



Group Enrollment Application/Change Form

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



**BlueCross BlueShield
of Texas**



**FORT DEARBORN LIFE
INSURANCE COMPANY**

GROUP ENROLLMENT APPLICATION / CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION / CHANGE FORM

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

SECTION 1

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 Sections 1, 2, 3, 4, 5, 6, 7, 8, 9 and 11 where applicable.

Add Dependent: Complete Sections 1, 2, 3, 4, 5, 6, 7, 8, 9 and 11 where applicable. If adding dependent by court order, please attach a copy of court order or decree and a completed Dependent Addition For Court-Mandated Health Coverage form.

Change Primary Care Physician (PCP) or Primary Care Dentist (PCD): Complete Sections 1, 2, 3, 4, and 11. In Section 1, please give the reason you are changing your PCP or PCD, and in Section 4 include enrollee or dependent's name, social security number, date of birth, and name and number of the new PCP or PCD.

Change Address / Name: Complete Sections 1, 2 and 11.

Cancel Enrollee or Dependent: Complete Sections 1, 2, 4, and 11. In Section 4 include name, social security number, and date of birth of individual(s) disenrolling.

SECTIONS 2 & 3

Complete all areas that apply to you.

SECTION 4

Complete all areas that are applicable to you and each dependent. Only those applying for HMO or POS coverage should then select a PCP for each dependent. List the name of the physician and the PCP number from the provider directory. Be sure to check the appropriate box for new or existing patient. Only HMO Blue Texas members that are applying for dental coverage should complete the Primary Care Dentist (PCD) information. **ATTENTION FEMALE MEMBERS:** In selecting your PCP, 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 your OB/GYN services from your PCP.

IMPORTANT NOTICE — DEPENDENT CHILD ELIGIBILITY

- 1) A child of the employee's child can be listed as a dependent if IRS guidelines are met at the time of application.
- 2) A court-ordered dependent child is eligible. Your Employer will supply a separate form for those dependents. A completed Dependent Addition For Court-Mandated Health Coverage form must be submitted with the court order or decree.
- 3a) **Non-HMO** — A child includes (1) a natural child, (2) a step-child, (3) a court ordered dependent child, (4) an adopted child, (5) a child involved in a suit for adoption, (6) a child of any age who is medically certified as disabled, or (7) a child of the employee's child.
- 3b) A child not identified in (1) through (7) above can be listed if the child's primary residence is the employee's household, to whom the employee is legal guardian or related by blood or marriage, and who is dependent upon the employee for more than one-half of his support as defined by the IRS of the United States.
- 4) **HMO only** — A child who is other than (1) a natural child or step-child, (2) a court ordered dependent child, or (3) a dependent child for whom the subscriber or subscriber's spouse is a court-appointed legal guardian. Proof of legal guardianship must be submitted with the enrollment form.
- 5) If adding a disabled child who exceeds the age limit in your Employer's contract and meets IRS support guidelines, complete Section 9, Disabled Dependent.

SECTION 5

Complete this section if your employer is offering life insurance coverage.

SECTION 6

Complete this section if you are applying for coverage other than HMO or In-Hospital Indemnity.

SECTION 7

Complete this section if you or any dependent have other health care coverage through an employer.

SECTION 8

Complete this section if you or any of your dependents are covered by Medicare.

SECTION 9

Complete this section if you are applying for coverage for a disabled dependent over the age limit. A disabled dependent must be certified by Medical Underwriting and a completed Statement of Dependent Disability form must be submitted with this enrollment application.

SECTION 10

Complete this section if you are declining health coverage for yourself and your dependents. Anyone declining coverage for any reason should complete section 10, not just those declining because of other coverage.

IMPORTANT NOTICE — DECLINATION OF HEALTH COVERAGE

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, provided 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, or adoption or becoming a party in a suit for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after marriage, birth, adoption or suit for adoption.

SECTION 11

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**, who will then submit your form to:
Group Accounts Dept. • P. O. Box 655730 • Dallas, TX 75265-5730

If you have any questions, please contact your Marketing Service Representative.

Last Name:

Social Security Number:

H Group #

SECTION 6 — PREVIOUS COVERAGE INFORMATION

COMPLETE ONLY IF APPLYING FOR COVERAGE OTHER THAN HMO OR IN-HOSPITAL INDEMNITY

In order to receive credit for pre-existing 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 prior 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 8. List names of every individual covered:

Form with fields: Name of Primary Enrollee, Birth Date (Mo Day Yr), Male/Female, Relationship to Applicant, Group or Policy No., ID Number, Employer's Name, Employment Date, Effective Date, Will Coverage be Continued?, If No, Expected Cancel Date, Type of Coverage, Type of Policy.

SECTION 7 — OTHER COVERAGE INFORMATION

Are you or any member of your family listed above covered by any other health or dental coverage? Yes No List names of every individual covered:

Form with fields: Type of Coverage, Group Coverage, Name and Address of Other Health Care Company, Name of Policyholder, Birth Date (Mo Day Yr), Male/Female, Relationship to Applicant, Type of Coverage, ID Number, Employment Date, Effective Date of Coverage, Group or Policy Number, Employer's Name.

SECTION 8 — MEDICARE COVERAGE INFORMATION

Form with fields: Name of person covered, Medicare A (Hospital) Effective Date, Medicare B (Medical) Effective Date, Medicare No. (From Medicare Card).

Please check the reason for Medicare Eligibility Entitled Age Entitled Disability End-Stage Renal Disease Disability and Current Renal Disease

SECTION 9 — DISABLED DEPENDENT

Form with fields: Name of disabled dependent, Nature of disability, Has disability been diagnosed as permanent? If temporary, how long is dependent expected to remain disabled? Is dependent unable to work due to the disability?

SECTION 10 — DECLINATION OF HEALTH 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 pre-existing condition waiting period.

Table with 2 columns: Name, Reason for declining. Rows for Employee, Spouse, Child, Child, Child.

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... Only those coverage(s) and amounts for which I am eligible will be available to me... I understand that the health coverage I am applying for may be subject to a pre-existing condition exclusion... I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s).

Applicant's Signature Date Employer Verification Signature (Optional) Date

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

Fort Dearborn Life Insurance Company, a Member of the Preferred Financial Group