H 048092 Group # | Section # | Dept # | Social Security Number

Group # | Section # | Dept # | Category

ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Texas

FORT DEARBORN LIFE Insurance Company — A Member of The Preferred Financial Group

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2 AND 10 ONLY.

☑ New Enrollee ☐ Add Dependent
Are you applying as a result of a Special Enrollment Event? ☐ Yes ☒ No If yes, select Event: ☐ Marriage ☐ Birth, Adoption, Suit for Adoption ☐ Court Order (see instructions) ☐ Loss of Other Coverage (provide Certification of Coverage) ☐ Other (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) Reason: ____________

☐ Change Primary Care Dentist (PCD) Reason: ____________

☐ Change Address/Name

☐ Cancel Enrollee ☐ Cancel Dependent
List names of those canceling in Section 4 below
Event: ☐ Divorce ☐ Death ☐ Terminated Employment ☐ Other

Indicate Event Date: ___/___/___

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

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

Last Name	First Name	MI (opt)	Suffix	Date of Birth	Social Security Number
Andrews	Ross	B		06/02/1982	462-59-9466

Mailing Address - Street - Apt#	City	State	Zip
4500 Ave. H	Austin	TX	78751

E-Mail Address (opt)		Business Phone #	Home Phone #
	☒ Male ☐ Female	512-410-0226	same

Name of Employer	Date of Employment	Do you usually work at least 30 hours a week for this employer?
Safe kick inc.	01/18/2010	☒ Yes ☐ No

Eligibility Status: ☒ Active Employee ☐ Retired Employee - Date of Retirement: ____________ ☐ COBRA Continuation ☐ Continuation of Group Coverage (insured plans only) ☐ Dependent Continuation of Group Coverage (insured plans, only)

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Health (select one)
☑ PPO ☐ HMO
☐ BlueEdge HCA ☐ BlueEdge HSA
☐ HMO Consumer Choice Plan (small group only)
☐ PPO Consumer Choice Plan (small group, only)
☐ Other: ____________
Plan #, if known: ____________

Enrollees (select one)
☒ Employee Only
☐ Employee /Spouse
☐ Employee /Child(ren)
☐ Family
☐ I am not applying for health coverage

Dental
☐ Yes
☐ No
Plan #, if known: ____________

Enrollees (select one)
☐ Employee Only
☐ Employee /Spouse
☐ Employee /Child(ren)
☐ Family
☐ I am not applying for dental coverage

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
If "Yes", 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 OPTION ONLY.

Employee/Enrollee's Name	PCP Name	PCP No.	New Patient? ☐ Y ☐ N	PCD Name	PCD No.	New Patient? ☐ Y ☐ N
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, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D), AND DISABILITY INSURANCE COVERAGES

Employee Occupation/Job title: Developer Wage rate $ 77 000 per ☐ hour ☐ week ☐ month ☒ year

Group Basic Term Life & 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 (STD)	☐ I do not apply	☐ I do apply	
Long Term Disability (LTD)	☐ I do not apply	☐ I do apply	

	First Name	Initial	Last Name	Relationship	Date of Birth	Social Security No.
Primary Beneficiary						
Contingent Beneficiary						