BlueCross BlueShield of Texas

Group Enrollment Application | Change Form

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

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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.

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ENROLLMENT APPLICATION/CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION/CHANGE FORM

Use a black or blue ballpoint pen only. Print neatly. Do not abbreviate.

SECTION 1 ENROLLMENT 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 Access℠ or Blue Premier Access℠ plans do not require a PCP selection.
- Those applying for Blue Advantage HMO℠, Blue Essentials℠ or Blue Premier℠ 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 Physician 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: **BCBSTX • 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.

ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Texas

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	☐ 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 for health? (select one)**	**BlueCare Dental℠ Coverage**	**Who is covered for dental? (select one)**
☐ Blue Premier Access℠ ☐ Blue Choice PPO℠ ☐ Blue Essentials℠ ☐ Blue Advantage HMO℠ ☐ Blue Essentials Access℠ ☐ Other _____ 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 for health? (select one)**	**Dental Coverage**	**Who is covered for dental? (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: _____

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	

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

** 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).*
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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? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #
Dependent's Name ☐ Husband ☐ Wife ☐ Domestic Partner	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, foster child, adopted child, or a child in suit for adoption? ☐ Y ☐ N		If not your eligible natural child, stepchild, 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, foster child, adopted child, or a child in suit for adoption? ☐ Y ☐ N		If not your eligible natural child, stepchild, 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, foster child, adopted child, or a child in suit for adoption? ☐ Y ☐ N		If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	

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 ☐ Yes ☐ No	Individual 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 7 — MEDICARE COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

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 # (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 # (From Medicare Card)

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 ☐ 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 ☐ Dependent — 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 ☐ Dependent — 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 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 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.

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 ________

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