ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Texas

Group #	Section #	Social Security #
Account #		Category

SECTION 1 — ENROLLMENT EVENTS
PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 7 AND 8 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**

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	Employee #	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 COVERAGE OPTIONS
PLEASE CHECK AND COMPLETE ALL AREAS THAT APPLY

Health Coverage	**Who is covered for health? (select one)**	**Dental Coverage**	**Who is covered for dental? (select one)**
☐ Blue Choice PPO℠	☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Family ☐ I am not applying for Health Coverage	☐ Blue Care Dental PPO℠	☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Family ☐ I am not applying for Dental Coverage

☐ Spouse***	Spouse's Name	Spouse's Social Security #	Birth Date (MM/DD/YYYY)	
	Home Address (if different) - # and Street Address	City	State	ZIP Code
☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Name	Dependent's Social Security #	Birth Date (MM/DD/YYYY)	
	Home Address (if different) - # and Street Address	City	State	ZIP Code
☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Name	Dependent's Social Security #	Birth Date (MM/DD/YYYY)	
	Home Address (if different) - # and Street Address	City	State	ZIP Code
☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Name	Dependent's Social Security #	Birth Date (MM/DD/YYYY)	
	Home Address (if different) - # and Street Address	City	State	ZIP Code
☐ Son ☐ Daughter ☐ Other Eligible Dependent	Dependent's Name	Dependent's Social Security #	Birth Date (MM/DD/YYYY)	
	Home Address (if different) - # and Street Address	City	State	ZIP Code

Group Term Life and Accidental Death and Dismemberment (AD&D) | **Annual Salary**

☐ I am enrolled the City of Lubbock paid Group Basic Term Life Insurance and AD&D: $10,000

Group Supplemental Life - Evidence of Insurability form (EOI) is required

☐ I do apply ☐ I do NOT apply **(Refer to packet for spouse and child coverage amounts)**

Employee Election: ☐ 1X ☐ 2X ☐ 3X ☐ Spouse Election: $_____________ ☐ Child Election: $_____________

Group Accident Insurance	**Voluntary AD&D**	**Long-Term Disability - EOI is required**
☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Family ☐ I am not applying for Group Accident Coverage	☐ I do apply ☐ I do NOT apply Employee Election: ☐ 1X ☐ 2X ☐ 3X (annual salary) ☐ Employee/Family: ☐ 1X ☐ 2X ☐ 3X (annual salary)	☐ I do apply ☐ I do NOT apply ☐ 90 days option ☐ 180 days option

Last Name: _____ Social Security #: | - - | Group #: _____

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

Cancel Coverage (List names of those canceling in "dependent" spaces on page one)
☐ Cancel Enrollee ☐ Cancel Dependent
Cancel Coverage Type: ☐ Health ☐ Dental ☐ Supplemental Life ☐ Accident Insurance ☐ AD&D ☐ Long-Term Disability
Event: ☐ Divorce** ☐ Death ☐ Terminated Employment ☐ Other **Indicate Event Date:** ____ / ____ / ____

SECTION 4 — DISABLED DEPENDENT
PLEASE COMPLETE IF ADDING A 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 5 — 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	Individual Coverage	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy
☐ Yes ☐ No	☐ Yes ☐ No			☐ 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 6 — 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 7 — 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 ☐ 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 ☐ 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 ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain) _____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage

SECTION 8 — 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 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 _____

* 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).