

ENROLLMENT APPLICATION/CHANGE FORM



dearborn national

Group No.					
Group No.					

Section No.			
Section No.			

Dept No.		
Dept No.		

Social Security No.							
Category							

SECTION 1 — ENROLLMENT EVENTS		PLEASE CHECK ALL THAT APPLY — IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 10, & 11 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, 10, & 11)		<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
Mailing Address - Street - Apt No.		City	State
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)
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	
Health Coverage (select one) <input type="checkbox"/> PPO <input type="checkbox"/> HMO <input type="checkbox"/> Blue Options <input type="checkbox"/> BlueEdge HCA <input type="checkbox"/> BlueEdge HSA <input type="checkbox"/> HMO Consumer Choice Plan (small group only) <input type="checkbox"/> PPO Consumer Choice Plan (small group only) <input type="checkbox"/> EPO <input type="checkbox"/> Other: _____ Plan #, if known: _____		Health Enrollees (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	
Complete only if you are applying for HMO coverage: Primary Language: _____ <input type="checkbox"/> Check here to request a Spanish 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: _____		Dental Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No Plan No., if known: _____	
Dental Enrollees (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		Do you usually work at least 30 hours a week for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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, adopted child, or a child in Suit for Adoption? <input type="checkbox"/> Y <input type="checkbox"/> N	If not your natural child, stepchild, 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, adopted child, or a child in Suit for Adoption? <input type="checkbox"/> Y <input type="checkbox"/> N	If not your natural child, stepchild, 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, adopted child, or a child in Suit for Adoption? <input type="checkbox"/> Y <input type="checkbox"/> N	If not your natural child, stepchild, 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

SECTION 5 — GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D), AND DISABILITY INSURANCE COVERAGES	
Employee Occupation/Job Title: _____	Wage Rate \$ _____ per <input type="checkbox"/> hour <input type="checkbox"/> week <input type="checkbox"/> month <input type="checkbox"/> year
Group Basic Term Life & AD&D	<input type="checkbox"/> I do not apply <input type="checkbox"/> I do apply Amount \$ _____
Group Dependents' Life	<input type="checkbox"/> I do not apply <input type="checkbox"/> I do apply
Group Supplemental Life	<input type="checkbox"/> I do not apply <input type="checkbox"/> I do apply
Employee Election: \$ _____	Spouse Election: \$ _____ Child Election: \$ _____
Short Term Disability (STD)	<input type="checkbox"/> I do not apply <input type="checkbox"/> I do apply
Long Term Disability (LTD)	<input type="checkbox"/> I do not apply <input type="checkbox"/> 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.

Last Name:

Social Security No.:

Group #

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 — PREVIOUS HEALTH COVERAGE INFORMATION DO NOT COMPLETE IF APPLYING FOR HMO OR IN-HOSPITAL INDEMNITY COVERAGE

In order to receive credit for preexisting 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.

List names of every individual covered:

Previous Coverage Policyholder Name Birth Date (MM/DD/YYYY) Relationship to Applicant Group or Policy No. ID Number

SECTION 8 — 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 Name and Address of Other Insurance Carrier Effective Date (MM/DD/YYYY) Type of Policy

SECTION 9 — 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 10 — 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.

Name Employee Reason for Declining Health: Other Group Health Coverage; Carrier: Medicare Medicaid

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) or Fort Dearborn Life Insurance Company (FDL).

Applicant's Signature Date