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 you are adding or enrolling a dependent due to court order, you must submit a copy of the court order or decree AND a completed Dependent Addition and Change Form for Court-Mandated Health Coverage.
- 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.
- If you are applying for coverage for a disabled dependent child over the dependent age limit of your employer's plan, you are required to submit a completed Dependent Child's Statement of Disability form. A disabled dependent over the dependent age limit of your employer's plan must be certified by medical underwriting.

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

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) canceling.

SECTIONS 2 & 3

Complete all areas that apply to you.

SECTION 4

Complete all areas that apply to you and each dependent.

For HMO and POS only: Those applying for HMO or POS coverage should then select a PCP for each individual to be covered. List the name of the physician and the provider number from the provider directory or Provider Finder at **www.bcbstx.com**. Be sure to check the appropriate box for a new patient.
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 OB/GYN services from your PCP.

SECTION 5

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

SECTION 6

Complete this section unless you are applying for HMO or In-Hospital Indemnity coverage.

The health coverage for which you are applying may have a pre-existing condition waiting period. On your group's first contract date or contract anniversary date on or after September 23, 2010, a pre-existing condition waiting period will not apply for individuals under the age of 19. Check with your employer if you have questions regarding pre-existing condition waiting period applicability for individuals under the age of 19.

SECTION 7

Complete this section if you or any dependent have other health care coverage through an employer (group coverage) that will not be cancelled when the coverage under this application becomes effective.

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 child over the dependent child age limit of your employer's plan. A disabled dependent must be certified by medical underwriting and a completed Dependent Child's Statement of 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, 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 the 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**

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 BCBSTX website at www.bcbstx.com, from your Marketing Service Representative, or from your employer. If you have any questions, please contact your Marketing Service Representative.

H ☐☐☐☐☐☐ Group # ☐☐☐☐ Section # ☐☐☐ Dept # ☐☐☐☐☐☐☐☐☐ Social Security Number

☐☐☐☐☐☐ Group # ☐☐☐☐ Section # ☐☐☐ Dept # ______ Category

ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Texas — Dearborn National

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2 AND 10 ONLY.

☐ New Enrollee ☐ Add Dependent
Are you applying as a result of a Special Enrollment Event? ☐ Yes ☐ No **If yes, select Event:** ☐ Marriage ☐ Birth, Adoption, Suit for Adoption
☐ Court Order (see instructions)
☐ Loss of Other Coverage (provide Certification of Coverage)
☐ Other (Explain): ______

Indicate Event Date: ___/___/___

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

☐ Change Primary Care Physician (PCP)
Reason: ______

☐ Change Address/Name

☐ Cancel Enrollee ☐ Cancel Dependent
List names of those canceling in Section 4 below
Event: ☐ Divorce ☐ Death ☐ Terminated Employment ☐ Other

Indicate Event Date: ___/___/___

Cancel Coverage: ☐ Health ☐ Dental ☐ Term Life ☐ Dependent Life ☐ STD ☐ LTD

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

Last Name	First Name	MI (opt)	Suffix	Date of Birth	Social Security Number
				/ /	– –

Mailing Address - Street - Apt#	City	State	Zip

E-Mail Address	☐ Male ☐ Female	Business Phone #	Cell Phone #	Home Phone #

Name of Employer	Date of Employment	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
☐ Continuation of Group Coverage (insured plans only) ☐ Dependent Continuation of Group Coverage (insured plans, only)

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Health (select one)
☐ PPO ☐ HMO
☐ BlueEdge HCA ☐ BlueEdge HSA
☐ HMO Consumer Choice Plan (small group only)
☐ PPO Consumer Choice Plan (small group, only)
☐ Other: ______
Plan #, if known: ______

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

Dental
☐ Yes
☐ No
Plan #, if known: ______

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.	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name	City	State	Zip
– –	/ /				

Dependent's Name ☐ Son ☐ Daughter	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N

Dependent's Social Security No.	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name	City	State	Zip
– –	/ /				

Dependent's Name ☐ Son ☐ Daughter	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N

Dependent's Social Security No.	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name	City	State	Zip
– –	/ /				

Dependent's Name ☐ Son ☐ Daughter	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N

Dependent's Social Security No.	DOB (Mo Day Yr)	Home Address, if different — No. and Street Name	City	State	Zip
– –	/ /				

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 Employee election: $______	☐ I do not apply Spouse election: $______	☐ I do apply	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	Date of Birth	Social Security No.
Primary Beneficiary						
Contingent Beneficiary						

Last Name: Social Security Number: | — — | H Group #

SECTION 6 — PREVIOUS COVERAGE INFORMATION

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

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:

Name of Primary Enrollee	Date of Birth / /	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent	Group or Policy No.	ID Number
Employer's Name: Name and address of other insurance company, TPA, HMO:	Employment Date ___ /___ /___ Effective Date ___ /___ /___ Will Coverage be Continued? ☐ Yes ☐ No If No, Expected Cancel Date ___ /___ /___			Type of Coverage ☐ Health ☐ Dental	Type of Policy ☐ Self ☐ Family ☐ Employee/Spouse ☐ Employee/Child

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:**

Type of Coverage ☐ Health ☐ Dental	Group Coverage ☐ Yes ☐ No	Name and Address of Other Health Care Company			
Name of Policyholder	Date of Birth / /	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent	Type of Policy ☐ Self ☐ Two Person ☐ Family	
ID Number	Employment Date	Effective Date of Coverage	Group or Policy Number	Employer's Name	

SECTION 8 — MEDICARE COVERAGE INFORMATION

Name of person covered: **Medicare HIC# (from ID card):**

☐ Medicare Part A (hospital)
Start Date:_____ End Date:_____
Month/Day/Year Month/Day/Year

☐ Medicare Part B (medical)
Start Date:_____ End Date:_____
Month/Day/Year Month/Day/Year

☐ Medicare Part D (prescription drugs)
Start Date:_____ End Date:_____
Month/Day/Year Month/Day/Year

If BCBSTX is not the Medicare Part D carrier, please provide name and address of the carrier:
Name: _____
Address: _____
City State

Check reason for Medicare eligibility: ☐ Entitled age ☐ Entitled disability ☐ End-stage renal disease ☐ Disability and current renal disease

Name of person covered: **Medicare HIC# (from ID card):**

☐ Medicare Part A (hospital)
Start Date:_____ End Date:_____
Month/Day/Year Month/Day/Year

☐ Medicare Part B (medical)
Start Date:_____ End Date:_____
Month/Day/Year Month/Day/Year

☐ Medicare Part D (prescription drugs)
Start Date:_____ End Date:_____
Month/Day/Year Month/Day/Year

If BCBSTX is not the Medicare Part D carrier, please provide name and address of the carrier:
Name: _____
Address: _____
City State

Check reason for Medicare eligibility: ☐ Entitled age ☐ Entitled disability ☐ End-stage renal disease ☐ Disability and current renal disease

SECTION 9 — DISABLED DEPENDENT

Name of disabled dependent	Nature of disability

Has disability been diagnosed as permanent? ☐ Yes ☐ No If temporary, how long is dependent expected to remain disabled? _____

Is dependent unable to work due to the disability? ☐ Yes ☐ No 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 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.

Employee _____
Reason for declining: ☐ Other Group Coverage ☐ Medicare ☐ Medicaid ☐ Other, explain: _____

Spouse _____
Reason for declining: ☐ Other Group Coverage ☐ Medicare ☐ Medicaid ☐ Other, explain: _____

Child(ren) _____
Reason for declining: ☐ Other Group Coverage ☐ Medicare ☐ Medicaid ☐ Other, explain: _____

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 misinterpretation 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 pre-existing 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).
- 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 _____