Texas Association of Counties Health and Employee Benefits Pool

Enrollment Application/Change Form

Office Personnel Use Only
Processed in OASYS:
On: _____ By: _____
Worker's Comp Code:
_____

Employer Name: Bowie County Group Number: 275443

SECTION 1 – EMPLOYEE INFORMATION

Social Security	Date of Hire (MM/DD/YYYY)	First Name	MI	Last Name	Suffix

Birth Date (MM/DD/YYYY)	Gender: ☐Male ☐Female	Marital Status: ☐Single ☐Married	Employee Type: ☐Full-Time Active ☐Appointed or Elected Official

Mailing Address / Street – Apt No.	City	State	Zip Code

Home Phone	Cell Phone	Work Phone	Email Address

SECTION 2 – ENROLLMENT / CHANGES

☐New Enrollee Effective Date: _____/_____/_____

☐Retirement Effective Date: _____/_____/_____

☐Open Enrollment Effective Date: _____/_____/_____

☐Name/Address Change

☐Add Dependent: Event Date: _____/_____/_____

Status Change: ***Select event below to add dependent.***

- ☐Birth/Adoption/Guardianship
- ☐Marriage
- ☐Court Order (QMCSO)
- ☐Dependent Loses Other Coverage
- ☐Other (Explain): _____

CANCELLATION EVENTS

☐Terminate Employee (Last date worked_____/_____/_____)

☐Cancel/Waive Employee Health Coverage Effective Date: _____/_____/_____

☐Cancel Dependent: Health

List dependents to be cancelled in Section 4 & Select Status Change Event Below

Status Change: Event Date: _____/_____/_____

- ☐Death
- ☐Dependent Gains Other Coverage
- ☐Dependent Drops Coverage

(Only allowed for participants not enrolled in a cafeteria plan.)

- ☐Divorce

SECTION 3 – COVERAGE ELECTIONS - Check all that apply

Medical Plan	☐Employee Only ☐Employee + 1 Child ☐Employee + Children ☐Employee + Spouse ☐Employee + Family ***(Complete Section 4 to add dependents)***	☐Waive Medical Coverage ***(Complete Section 8)***

SECTION 4 – DEPENDENT INFORMATION - Please fill out all dependents for medical coverage.

	Coverage Type	Relationship	Social Security No.	First Name	MI	Last Name	Date of Birth	Gender
☐Add ☐Drop	Medical	Spouse						☐Male ☐Female
☐Add ☐Drop	Medical	Child/Other Eligible Dep.						☐Male ☐Female
☐Add ☐Drop	Medical	Child/Other Eligible Dep.						☐Male ☐Female
☐Add ☐Drop	Medical	Child/Other Eligible Dep						☐Male ☐Female
☐Add ☐Drop	Medical	Child/Other Eligible Dep.						☐Male ☐Female

Group No. | Section No. | Social Security No.

SECTION 5 – DISABLED DEPENDENT (If applicable)

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 6 – OTHER COVERAGE INFORMATION (If applicable)

For Coordination of Benefits (COB), complete this section only if you or any of your covered dependents have health and/or dental coverage ***that will not be cancelled*** when the coverage under this enrollment becomes effective.

Group Coverage ☐Yes ☐No	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy: ☐Employee Only ☐Employee / Spouse ☐Employee / Child(ren) ☐Employee / Family
Name of Policyholder	Date of Birth (MM/DD/YYYY)	Gender: ☐Male ☐Female	Relationship to Applicant: ☐Self ☐Spouse ☐Dependent

Employer's Name	Employment Date (MM/DD/YYYY)	Health Group No.	Health ID No.	Dental Group No:	Dental ID No.

SECTION 7 – MEDICARE COVERAGE INFORMATION Complete this section (If applicable)

Name of person covered Medicare HIC No. (from Medicare Card)	☐Medicare A(Hospital) Effective Date: _____ ☐Medicare B (Medical) Effective Date: _____ ☐Medicare D (Rx) Effective Date: _____ RX Carrier: _____	Please indicate reason for Medicare Eligibility: ☐Entitled Age ☐Entitled Disability ☐End-Stage Renal Disease ☐Disability & Current Renal Disease

SECTION 8 – DECLINATION OF COVERAGE Complete this section (if applicable)

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 dependent(s) and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage later, I understand there may be a delay in the effective date of the coverage.

Employee Name	Reason for Declining Health: ☐Other Group/Individual Health Coverage ☐Medicare ☐Medicaid ☐I am not enrolled in any Health insurance plan, but do not want this coverage. ☐Other _____
Spouse Name	Reason for Declining Health: ☐Other Group/Individual Health Coverage ☐Medicare ☐Medicaid ☐I am not enrolled in any Health insurance plan, but do not want this coverage. ☐Other _____
Child(ren) Name	Reason for Declining Health: ☐Other Group/Individual Health Coverage ☐Medicare ☐Medicaid ☐I am not enrolled in any Health insurance plan, but do not want this coverage. ☐Other _____

SECTION 9 – COVERAGE CONDITIONS AND AUTHORIZATION

- 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 Texas Association of Counties Health and Employee Benefits Pool (TACHEBP) / Blue Cross and Blue Shield of Texas (BCBSTX). 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 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 my coverage begins on the effective date assigned by my employer, provided I am actively at work.

Applicant's Signature_____Date_____

BlueCross BlueShield of Texas