



## Group Enrollment Application/Change Form

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



**BlueCross BlueShield**  
of Texas



**FORT DEARBORN LIFE**  
*Insurance Company*

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# 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 you are adding or enrolling a dependent due to court order, you must submit a copy of the court order or decree AND a completed Dependent Addition and Change Form for Court-Mandated Health Coverage.
- If student dependent coverage is part of your employer's plan and you are adding or enrolling a dependent child 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 child over the dependent age limit of your employer's plan, you are required to submit a completed Dependent Child's Statement of Disability form. A disabled dependent over the dependent age limit of your employer's plan must be certified by medical underwriting.

**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) canceling.

## SECTIONS 2&3

Complete all areas that apply to you.

## SECTION 4

Complete all areas that apply to you and each dependent. Only those applying for HMO or POS coverage should then 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](http://www.bcbstx.com). Be sure to check the appropriate box for a new patient. Only HMO Blue Texas members that are applying for certain dental plans are required to select a Primary Care Dentist (PCD). **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.

## SECTION 5

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

## SECTION 6

Complete this section unless you are applying for HMO or In-Hospital Indemnity coverage.

## SECTION 7

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.

## 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 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.

## 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, 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 the 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**

Forms referenced above may be obtained by accessing the BCBSTX website at [www.bcbstx.com](http://www.bcbstx.com), from your Marketing Service Representative, or from your employer. If you have any questions, please contact your Marketing Service Representative.



Last Name:

Social Security Number:

H Group #

SECTION 6 — PREVIOUS COVERAGE INFORMATION

Do NOT COMPLETE IF APPLYING FOR HMO OR IN-HOSPITAL INDEMNITY COVERAGE

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.

List names of every individual covered:

Form with fields for Name of Primary Enrollee, Date of Birth, Gender, Relationship to Applicant, Group or Policy No., ID Number, Employer's Name, Employment Date, Effective Date, Will Coverage be Continued?, If No, Expected Cancel Date, Type of Coverage, Type of Policy.

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:

Form with fields for Type of Coverage, Group Coverage, Name and Address of Other Health Care Company, Name of Policyholder, Date of Birth, Gender, Relationship to Applicant, Type of Policy, ID Number, Employment Date, Effective Date of Coverage, Group or Policy Number, Employer's Name.

SECTION 8 — MEDICARE COVERAGE INFORMATION

Form with fields for Name of person covered, Medicare HIC# (from ID card), Medicare Part A (hospital), Medicare Part B (medical), Medicare Part D (prescription drugs), Start Date, End Date, Address, City, State.

Check reason for Medicare eligibility: Entitled age, Entitled disability, End-stage renal disease, Disability and current renal disease

Form with fields for Name of person covered, Medicare HIC# (from ID card), Medicare Part A (hospital), Medicare Part B (medical), Medicare Part D (prescription drugs), Start Date, End Date, Address, City, State.

Check reason for Medicare eligibility: Entitled age, Entitled disability, End-stage renal disease, Disability and current renal disease

SECTION 9 — DISABLED DEPENDENT

Form with fields for Name of disabled dependent, Nature of disability, Has disability been diagnosed as permanent?, If temporary, how long is dependent expected to remain disabled?, Is dependent unable to work due to the 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 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.

Form with fields for Employee, Spouse, Child(ren), 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) or Fort Dearborn Life Insurance Company (FDL).
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 Contracts(s)/Plan(s).
I understand that the Health coverage for which I am applying may have a pre-existing condition exclusion waiting period.
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).
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 binding upon me.

Applicant's Signature Date