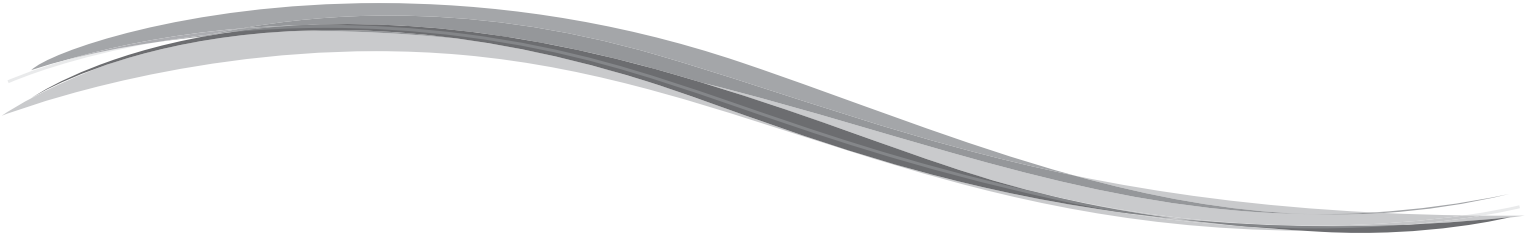


Enrollment Application/Change Form



**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	<p>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.</p> <p>New Enrollee: Complete all Sections where applicable.</p> <p>Add Dependent: Complete all Sections where applicable.</p> <ul style="list-style-type: none">• If you are enrolling a court-ordered dependent for coverage beyond the automatic 31 day period for coverage, you must submit a copy of the court order or decree.• 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 over the age limit of your employer's plan, please provide the additional information requested in Section 6. Additional documentation may be required as addressed in that section. <p>Cancel Enrollee: Complete Sections 1, 2, 4, and 10. In Section 4 include name, social security number, and date of birth of individual(s) cancelling.</p> <p>Cancel Dependent: Complete Sections 1, 2, 4, and 10. In Section 4 include name and date of birth of individual(s) cancelling.</p> <p>Declining Coverage: Complete Sections 2, 9, and 10.</p>
SECTIONS 2 & 3	<p>Complete all portions related to the coverages for which you are applying.</p> <p>If you work for an employer with 2-50 employees: Please list the seven-character plan ID for your selected benefit design (example: B634ADT) in the Plan # field. If you are unsure of your group size or do not know your plan ID, please ask for guidance from your employer.</p>
SECTION 4	<p>Complete all areas that apply to you and each dependent.</p> <p>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.</p> <p>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.</p> <p>Change Primary Care Physician (PCP): In Section 1, check the "Other Change(s)" box, then complete sections 2, 3, 4, and 10. 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.</p> <p>Change Address / Name: In Section 1, check the "Other Change(s)" box, then complete sections 1, 2, and 10.</p>
SECTION 5	<p>Complete this section if your employer is offering life insurance coverage.</p>
SECTION 6	<p>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.</p>
SECTION 7	<p>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.</p>
SECTION 8	<p>Complete this section if you or any of your dependents are covered by Medicare.</p>
SECTION 9	<p>Complete this section if you are declining health coverage for yourself and your dependents. Anyone declining coverage for any reason should complete Section 9, not just those declining because of other coverage.</p>
	<div style="border: 1px solid black; padding: 5px;"><p>IMPORTANT NOTICE – DECLINATION OF HEALTH COVERAGE</p><p>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, becoming a party in a suit for adoption, or placement in your home as a foster child, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption, suit for adoption, or placement of an eligible foster child in your home.</p></div>
SECTION 10	<p>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</p>

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



dearborn national**

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Group No.	Section No.	Dept No.	Social Security No.
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Group No.	Section No.	Dept No.	Category

SECTION 1 — ENROLLMENT EVENTS		PLEASE CHECK ALL THAT APPLY — IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 9, & 10 ONLY	
<input type="checkbox"/> New Enrollee <input type="checkbox"/> Add Dependent <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Other Change(s) Are you applying as a result of a Special Enrollment Event? <input type="checkbox"/> No <input type="checkbox"/> Yes, Event Date: ___/___/___ Event: <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Adoption or Suit for Adoption (Provide Legal Documents) <input type="checkbox"/> Court Order (Provide Court Order or decree) <input type="checkbox"/> Loss of Other Coverage (Provide Certificate of Creditable Coverage) <input type="checkbox"/> Other (Explain): _____		Add Coverage: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Term Life <input type="checkbox"/> Dependent Life <input type="checkbox"/> Short Term Disability (STD) <input type="checkbox"/> Long Term Disability (LTD)	
NOTE: Declination of Coverage (Complete Sections 2, 9, & 10)		<input type="checkbox"/> Cancel Enrollee <input type="checkbox"/> Cancel Dependent Cancel Coverage: <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Term Life <input type="checkbox"/> Dependent Life <input type="checkbox"/> STD <input type="checkbox"/> LTD List names of those cancelling in Section 4 below Event: <input type="checkbox"/> Divorce <input type="checkbox"/> Death <input type="checkbox"/> Terminated Employment <input type="checkbox"/> 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		<input type="checkbox"/> Male <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Eligibility Status: <input type="checkbox"/> Active Employee <input type="checkbox"/> Retired Employee - Date of Retirement: _____		<input type="checkbox"/> COBRA Continuation				
<input type="checkbox"/> State Continuation of Group Coverage (insured plans only)		<input type="checkbox"/> Dependent State Continuation of Group Coverage (insured plans only)				

SECTION 3 — SELECT YOUR COVERAGE		PLEASE CHECK ALL THAT APPLY	
Small Group Plans (2-50 employees)			
Health Coverage (select one) <input type="checkbox"/> BlueChoice PPO SM <input type="checkbox"/> BlueAdvantage HMO SM 7-character Plan # (required) _____	Who is covered? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee /Spouse <input type="checkbox"/> Employee /Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Health coverage	BlueCare Dental Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No	Who is covered? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee /Spouse <input type="checkbox"/> Employee /Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Dental coverage
Large Group Plans (more than 50 Employees)			
Health Coverage (select one) <input type="checkbox"/> BlueChoice PPO SM <input type="checkbox"/> EPO <input type="checkbox"/> BlueEdge HCA SM <input type="checkbox"/> HMOBlue [®] Texas <input type="checkbox"/> BlueEdge HSA SM <input type="checkbox"/> [BlueAdvantage HMO] <input type="checkbox"/> [BlueOptions SM] <input type="checkbox"/> [Community HMO] <input type="checkbox"/> Other _____ Plan # _____	Who is covered? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee /Spouse <input type="checkbox"/> Employee /Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Health coverage	Dental Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No Plan # (required) _____	Who is covered? (select one) <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee /Spouse <input type="checkbox"/> Employee /Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> I am not applying for Dental coverage
Primary Language: _____		<input type="checkbox"/> Check here to request a Spanish HMO Member Handbook	
Do you have a disability affecting your ability to communicate or read? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Y <input type="checkbox"/> N
Dependent's Name <input type="checkbox"/> Husband <input type="checkbox"/> Wife	Dependent's PCP Name	PCP No.	New Patient? <input type="checkbox"/> Y <input type="checkbox"/> N
Dependent's Social Security No.	Birth Date (MM/DD/YYYY)	Address (if different) - No. and Street Address	
City	State	Zip	
Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent _____	Dependent's Social Security No.	Dependent's PCP Name	PCP No.
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption? <input type="checkbox"/> Y <input type="checkbox"/> N	If not your natural child, stepchild, eligible foster child, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N
Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent _____	Dependent's Social Security No.	Dependent's PCP Name	PCP No.
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption? <input type="checkbox"/> Y <input type="checkbox"/> N	If not your natural child, stepchild, eligible foster child, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N
Dependent's Name <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Eligible Dependent _____	Dependent's Social Security No.	Dependent's PCP Name	PCP No.
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, eligible foster child, adopted child, or a child in Suit for Adoption? <input type="checkbox"/> Y <input type="checkbox"/> N	If not your natural child, stepchild, eligible foster child, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent? <input type="checkbox"/> Y <input type="checkbox"/> N

Last Name:

Social Security No.:

Group #

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
Primary Beneficiary First Name Initial Last Name Relationship Birth Date (MM/DD/YYYY) Social Security No.
Contingent Beneficiary First Name Initial Last Name Relationship Birth Date (MM/DD/YYYY) Social Security No.

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 — 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
Name of Policyholder Birth Date (MM/DD/YYYY) Relationship to Applicant
Employer's Name Employment Date (MM/DD/YYYY) Health Group No. Health ID No. Dental Group No. Dental ID No.

SECTION 8 — MEDICARE COVERAGE INFORMATION

Name of person covered: Medicare A (Hospital) Effective Date: _____ End Date: _____ 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 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 9 — 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.
Name Employee Reason for Declining Health: Other Group Health Coverage; Carrier: _____ Medicare Medicaid
Name Employee Reason for Declining Dental: Other Group Dental Coverage Medicaid Individual Dental Coverage
Name Spouse Reason for declining: Other Group Health Coverage Medicare Medicaid Other Individual Health Coverage
Name Child Reason for declining: Other Group Health Coverage Medicare Medicaid Other Individual Health Coverage
Name Child Reason for declining: Other Group Health Coverage Medicare Medicaid Other Individual Health Coverage

SECTION 10 — 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).
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 receiving my documents electronically, that I have a right to obtain a paper copy and to withdraw my consent.
Applicant's Signature _____ Date _____

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