ Husband ☐ Wife	Dependent's PCP Name	PCP #	New Patient? ☐Y ☐N	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 ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security #	Dependent's PCP Name	PCP #	New Patient ☐Y ☐N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code		Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption? ☐Y ☐N		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	
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security #	Dependent's PCP Name	PCP #	New Patient ☐Y ☐N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code		Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption? ☐Y ☐N		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	
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Social Security #	Dependent's PCP Name	PCP #	New Patient ☐Y ☐N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Birth Date (MM/DD/YYYY)	Home Address (If different) Street/City/State/ZIP code		Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption? ☐Y ☐N		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	

Last Name: Social Security #: — — Group #

SECTION 5 — GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D), AND DISABILITY INSURANCE COVERAGE

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 #
Primary Beneficiary						– –
Contingent Beneficiary						– –

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:**

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 #	Health ID #	Dental Group #	Dental ID #

SECTION 8 — MEDICARE COVERAGE INFORMATION

Name of person covered.			Medicare HIC # (From Medicare Card)
	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

Name of person covered:			Medicare HIC # (From Medicare Card)
	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

SECTION 9 — 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.

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 10 — 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 National® 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 Contracts(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 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 consent to receive my documents electronically, that I have a right to obtain a paper copy and to withdraw my consent.

Applicant's Signature Date