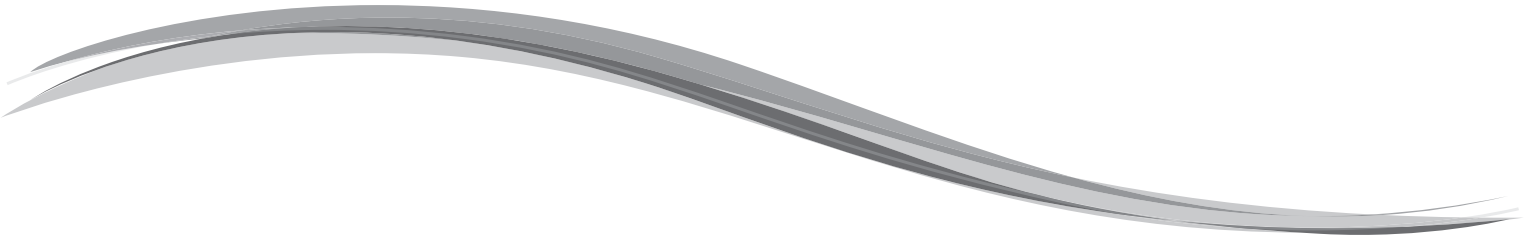
Enrollment Application/Change Form



BlueCross BlueShield of Texas

Dearborn National®*

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

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.

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 (Certificate of Coverage).

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 all Sections where applicable.

Add Dependent: Complete all Sections 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.

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

Cancel Dependent: Complete Sections 1, 2, 4, and 11. In Section 4 include name and date of birth of individual(s) cancelling.

Declining Coverage: Complete Sections 2, 10, and 11.

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 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.

Change Primary Care Physician (PCP): In Section 1, check the "Other Change(s)" box, then complete sections 2, 3, 4, and 11. 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: In Section 1, check the "Other Change(s)" box, then complete sections 1, 2, and 11.

SECTION 5

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

SECTION 6

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 7

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 preexisting condition waiting period. On your group's first contract date or contract anniversary date on or after September 23, 2010, a preexisting condition waiting period will not apply for individuals under the age of 19. Check with your employer if you have questions regarding preexisting condition waiting period applicability for individuals under the age of 19.

SECTION 8

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 9

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

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 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 or becoming a party in a suit for adoption, you may be able to enroll yourself and your dependents if 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**, which 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.

ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Texas   Dearborn National

Group No. | Section No. | Dept No. | Social Security No.

Group No. | Section No. | Dept No. | Category

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 10, & 11 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 (Provide Certificate of Creditable Coverage)
☐ Other (Explain): ______________________

NOTE: Declination of Coverage (Complete Sections 2, 10, & 11)

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 No. – –

Mailing Address - Street - Apt No.	City	State	Zip

E-Mail Address	☐ Male ☐ Female	Home/Cell Phone No.

Name of Employer	Job Title	Business Phone No.	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

Health Coverage (select one)
☐ PPO ☐ HMO
☐ Blue Options ☐ BlueEdge HCA ☐ BlueEdge HSA
☐ HMO Consumer Choice Plan (small group only)
☐ PPO Consumer Choice Plan (small group only)
☐ EPO
☐ Other: ______________
Plan #, if known: ______________

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

Dental Coverage
☐ Yes
☐ No
Plan No., if known: ________

Dental 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. – –	Birth Date (MM/DD/YYYY)	Address (if different) - No. and Street Address	City	State	Zip

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent ________	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, adopted child, or a child in Suit for Adoption? ☐ Y ☐ N	If not your natural child, stepchild, 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 No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, adopted child, or a child in Suit for Adoption? ☐ Y ☐ N	If not your natural child, stepchild, 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 No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, adopted child, or a child in Suit for Adoption? ☐ Y ☐ N	If not your natural child, stepchild, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	

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 ☐ 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 No.
Primary Beneficiary						– –
Contingent Beneficiary						– –

Last Name: Social Security No.: — — Group #

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 — PREVIOUS HEALTH COVERAGE INFORMATION

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

In order to receive credit for preexisting 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 Creditable 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 9. Please see instruction page for more information.

List names of every individual covered:

Previous Coverage Policyholder Name	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent	Group or Policy No.	ID Number

Name of Previous Insurance Company, TPA, HMO:	Effective Date (MM/DD/YYYY)	Type of Coverage ☐ Health ☐ Dental	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Employer's Name:	Employment Date under Previous Coverage (MM/DD/YYYY)	Will Coverage be Continued? ☐ Health ☐ Dental If No, Expected Cancel Date (MM/DD/YYYY) _____

SECTION 8 — 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 No.	Health ID No.	Dental Group No.	Dental ID No.

SECTION 9 — MEDICARE COVERAGE INFORMATION

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 No. (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 No. (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

SECTION 10 — 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 as well as a preexisting condition waiting period.

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 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 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).
- For individuals age 19 and over, I understand that the Health coverage for which I am applying may have a preexisting 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). 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.

Applicant's Signature _____ Date _____