

Group Enrollment Application/Change Form

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





BlueCross BlueShield of Texas



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 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) 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) canceling.

SECTIONS 2&3

Complete all areas that apply to you.

SECTION 4

Complete all areas that apply to you and each dependent. 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. Only HMO Blue Texas members that are applying for certain dental plans are required to select a Primary Care Dentist (PCD). 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.

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

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.

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ENROLLMENT APPLICATION/CHANGE FORM Social Security Number Section # Dept # Group # BlueCross BlueShield of Texas Dept # Category Group # Section # Please Check all that apply – If you are declining coverage, complete Sections 2 and 10 only. SECTION 1 ENROLLMENT EVENTS ☐ Add Dependent ☐ New Enrollee Add Coverage: □ Health □ Dental ☐ Cancel Enrollee ☐ Cancel Dependent Are you applying as a result of a Special Enrollment ☐ Term Life ☐ Dependent Life List names of those canceling in Section 4 below Event? ☐ Yes ☐ No If yes, select ☐ Short Term Disability (STD) Event: □ Divorce □ Death **Event:** Marriage Birth, Adoption, Suit for Adoption ☐ Long Term Disability (LTD) ☐ Terminated Employment ☐ Court Order (see instructions) ☐ Change Primary Care Physician (PCP) ☐ Other ☐ Loss of Other Coverage (provide Certification of Coverage) Indicate Event Date: ___ ☐ Other (Explain): ☐ Change Primary Care Dentist (PCD) Cancel Coverage: ☐ Health ☐ Dental ☐ Term Life Reason: ☐ Dependent Life ☐ STD ☐ LTD Indicate Event Date: _ ☐ Change Address/Name 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 City Zip Mailing Address - Street - Apt# E-Mail Address (opt) ☐ Male ☐ Female Business Phone # Home Phone # Do you usually work at least 30 hours a week for this employer? Name of Employer Date of Employment ☐ Yes ☐ No Eligibility Status: ☐ Active Employee ☐ Retired Employee - Date of Retirement: ☐ 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) Enrollees (select one) Dental Enrollees (select one) \square HMO \square PPO ☐ Employee Only ☐ Yes ☐ Employee Only ☐ Employee /Spouse ☐ BlueEdge HCA ☐ BlueEdge HSA \square No ☐ Employee /Spouse ☐ HMO Consumer Choice Plan (small group only) ☐ Employee /Child(ren) ☐ Employee /Child(ren) ☐ PPO Consumer Choice Plan (small group, only) ☐ Family Plan #, if known: ☐ Family ☐ Other: ☐ I am not applying for ☐ I am not applying Plan #, if known: health coverage 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. Select a PCD for HMO Blue Texas Dental Option Only. Employee/Enrollee's Name New Patient? PCD Name PCD No. New Patient? PCP Name \square Y \square N $\square Y \square N$ Dependent's Name ☐ Husband ☐ Wife Dependent's PCP Name PCP No. New Patient? Dependent's PCD Name PCD No. New Patient? $\square Y \square N$ \square Y \square N Dependent's Social Security No. DOB (Mo Dav Yr) Home Address, if different — No. and Street Name Zip State Dependent's Name ☐ Son ☐ Daughter Dependent's PCP Name PCP No. New Patient? Dependent's PCD Name PCD No. New Patient? $\square Y \square N$ $\square Y \square N$ 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? Dependent's PCD Name PCD No. New Patient? $\square Y \square N$ $\square Y \square N$ Dependent's Social Security No. DOB (Mo Day Yr) Home Address, if different — No. and Street Name State Zip Dependent's Name ☐ Son ☐ Daughter Dependent's PCP Name PCP No. New Patient? Dependent's PCD Name PCD No. New Patient? $\square Y \square N$ $\square Y \square N$ Home Address, if different — No. and Street Name Dependent's Social Security No. DOB (Mo Day Yr) City State Zip / ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D), AND DISABILITY INSURANCE COVERAGES SECTION 5 — GROUP TERM Employee Occupation/Job title: Wage rate \$_ per \square hour \square week \square month \square year ☐ I do apply Group Basic Term Life & AD&D ☐ I do not apply Amount \$ Group Dependents' Life ☐ I do not apply ☐ I do apply Group Supplemental Life ☐ I do not apply ☐ I do apply Child election: \$_ Employee election: \$_ Spouse election: \$ Short Term Disability (STD) ☐ I do not apply ☐ I do apply ☐ I do apply Long Term Disability (LTD) \square I do not apply First Name Initial Last Name Primary Relationship Date of Birth Social Security No. Beneficiary First Name Initial Last Name Relationship Date of Birth Contingent Social Security No. Beneficiary

Last Name: Social Secu				lumber:	_	_	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 Group or Policy No. I □ Self □ Spouse □ Dependent		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 / /		/ ned? □ Yes □ No	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 :									
,,						mpany			
Name of Policyholder		Date of Birt	h [Male	Relations	ship to Applicant	Type of Poli	CV	
,		/ /] Female		pouse 🗆 Dependent	☐ Self ☐ Two Person	•	
ID Number	Employment Date		Effective Date o	f Coverage	Group or	Policy Number	Employer's Name		
SECTION 8 — MED		E IVIEODWY.	TION						
SECTION 8 — MEDICARE COVERAGE INFORMATION Name of person covered:					Medicare HIC# (from ID card):				
☐ Medicare Part A (hospital)					☐ Medicare Part B (medical)				
Start Date: End Date: Month/Day/Year Month/Day/Year					Start Date: End Date: Month/Day/Year				
☐ Medicare Part D (prescription drugs) Start Date: End Date:					If BCBSTX is not the Medicare Part D carrier, please provide name and address of the carrier: Name:				
Month/Day/Year Month/Day/Year					Address:City State				
Check reason for Medicare eligibility: Entitled age Entitled disability End-stage renal disease Disability and current renal disease									
						Medicare HIC# (from ID card):			
☐ Medicare Part A (hospital)					☐ Medicare Part B (medical)				
Start Date: End Date: Month/Day/Year Month/Day/Year					Start Date: End Date: Month/Day/Year End Date: Month/Day/Year				
☐ Medicare Part D (prescription drugs)					If BCBSTX is not the Medicare Part D carrier, please provide name and address of the carrier:				
Start Date: End Date: Month/Day/Year Month/Day/Year					Name:				
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 availar voluntarily elected to decl as well as a pre-existing co	able coverage has been ine the coverage as ind andition waiting period	explained to m licated below. If	ie. I have been gi f I desire to apply	ven the opport for coverage	tunity to apply f at a later date, I	or the coverage offered to understand there may be a	me and my eligible depend delay in the effective date	ents and have of the coverage	
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 — CO	VERAGE CONDITI	IONS							
 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 incorrect statements material to the risk and knowingly 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 understand that the Health coverage for which I am applying may have a pre-existing condition exclusion waiting period. 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 binding upon me. Applicant's Signature Date									
rppheams signature						Date			

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