enroll

Group Enrollment Application/Change Form

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

FORT DEARBORN LIFE INSURANCE COMPANY

EE/CHG3 1003

BlueCross BlueShield of Texas

8710.244.0605

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 adding dependent by court order, please attach a copy of court order or decree and a completed Dependent Addition For Court-Mandated Health Coverage form.

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) disenrolling.

SECTIONS 2 & 3

Complete all areas that apply to you.

SECTION 4

Complete all areas that are applicable to you and each dependent. **Only those applying for HMO or POS coverage should then select a PCP for each dependent.** List the name of the physician and the PCP number from the provider directory. Be sure to check the appropriate box for new or existing patient. **Only HMO Blue Texas members that are applying for dental coverage should complete the Primary Care Dentist (PCD) information. 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 your OB/GYN services from your PCP.

IMPORTANT NOTICE — DEPENDENT CHILD ELIGIBILITY

1) A child of the employee's child can be listed as a dependent if IRS guidelines are met at the time of application.
2) A court-ordered dependent child is eligible. Your Employer will supply a separate form for those dependents. A completed Dependent Addition For Court-Mandated Health Coverage form must be submitted with the court order or decree.
3a) **Non-HMO** — A child includes (1) a natural child, (2) a step-child, (3) a court ordered dependent child, (4) an adopted child, (5) a child involved in a suit for adoption, (6) a child of any age who is medically certified as disabled, or (7) a child of the employee's child.
3b) A child not identified in (1) through (7) above can be listed if the child's primary residence is the employee's household, to whom the employee is legal guardian or related by blood or marriage, and who is dependent upon the employee for more than one-half of his support as defined by the IRS of the United States.
4) **HMO only** — A child who is other than (1) a natural child or step-child, (2) a court ordered dependent child, or (3) a dependent child for whom the subscriber or subscriber's spouse is a court-appointed legal guardian. Proof of legal guardianship must be submitted with the enrollment form.
5) If adding a disabled child who exceeds the age limit in your Employer's contract and meets IRS support guidelines, complete Section 9, Disabled Dependent.

SECTION 5

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

SECTION 6

Complete this section if you are applying for coverage other than HMO or In-Hospital Indemnity.

SECTION 7

Complete this section if you or any dependent have other health care coverage through an employer.

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 over the age limit. A disabled dependent must be certified by Medical Underwriting and a completed Statement of Dependent 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, or 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 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**

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

Fort Dearborn Life Insurance Company

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY

☐ **New Enrollee** ☐ **Add Dependent**

Event: ☐ Marriage ☐ Birth or Adoption ☐ Court Order (See Instructions) ☐ Suit for Adoption ☐ Other (See Instructions) 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) or Primary Care Dentist (PCD). Reason:

☐ **Cancel Enrollee** ☐ **Cancel Dependent**

List names of those canceling in section 4 below

Event: ☐ Divorce ☐ Death ☐ Terminated Employment

Indicate Event Date: ____ / ____ / ____

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

☐ Change Address/Name

☐ Declination of Coverage (refer to section 10)

Are you applying as a result of a Special Enrollment Event? ☐ **Yes** ☐ **No If yes, Indicate Event Date:**

☐ Married ☐ Birth or Adoption

☐ Suit for Adoption ☐ Court Order

☐ Loss of Coverage (provide Certification of Coverage)

☐ Other. Explain:

Indicate Event Date: ____ / ____ / ____

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

Last Name	First	Middle	Birth Date (Mo Day Yr)	Social Security Number

Sex	Employment Date (Mo Day Yr)	Name of Employer	Payroll No.	Work Phone No.
☐ Male ☐ Female				( )

Home Address — No. and Street Address	City	State	Zip	Do you usually work at least 30 hours a week for this employer? ☐ Y ☐ N	Home Phone No.
					( )

SECTION 3 — SELECT YOUR COVERAGE

Health (select one)

☐ PPO
☐ Traditional
☐ POS (Self-Funded only)
☐ BlueEdge (Consumer Driven Health Plan)
☐ HMO
☐ In-Hospital Indemnity (Large Group/Employee only)

Plan Selection ________

Enrollees (select one)

☐ Employee Only
☐ Employee/Spouse
☐ Employee/Child(ren)
☐ Family
☐ I DO NOT APPLY

PPO Network (select one)

☐ BlueChoice® Network
☐ BlueChoice Solutions℠ Network

Dental (select one)

☐ PPO (Self-Funded only)
☐ Traditional

Plan Selection ________

Enrollees (select one)

☐ Employee Only
☐ Employee/Spouse
☐ Employee/Child(ren)
☐ Family
☐ I DO NOT APPLY

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 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 RIDER ONLY. **OB/GYN No.**

Employee/Enrollee's Name	Applicant's PCP Name	PCP No.	New Patient? ☐ Y ☐ N	Applicant's PCD Name	PCD No.	New Patient? ☐ Y ☐ N	OB/GYN No.
Dependent's Name ☐ Husband ☐ Wife	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N	Dependent's PCD Name	PCD 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 PCD Name	PCD 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 PCD Name	PCD 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 PCD Name	PCD 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 INSURANCE, ACCIDENT AND DISABILITY COVERAGES

Employee Occupation: ☐ Salary ☐ Hourly Wage Rate $________ per ☐ Hour ☐ Week ☐ Month ☐ Year

Group Basic Life & AD&D ☐ I Apply ☐ I Do Not Apply Amount $________ Group Supplemental Life ☐ I Apply ☐ I Do Not Apply Amount $________

Group Dependent Life ☐ I Apply ☐ I Do Not Apply Spouse Volume $________ Dep Child Volume – 15 days to 6 mos. $________ 6 mos. to older $________ Students $________

Short Term Disability (STD) ☐ I Apply ☐ I Do Not Apply Long Term Disability (LTD) ☐ I Apply ☐ I Do Not 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

COMPLETE ONLY IF APPLYING FOR COVERAGE OTHER THAN HMO OR IN-HOSPITAL INDEMNITY

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	Birth Date (Mo Day Yr)	☐ 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 ☐ Employer Sponsored or ☐ Individual Purchase	Type of Policy ☐ Self ☐ Family ☐ Employee/Spouse or ☐ Employee/Child

SECTION 7 — OTHER COVERAGE INFORMATION

Are you or any member of your family listed above covered by any other health or dental coverage? ☐ Yes ☐ No List names of every individual covered:

Type of Coverage ☐ Health ☐ Dental	Group Coverage ☐ Yes ☐ No	Name and Address of Other Health Care Company

Name of Policyholder	Birth Date (Mo Day Yr)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent	Type of Coverage ☐ 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 A (Hospital) Effective Date: ____/____/____ ☐ Medicare B (Medical) Effective Date: ____/____/____	Medicare No. (From Medicare Card)
Name of person covered:	☐ Medicare A (Hospital) Effective Date: ____/____/____ ☐ Medicare B (Medical) Effective Date: ____/____/____	Medicare No. (From Medicare Card)

Please check the 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

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.

Name ☐ Employee	Reason for declining: ☐ Other Group Coverage	☐ Medicare	☐ Medicaid	☐ Other, explain:	
Name ☐ Spouse	Reason for declining: ☐ Other Group Coverage	☐ Medicare	☐ Medicaid	☐ Other, explain:	
Name ☐ Child	Reason for declining: ☐ Other Group Coverage	☐ Medicare	☐ Medicaid	☐ Other, explain:	
Name ☐ Child	Reason for declining: ☐ Other Group Coverage	☐ Medicare	☐ Medicaid	☐ Other, explain:	
Name ☐ Child	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), HMO Blue Texas, 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 Contract(s).
- I understand that the health coverage I am applying for may be subject to a pre-existing condition exclusion (not applicable if applying for HMO or In-Hospital Indemnity).
- I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). I agree that my Employer acts as my agent. All notices given to my Employer are binding upon me. I also agree that my participation in the coverage(s) is subject to any future amendments.

Applicant's Signature _____ Date _____

Employer Verification Signature (Optional) _____ Date _____

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

Fort Dearborn Life Insurance Company, a Member of the Preferred Financial Group