BlueCross BlueShield of Texas

Group Enrollment Application/Change Form

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

730197.0425

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.**

SECTION 1 ENROLLMENT EVENTS	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 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 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 5. Additional documentation may be required as addressed in that section. •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. **Open Enrollment:** The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current membership. **Special Enrollment Event:** If you qualify, special enrollment is any change to your current membership such as marriage*, divorce**, adoption, suit for adoption or placement for adoption, leave/layoff, moving out of the service area, etc. This change may occur outside of open enrollment. **Effective Date of Benefits:** Field is mandatory and should reflect your requested date. **Completion of Other Eligibility Requirements:** Check this box only if your employer has eligibility requirements that you have met/completed prior to enrollment, such as measurement period or orientation period. **Cancel Enrollee/Cancel Dependent/Cancel Coverage:** Complete Sections 1, 2, 4 (skip Section 4 if declining coverage) and 9. In Section 4 include name, social security number and date of birth of individual(s) canceling.
SECTION 2 YOUR INFORMATION	Complete this section with details about yourself even if you are declining coverage.
SECTION 3 YOUR COVERAGE	Complete all portions related to the coverages for which you are applying. Please list the seven character plan ID for your selected benefit design (example for a small group plan: 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. If you are enrolling for life or disability insurance enter the information requested. When listing the beneficiary, provide both the first and last name and the relationship to you. List all beneficiaries that apply.
SECTION 4 COVERAGE OPTIONS	Complete all areas that apply to you and each dependent. **For HMO Plans Only:** • Blue Essentials AccessSM or Blue Premier AccessSM plans do not require a PCP selection. • Those applying for Blue Advantage HMOSM, Blue EssentialsSM or Blue PremierSM plans are required to select a primary care physician/practitioner (PCP) for each covered individual. List the name of the physician/practitioner and the provider number from the provider directory or Provider Finder® at bcbstx.com. Be sure to check the appropriate box for a new patient. • ATTENTION FEMALE MEMBERS: If you select an HMO plan that requires PCP selection, 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/Practitioner:** Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2, 3, 4 and 9. 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:** Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2 and 9.
SECTION 5 DISABLED DEPENDENT	A disabled dependent must be medically certified as disabled and dependent upon you or your spouse***/domestic partner in order to be considered for coverage if dependent coverage is part of your employer's plan. A Disabled Dependent Authorization and Disabled Dependent Physician Certification form must be completed and submitted with this enrollment application, if applicable.
SECTION 6 OTHER COVERAGE	Complete this section if you or any dependent have other group or individual health and/or dental coverage (if applicable) that will not be canceled when the coverage under this application becomes effective.
SECTION 7 MEDICARE COVERAGE	Complete this section if you or any of your dependents are covered by Medicare. Enter the start and end dates for the coverage that applies. Your Medicare HIC number must be listed (it can be found on your Medicare ID card). Check the reason for your Medicare coverage.
SECTION 8 DECLINATION OF COVERAGE	Complete this section if you are declining health coverage for yourself and your dependents. Anyone declining coverage for any reason should complete Section 8, not just those declining because of other coverage. **IMPORTANT NOTICE:** 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, party to a civil union, birth, adoption, becoming a party in a suit for adoption, or placement of a foster child in your home, 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 for adoption, or placement of an eligible foster child in your home.
SECTION 9 COVERAGE CONDITIONS	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 by mail or email to: BCBSTX, Group Accounts Dept., PO Box 655730, Dallas, TX 75265-5730.

• 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).

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 BLUE CROSS AND BLUE SHIELD OF TEXAS WEBSITE AT BCBSTX.COM, OR FROM YOUR EMPLOYER. IF YOU ARE A CURRENT MEMBER AND HAVE QUESTIONS, YOU MAY ALSO CALL THE CUSTOMER SERVICE NUMBER ON THE BACK OF YOUR MEMBER ID CARD.

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GROUP #	SECTION #	SOC. SEC. #	ACCOUNT #	CATEGORY

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.

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 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, PLACEMENT FOR 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**

☐ **CANCEL ENROLLEE** ☐ **CANCEL DEPENDENT**

CANCEL COVERAGE: ☐ HEALTH ☐ DENTAL ☐ TERM LIFE

☐ DEPENDENT LIFE ☐ SUPPLEMENTAL LIFE ☐ STANDALONE VISION

☐ SHORT-TERM DISABILITY ☐ LONG-TERM DISABILITY

☐ SPECIFIED DISEASE ☐ ACCIDENT INSURANCE ☐ HOSPITAL INDEMNITY

LIST NAMES OF THOSE CANCELING 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 #

MAILING ADDRESS - STREET - APT #	CITY	STATE	ZIP CODE

EMAIL ADDRESS	☐ MALE ☐ FEMALE	HOME/CELL PHONE #

NAME OF EMPLOYER	JOB TITLE	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 YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

SMALL GROUP PLANS (2-50 EMPLOYEES)

HEALTH COVERAGE (SELECT ONE)	WHO IS COVERED FOR HEALTH? (SELECT ONE)	BLUECARE DENTAL℠ COVERAGE	WHO IS COVERED FOR DENTAL? (SELECT ONE)
☐ BLUE PREMIER ACCESS℠ ☐ BLUE CHOICE PPO℠ ☐ BLUE ESSENTIALS℠ ☐ BLUE ADVANTAGE HMO℠ ☐ BLUE ESSENTIALS ACCESS℠ ☐ OTHER PLAN # (REQUIRED)	☐ EMPLOYEE ONLY ☐ EMPLOYEE/SPOUSE*** ☐ EMPLOYEE/CHILD(REN) ☐ FAMILY ☐ I AM NOT APPLYING FOR HEALTH COVERAGE	☐ YES ☐ NO	☐ EMPLOYEE ONLY ☐ EMPLOYEE/SPOUSE ☐ EMPLOYEE/CHILD(REN) ☐ FAMILY ☐ I AM NOT APPLYING FOR DENTAL COVERAGE

LARGE GROUP PLANS (MORE THAN 50 EMPLOYEES)

HEALTH COVERAGE (SELECT ONE)	WHO IS COVERED FOR HEALTH? (SELECT ONE)	DENTAL COVERAGE	WHO IS COVERED FOR DENTAL? (SELECT ONE)
☐ BLUE CHOICE PPO℠ ☐ BLUE ESSENTIALS℠ ☐ BLUE PREMIER℠ ☐ BLUE ESSENTIALS ACCESS℠ ☐ BLUE PREMIER ACCESS℠ ☐ OTHER PLAN # (REQUIRED)	☐ EMPLOYEE ONLY ☐ EMPLOYEE/SPOUSE*** ☐ EMPLOYEE/CHILD(REN) ☐ FAMILY ☐ I AM NOT APPLYING FOR HEALTH COVERAGE	☐ YES ☐ NO PLAN # (REQUIRED)	☐ EMPLOYEE ONLY ☐ EMPLOYEE/SPOUSE ☐ EMPLOYEE/CHILD(REN) ☐ FAMILY ☐ I AM NOT APPLYING FOR DENTAL COVERAGE

PRIMARY LANGUAGE: ☐ ENGLISH ☐ SPANISH ☐ CHECK HERE TO REQUEST A SPANISH HMO MEMBER HANDBOOK

DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? ☐ YES ☐ NO IF "YES," DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D), DISABILITY, ACCIDENT, SPECIFIED DISEASE, HOSPITAL INDEMNITY AND STANDALONE VISION INSURANCE

☐ I AM NOT APPLYING FOR GROUP TERM LIFE, AD&D, DISABILITY, ACCIDENT, SPECIFIED DISEASE, HOSPITAL INDEMNITY OR STANDALONE VISION INSURANCE COVERAGE

EMPLOYEE OCCUPATION/JOB TITLE: WAGE RATE $ PER ☐ HOUR ☐ WEEK ☐ MONTH ☐ YEAR

GROUP BASIC TERM LIFE AND 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	☐ I DO NOT APPLY	☐ I DO APPLY	LONG-TERM DISABILITY	☐ I DO NOT APPLY	☐ I DO APPLY	
SPECIFIED DISEASE	☐ I DO NOT APPLY	☐ I DO APPLY	EMPLOYEE ELECTION: $	SPOUSE ELECTION: $	CHILD ELECTION: $	
ACCIDENT	☐ I DO NOT APPLY	☐ I DO APPLY	☐ INDIVIDUAL/EMPLOYEE	☐ EMPLOYEE/SPOUSE	☐ EMPLOYEE/CHILD	☐ FAMILY
HOSPITAL INDEMNITY	☐ I DO NOT APPLY	☐ I DO APPLY	☐ INDIVIDUAL/EMPLOYEE	☐ EMPLOYEE/SPOUSE	☐ EMPLOYEE/CHILD	☐ FAMILY
STANDALONE VISION	☐ I DO NOT APPLY	☐ I DO APPLY	☐ INDIVIDUAL/EMPLOYEE	☐ EMPLOYEE/SPOUSE	☐ EMPLOYEE/CHILD	☐ FAMILY

	FIRST NAME	INITIAL	LAST NAME	RELATIONSHIP	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY #
PRIMARY BENEFICIARY						
CONTINGENT BENEFICIARY						

LAST NAME	SOC. SEC. #	GROUP #

SECTION 4 — COVERAGE OPTIONS

PLEASE COMPLETE ALL AREAS THAT APPLY. PCP SELECTION IS REQUIRED FOR BLUE ADVANTAGE, BLUE PREMIER AND BLUE ESSENTIALS PLANS. PCP SELECTION IS NOT REQUIRED FOR BLUE PREMIER ACCESS AND BLUE ESSENTIALS ACCESS PLANS.

EMPLOYEE/ENROLLEE'S NAME	PCP NAME	PCP #	NEW PATIENT? ☐ YES ☐ NO	HMO OB/GYN NAME (OPTIONAL)	HMO OB/GYN #
DEPENDENT'S NAME ☐ HUSBAND ☐ WIFE ☐ DOMESTIC PARTNER ☑ PARTY TO A CIVIL UNION	DEPENDENT'S PCP NAME	PCP #	NEW PATIENT? ☐ YES ☐ NO	HMO OB/GYN NAME (OPTIONAL)	HMO OB/GYN #
DEPENDENT'S SOCIAL SECURITY #	BIRTH DATE (MM/DD/YYYY)	HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE			

DEPENDENT'S NAME	DEPENDENT'S PCP NAME	PCP #	NEW PATIENT?	HMO OB/GYN NAME (OPTIONAL)	HMO OB/GYN #
☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT			☐ YES ☐ NO		
DEPENDENT'S SOCIAL SECURITY #	BIRTH DATE (MM/DD/YYYY)	HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE			
IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO	IF NOT YOUR ELIGIBLE NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR CHILD IN SUIT FOR ADOPTION, ARE YOU (OR YOUR SPOUSE) RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO				

DEPENDENT'S NAME	DEPENDENT'S PCP NAME	PCP #	NEW PATIENT?	HMO OB/GYN NAME (OPTIONAL)	HMO OB/GYN #
☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT			☐ YES ☐ NO		
DEPENDENT'S SOCIAL SECURITY #	BIRTH DATE (MM/DD/YYYY)	HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE			
IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO	IF NOT YOUR ELIGIBLE NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR CHILD IN SUIT FOR ADOPTION, ARE YOU (OR YOUR SPOUSE) RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO				

DEPENDENT'S NAME	DEPENDENT'S PCP NAME	PCP #	NEW PATIENT?	HMO OB/GYN NAME (OPTIONAL)	HMO OB/GYN #
☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT			☐ YES ☐ NO		
DEPENDENT'S SOCIAL SECURITY #	BIRTH DATE (MM/DD/YYYY)	HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE			
IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO	IF NOT YOUR ELIGIBLE NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR CHILD IN SUIT FOR ADOPTION, ARE YOU (OR YOUR SPOUSE) RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO				

DEPENDENT'S NAME	DEPENDENT'S PCP NAME	PCP #	NEW PATIENT?	HMO OB/GYN NAME (OPTIONAL)	HMO OB/GYN #
☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT			☐ YES ☐ NO		
DEPENDENT'S SOCIAL SECURITY #	BIRTH DATE (MM/DD/YYYY)	HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE			
IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO	IF NOT YOUR ELIGIBLE NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR CHILD IN SUIT FOR ADOPTION, ARE YOU (OR YOUR SPOUSE) RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO				

SECTION 5 — DISABLED DEPENDENT

PLEASE COMPLETE IF APPLICABLE

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 DISABLED DEPENDENT CERTIFICATION AND THE DISABLED DEPENDENT PHYSICIAN CERTIFICATION DOCUMENT.

SECTION 6 — OTHER COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

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)		RELATIONSHIP TO APPLICANT
		☐ MALE ☐ FEMALE	☐ SELF ☐ SPOUSE ☐ DEPENDENT

EMPLOYER'S NAME	EMPLOYMENT DATE (MM/DD/YYYY)	HEALTH GROUP #	HEALTH ID #	DENTAL GROUP #	DENTAL ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

NAME OF PERSON COVERED:			MEDICARE HIC # (FROM MEDICARE CARD)
	MEDICARE A (HOSPITAL) EFFECTIVE DATE: MEDICARE B (MEDICAL) EFFECTIVE DATE: MEDICARE D (DRUG) EFFECTIVE DATE: MEDICARE D (DRUG) CARRIER:	END DATE: END DATE: END DATE:	

PLEASE INDICATE REASON FOR MEDICARE ELIGIBILITY: ☐ ENTITLED AGE ☐ ENTITLED DISABILITY ☐ END-STAGE RENAL DISEASE ☐ DISABILITY AND CURRENT RENAL DISEASE

NAME OF PERSON COVERED:			MEDICARE HIC # (FROM MEDICARE CARD)
	MEDICARE A (HOSPITAL) EFFECTIVE DATE: MEDICARE B (MEDICAL) EFFECTIVE DATE: MEDICARE D (DRUG) EFFECTIVE DATE: MEDICARE D (DRUG) CARRIER:	END DATE: END DATE: END DATE:	

PLEASE INDICATE REASON FOR MEDICARE ELIGIBILITY: ☐ ENTITLED AGE ☐ ENTITLED DISABILITY ☐ END-STAGE RENAL DISEASE ☐ DISABILITY AND CURRENT RENAL DISEASE

LAST NAME	SOC. SEC. #	GROUP #

SECTION 8 — 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 ☐ 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 ☐ INDIVIDUAL HEALTH COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE	

SECTION 9 — 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 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).
- 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.
- 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

Non-Discrimination Notice

Health care coverage is important for everyone.

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Washington, DC 20201	Complaint Forms:	hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at bcbstx.com/legal-and-privacy/non-discrimination-notice

BlueCross BlueShield
of Texas

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.
中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.